~~B-120544~~
120544

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Improving Medicare And Medicaid Systems To Control Payments For Unnecessary Physicians' Services

Some services provided to Medicare and Medicaid recipients by physicians or suppliers are medically unnecessary and, under the law, should not be paid for by these programs. This report discusses the systems to identify, prevent, or recover payments for unnecessary services and describes how they can be improved to reduce program costs.

120544

GAO/HRD-83-16
FEBRUARY 8, 1983

024585

Request for copies of GAO reports should be sent to:

U.S. General Accounting Office
Document Handling and Information
Services Facility
P.O. Box 6015
Gaithersburg, Md. 20760

Telephone (202) 275-6241

The first five copies of individual reports are free of charge. Additional copies of bound audit reports are $3.25 each. Additional copies of unbound report (i.e., letter reports) and most other publications are $1.00 each. There will be a 25% discount on all orders for 100 or more copies mailed to a single address. Sales orders must be prepaid on a cash, check, or money order basis. Check should be made out to the "Superintendent of Documents".

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-207363

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses efforts under Medicare and Medicaid to contain program costs for medically unnecessary services and the actions that the Department of Health and Human Services should take to improve program operation and administration. We made this review because of indications that the medical necessity of services provided by physicians and suppliers to Medicare and Medicaid beneficiaries was not adequately examined.

We are sending copies of this report to the Chairman, Subcommittee on Oversight, House Committee on Ways and Means; the Director, Office of Management and Budget; and the Secretary of Health and Human Services.

Charles A. Bowsher

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

IMPROVING MEDICARE AND MEDICAID SYSTEMS TO CONTROL PAYMENTS FOR UNNECESSARY PHYSICIANS' SERVICES

D I G E S T

Controls over health care costs can be improved through more effective Medicare and Medicaid utilization review systems to identify, prevent, or recover payments for unnecessary physicians' services. A comprehensive system for monitoring the utilization of physicians' services detects medically unnecessary services before and after payment has been made.

With the aid of computerized edits or checks to limit the number of claims requiring manual review, reviewers can prevent the payment of some medically unnecessary services by determining whether they are appropriate, given the patient's diagnosis and claims history. Payments for other medically unnecessary services may be recouped after postpayment reviews of providers whose patterns of practice differ significantly from those of their peers.

GAO made this review because of (1) its long-term commitment to focus on areas that offer high potential for budgetary savings and (2) indications that utilization reviews of services provided by physicians and suppliers to Medicare and Medicaid beneficiaries did not receive the attention they deserve.

At the Federal level, the Department of Health and Human Services' Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs. HCFA is responsible for assuring that its Medicare contractors--called carriers--and the State agencies administering Medicaid operate utilization review programs in compliance with Federal law and regulations.

MEDICARE PROGRAM

The nine Medicare carriers GAO visited supplied information which showed that their prepayment utilization review activities were cost beneficial, but the performance in terms of cost/benefit ratios and other indicators varied widely. Those making more extensive use of automated edits to identify unnecessary services generally performed better and saved comparatively more Medicare program dollars.

Of the 20 most productive edits in use by the carriers visited, only 5 were being used by all of them. The experiences of the carriers using the other 15 edits indicate that another $3 million to $9 million a year could be saved if all nine carriers were to implement these edits. Of course, these estimates depend on several variables, such as the way the edits are implemented and the reviewers' effectiveness in identifying and denying claims for medically unnecessary services. (See pp. 12 to 17.)

There are also opportunities for increased effectiveness in the carriers' postpayment utilization review activities. While these activities have a deterrent effect that GAO could not determine, considering only the measurable savings (recoveries of payments for unnecessary services) postpayment utilization review was not cost beneficial at six carriers and was about breaking even at the other three. Whether postpayment review can be made to be cost beneficial at all carriers is uncertain, but GAO identified a number of changes that could improve the low cost/benefit ratios experienced. (See p. 25.)

Impediments to effective utilization review

HCFA's policies and practices have tended to provide disincentives to carriers for performing effective prepayment utilization review. It judged carriers' performance largely on how fast claims are processed and how well administrative costs are minimized. Carriers were required to include utilization review costs and the time to do utilization review in computing their average unit costs and processing times, but did not get credit for the savings realized. (See p. 19.) In evaluating carriers' utilization review activities, HCFA has focused on verifying the existence of processes that are assumed to be productive, rather than determining whether these processes are cost beneficial. (See pp. 17 to 21 and 34 to 36.)

A further impediment was that, in response to fiscal year 1982 budget constraints, HCFA officials said they had no choice but to direct significant cuts in carriers' utilization review budgets. This action could result in program payments of millions of dollars for unnecessary medical services, while saving much less in administrative costs. However, a recent act

provided for the funding in fiscal years 1983-85 of utilization review activities. (See pp. 21 and 22.)

Medicare carriers are incurring extraordinary costs to continually review the claims of habitual overutilizers. In some cases HCFA had declined to use its authority to exclude habitual overutilizers when exclusion action appeared warranted. Since obtaining exclusion authority in 1975 and through September 1982, HCFA had excluded only 2 dozen providers for reasons other than being convicted of defrauding Medicare or Medicaid, and only a few of the dozen GAO reviewed could have been excluded primarily for overutilization. (See p. 42.)

MEDICAID PROGRAMS

Only 3 of the 11 State Medicaid programs GAO visited used automated prepayment edits to detect possible overutilization. Only one of these programs could provide enough information for GAO to estimate the costs and benefits of prepayment utilization review operations in Medicaid. This program showed a savings of $5 in medical necessity denials for every $1 spent on this activity--a cost/benefit ratio that was close to the overall $7 to $1 ratio experienced by the Medicare carriers reviewed. (See p. 55.)

Regarding postpayment utilization review, some States generated reports which identified instances of possible overutilization, but GAO could identify few tangible benefits resulting from medical necessity issues raised through this activity. (See p. 57.)

The Congress has given the States financial incentives to develop effective utilization review programs. One incentive provides for higher than usual Federal sharing in the cost of operating a qualified automated information system. However, HCFA has not implemented this provision to focus on the benefits being obtained in return for the additional money being provided.

Another incentive provides for increased payments to States that can demonstrate tangible monetary results from their utilization review efforts. However, only 1 of the 11 States

visited was able to identify the costs and benefits associated with this activity--a necessary capability to order to attempt to qualify for the increased payments.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO made nine recommendations to the Secretary to improve utilization review activities within the Medicare and Medicaid programs. In its comments the Department generally concurred with GAO's recommendations and said it was in various stages of implementing them. (See pp. 23, 37, 46, 61, and app. IV.)

GAO also received comments from Medicare carriers and Medicaid agencies discussed in this report. The respondents generally agreed that improvements are needed in Medicare and Medicaid systems to identify, prevent, or recover payments for unnecessary services. (See apps. V and VI.)

Contents

ABBREVIATIONS

ACER	Annual Contractor Evaluation Report
CPEP	Contractor Performance and Evaluation Program
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
ITPIL	Initial Three Percent Investigation List
MMIS	Medicaid Management Information System
OIG	Office of Inspector General
OMB	Office of Management and Budget
PSAF	Physician/Supplier Action File
PSRO	Professional Standards Review Organization
SURS	Surveillance and Utilization Review Subsystem
UR	Utilization Review

CHAPTER 1

INTRODUCTION

This review was undertaken as part of our long-term commitment to focus audit resources on areas that offer high potential for budgetary savings. It was based on indications that the review of the medical necessity of services provided by physicians and suppliers (such as independent laboratories, ambulance, and medical equipment companies) and paid for under the Medicare and Medicaid programs does not receive enough attention in program operations and in performance evaluations of entities processing claims for such services.

We studied the mechanisms the Medicare and Medicaid programs have to identify claims for those services provided by physicians and suppliers that are judged not medically necessary. These control mechanisms are hereafter referred to as "utilization review" (UR). Mechanisms used to assure the medical necessity of services provided by hospitals, nursing homes, and other institutional providers are not covered in this report. Therefore, unless otherwise indicated, the term "provider" as used in this report refers to physicians and other noninstitutional providers.

Titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 and 1396), enacted on July 30, 1965, established the Medicare and Medicaid programs to help eligible participants pay the costs of health care services.

Under Medicare, eligible persons, usually those who are disabled or over age 65, may receive two basic forms of protection:

--Part A, Hospital Insurance Benefits, covers inpatient hospital services and posthospital care in skilled nursing facilities and in the patients' homes. Benefits paid are principally financed by social security taxes collected from employees, employers, and self-employed persons. During fiscal year 1981 about 28 million people were enrolled for part A benefits, and benefit payments were about $29 billion.

--Part B, Supplementary Medical Insurance Benefits, a voluntary program, covers physicians' services, outpatient hospital care, and a number of other medical costs. Benefits paid are financed by premiums collected from enrollees and by appropriations from general revenues. During fiscal year 1981 an estimated 27 million people were enrolled for part B benefits, and benefit payments were about $12 billion. Medicare

reimburses the beneficiary or the provider 80 percent of what the program determines is the "reasonable charge"[1] (20-percent coinsurance is paid by the beneficiary) after the beneficiary incurs $75 in covered expenses a year (the deductible).

Under Medicaid, a grant-in-aid program, the Federal Government shares with the States the costs of providing medical assistance to persons whose incomes and resources are insufficient to pay for health care. Medicaid programs can cover two groups of people. The first group generally covered is the "categorically needy," which includes those who are eligible to receive cash assistance under either the Supplemental Security Income program or the Aid to Families with Dependent Children program. The second group is the "medically needy," which includes persons whose income and/or resources are too high to be eligible for cash assistance, but too low to pay for their medical care. All States cover the categorically needy, and as of March 1982, 29 States and 5 jurisdictions[2] were covering the medically needy.

During 1981, according to the President's 1983 Budget, State and Federal Medicaid payments were about $28.8 billion on behalf of about 22 million recipients. The Federal share of this amount was about $16.2 billion.

ADMINISTRATION OF THE MEDICARE AND MEDICAID PROGRAMS

The Department of Health and Human Services (HHS) has overall responsibility at the Federal level for administering Medicare and Medicaid. Within HHS, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and assuring compliance with Federal legislation and regulations for both programs.

HCFA contracts with Blue Shield plans and commercial insurance companies to act as "carriers" in the administration of benefits provided by noninstitutional providers under part

---

[1]The "reasonable charge" is the lowest of (1) the actual charge the physician or supplier bills for the service, (2) the charge the provider usually bills most patients for the same service, or (3) the prevailing charge for the same service by all the physicians or suppliers in the same geographic area (with certain limitations).

[2]The District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

B of the Medicare program. The carriers' responsibilities include

--processing and paying claims;

--determining the "reasonable charge" for services provided;

--assuring that payments to physicians and suppliers are only for covered and medically necessary services;

--forwarding cases of habitual overutilization or other abuse to HCFA for sanctioning or other administrative action; and

--forwarding cases where provider fraud is suspected to HCFA, which forwards cases it considers to warrant full-scale investigation to the Office of Investigations in HHS' Office of the Inspector General.

The States are responsible for initiating and administering their Medicaid programs. The nature and scope of a State's Medicaid program are contained in a State plan which, after approval by HHS, provides the basis for Federal grants to the State. Although some States administer the entire program through their State agencies, others contract with private organizations to help administer their programs. The responsibilities assigned to the contractors, called "fiscal agents," vary depending on the contractual arrangements established by the States. All of the States have adopted Medicaid programs.[3] Depending on the State's per capita income, the Federal Government pays from 50 to 78 percent of the costs incurred by the States under their Medicaid programs.[4]

THE COSTS OF PHYSICIAN SERVICES

Payment for physicians' services under Medicare increased from $2.7 billion in fiscal year 1974 to $8.8 billion in fiscal year 1981. This represented about 21 percent of total Medicare benefit payments during 1981. Medicaid payments for

---

[3]Arizona was the last State to adopt a Medicaid program. Its program is being operated under a waiver of certain Federal requirements.

[4]Under section 2161 of Public Law 97-35 (Omnibus Budget Reconciliation Act of 1981), the amount of Federal participation will be reduced by 3 percent in 1982, 4 percent in 1983, and 4.5 percent in 1984, with the provision that such reductions can be restored under certain conditions.

these services increased from $1.1 billion to $2.1 billion during the same period, representing about 7 percent of total Medicaid payments to all institutional and noninstitutional providers during fiscal year 1981.

The Medicare and Medicaid programs are to provide quality care to eligible beneficiaries, and the law requires that payments be made only for medically necessary services. The program statutes prohibit payment for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury. Therefore, carriers and States are required to establish UR safeguards to assure that payments--including payments to physicians and suppliers--are made only for medically necessary services.

Some officials believe that the number of physicians who provide a substantial amount of unnecessary medical services to patients may represent a small part of the total medical community. Nevertheless, most agreed that efforts to prevent and recover payments for medically unnecessary services are both necessary and worthwhile.

MEDICARE AND MEDICAID EFFORTS TO CONTROL OVERUTILIZATION

To prevent and recover payments for medically unnecessary services, evaluations can be made both before payment of a claim (called prepayment UR)--emphasizing the avoidance of an inappropriate payment--and after payment of a claim (called postpayment UR)--emphasizing the analysis of paid claims data to identify physicians and suppliers with unusual patterns of service.

What is prepayment UR?

Prepayment utilization review is intended to detect excessive or unnecessary medical services before claims are paid. In most cases, the review is beneficiary-specific, which means that the claims are evaluated for medical necessity in terms of a particular beneficiary's current diagnosis and past claims history. In other cases, however, prepayment review is applied to all or certain types of claims of a particular physician or supplier who has been identified as a chronic overutilizer or misutilizer of services.

Prepayment UR provides for the manual or automated identification of claims to be suspended from normal automated processing for closer manual scrutiny because they exceed certain established criteria or have other unusual characteristics.

Because such manual review adds to the time and cost of processing claims, parameters are established for each computer edit or check to limit the number of claims requiring such review. For example, the parameter for an edit relating to physician office visits may be set at four visits per month per beneficiary; this means that claims would suspend for manual review only when a beneficiary had at least five office visits during a 30-day period. In effect, the parameters limit the number of claims requiring manual evaluation and focus attention on services that are most likely to be unnecessary.

After a manual review of such claims, which may include a request for additional information, the carrier or paying agent decides whether to pay, deny, or reduce the amounts claimed. A claim for services may be denied because (1) they are considered unwarranted given the patient's diagnosis (misutilization) or (2) although consistent with the diagnosis, they were rendered too frequently and, thus, are considered excessive (overutilization).

What is postpayment UR?

Postpayment review is a carrier's or paying agent's principal means of identifying doctors or suppliers who misutilize or overutilize Medicare or Medicaid services on a practicewide basis. Thus, it differs from prepayment review in that it focuses on providers and their pattern of practice rather than the services rendered to specific beneficiaries. Because of the capability of the postpayment UR process to identify payments for medically unnecessary services that have gone undetected by even the best prepayment UR system, HCFA considers it a desirable and necessary complement to prepayment UR.

Unlike Medicaid, under which the States have considerable flexibility in operating their postpayment UR programs, HCFA has established certain postpayment review requirements for the Medicare carriers. For example, the carriers are required by the Medicare Carriers Manual to give a preliminary review of the practices of 3 percent of their providers who exceed the "norms" of their peer group. This exercise is known as the Initial Three Percent Investigation List (ITPIL).[5] A provider is determined by a computer analysis to exceed the "norm" for a particular service or medical procedure if he or she provides more services per 100 patients than 97.5 percent of the practitioners in his or her peer group.

---

[5]As a result of fiscal year 1982 budget constraints, the application of this requirement was at least temporarily relaxed.

According to the Medicare Carriers Manual, the carrier personnel have 1 year to begin action regarding providers on the initial list. Carriers may decide from their preliminary reviews that no further action is needed if a provider exceeded the norm simply because he or she was placed in an inappropriate peer group. Providers not eliminated from further consideration during preliminary reviews are subject to being selected for further investigation and possibly a full-scale review (a review of all claims for 15 selected beneficiaries for at least a 6-month period). The Manual states that carriers should consider those providers exceeding the "norm" for the greatest number of categories and those who exceed the "norms" by a large extent when selecting providers for a full-scale review. If problems such as overutilization are detected, the carrier is to take "appropriate corrective action," which includes (1) contacting the provider, (2) reviewing some or all of the provider's future claims before payment, (3) referring the provider to a professional peer organization for further review, and/or (4) determining an overpayment and recovery action to the extent that the provider has accepted assignment.[6] If fraud is suspected, the carrier is to forward the case to the HCFA regional office, which is to forward cases having a strong potential for fraud and warranting a full-scale investigation to HHS' Office of Investigations.

DIFFICULTIES IN OPERATING UR PROGRAMS

Program officials told us that, to be effective, a UR group must overcome the difficulties and frustrations associated with identifying provider overutilization or misutilization. These include

--the subjective nature of the determination,

--the time it takes to complete the determination, and

---

[6]Under Medicare law, physicians and suppliers may choose on a claim-by-claim basis whether to take assignment. If the provider accepts assignment, the beneficiary transfers to the physician his or her right to reimbursement for covered Medicare services. The physician in return agrees to accept the reasonable charge determined by the Medicare carrier as his full charge for the services. If the provider does not accept assignment, the beneficiary is responsible for paying the physician his or her full charge for the services and requesting reimbursement from the Medicare carrier, which bases payment on Medicare's "reasonable" charge.

--the need to defend the determination if the provider appeals.

More specifically, a wide range of medical services may be appropriate for a given diagnosis, and complex medical judgments may be required to assess their necessity. Patterns of overutilization often must be established through time-consuming reviews of samples of patient records and through evaluations of sometimes unreliable statements by elderly and sick patients. Additionally, providers do not always allow access to the necessary records and may disagree with medical necessity determinations, thereby requiring arbitration by local medical societies or other independent bodies.

Finally, providers may sometimes pass on to Medicare patients the cost of services determined to be medically unnecessary. If the provider refuses to accept assignment, the beneficiary is responsible for paying the provider and must claim reimbursement from the Medicare program. In cases where beneficiaries have been reimbursed for services determined to be medically unnecessary during postpayment reviews, Medicare routinely does not seek recovery.

OBJECTIVES, SCOPE, AND METHODOLOGY

This review was made to assess the mechanisms that paying agents under the Medicare and Medicaid programs are using to identify and prevent reimbursement to physicians and suppliers for medically unnecessary services and to recoup payments determined to have been made for such services. We focused on three objectives:

--To assess and compare the costs and benefits of the prepayment and postpayment utilization review functions at a representative number of carriers and State Medicaid agencies.

--To identify probable causes for the variations in the performance of these UR functions.

--To evaluate HCFA's role (particularly under Medicare) in providing direction to these activities.

This review was performed in accordance with generally accepted government auditing standards. It was made at HCFA headquarters in Woodlawn, Maryland; at HCFA regional offices in Boston, Philadelphia, Chicago, and Atlanta; at 9 Medicare carriers; and at 12 State Medicaid agencies or their fiscal agents. The locations were selected to allow the review of

(1) large, medium, and small Medicare carriers and State Medicaid programs and (2) both Blue Shield and commercial health insurance companies serving as Medicare carriers. The following Medicare carriers and State Medicaid programs were selected for review:

State	Medicare carriers
Connecticut	Connecticut General Life Insurance Company
Indiana	Mutual Medical Insurance, Inc. (Indiana Blue Shield)
Kentucky	Metropolitan Life Insurance Company[7]
Maine	Blue Shield of Massachusetts, Inc.
Maryland	Blue Shield of Maryland, Inc.
Massachusetts	Blue Shield of Massachusetts, Inc.
New Hampshire	New Hampshire-Vermont Health Service (Blue Shield)
Ohio	Nationwide Mutual Insurance Company
Pennsylvania	Pennsylvania Blue Shield
Rhode Island	Blue Shield of Rhode Island
Vermont	New Hampshire-Vermont Health Service (Blue Shield)
West Virginia	Nationwide Mutual Insurance Company

At each location we visited (except for the Pennsylvania State Medicaid Agency[8]) we attempted to (1) identify and evaluate the prepayment and postpayment utilization review activities in use; (2) identify the cost of operating these

---

[7]Effective October 1, 1982, Blue Cross and Blue Shield of Kentucky replaced Metropolitan as the Medicare carrier for that State.

[8]Pennsylvania's UR controls were not evaluated because the State switched to an automated management information system during our review.

activities, together with any associated dollar benefits (prepayment denials and/or overpayments identified and collected by postpayment review); and (3) determine the positive or negative influence the associated HCFA regional office had on the UR operations. Also, we assessed the extent to which sanctions were used against habitual overutilizers.

CHAPTER 2

ADDITIONAL MEDICARE DOLLARS COULD BE SAVED IF INCREASED EMPHASIS WERE PLACED ON PREPAYMENT UTILIZATION REVIEW

The nine carriers we reviewed saved millions of dollars in Federal payments, but we believe they could save substantially more if they used additional prepayment UR edits. For the annual periods studied, all of the carriers saved more money than they spent in this activity, but carriers' performance varied widely in terms of (1) cost/benefit ratios, (2) denials based on workloads, and (3) the number and type of automated edits used. This suggests to us that expanding this activity--particularly at carriers with comparatively poor performance indicators and a minimal UR effort--should result in significant additional savings.

HCFA's system for evaluating carrier performance has tended to act as a disincentive to performing more effective prepayment UR. The performance standards HCFA used were aimed at determining whether prepayment UR processes were in place, but not whether they were cost beneficial. Moreover, other HCFA standards relating to administrative cost per claim processed and claim processing times discouraged carriers from going beyond the minimum UR effort required by HCFA. In addition, because budget constraints during 1982 related to Medicare administrative costs (as opposed to benefit payments), carrier UR efforts have been further curtailed.

PREPAYMENT REVIEW IS COST BENEFICIAL

The savings realized through prepayment review more than offset the associated costs. At eight of the carriers visited, an average of over $7 was saved for each $1 spent. The remaining carrier (Metropolitan) gave us information which strongly suggested that its prepayment review operations were cost beneficial but was unable to provide enough information for us to compute a reliable cost/benefit ratio. The specific 1-year time period considered varied by carrier, ranging from fiscal year 1979 for the five carriers in HCFA's Boston region to the year ended June 30, 1981, for Blue Shield of Maryland. Because HCFA does not require that the costs of prepayment UR be reported separately, we had to develop the costs. We also obtained claims volumes from carrier reports to HCFA in order to determine if there were significant differences in the average amount of prepayment costs and denials based on the number of claims processed for the periods considered. The following table shows the results of our analyses.

Cost/Benefit Analysis of Carriers' Prepayment UR Operations

Carrier	Annual claims volume	Prepayment review cost		Prepayment denials (note a)		Cost/ benefit ratio
		Total	Per claim processed	Total	Per claim processed	
Blue Shield of Massachusetts (Mass) (note b)	4,638,838	$400,954	$0.09	$4,552,169	$0.98	1:$11.35
Blue Shield of Massachusetts (Maine) (note b)	699,969	48,114	.07	538,048	.77	1: 11.18
Nationwide (OH/WV)	7,227,939	249,837	.03	1,903,367	.26	1: 7.62
Pennsylvania Blue Shield	8,263,096	715,316	.09	5,352,140	.65	1: 7.48
Indiana Blue Shield	2,561,074	143,963	.06	845,412	.33	1: 5.87
Connecticut General	1,997,363	95,194	.05	357,811	.18	1: 3.76
New Hampshire-Vermont Blue Shield	1,022,439	45,840	.04	152,865	.15	1: 3.33
Blue Shield of Maryland	1,656,682	105,922	.06	193,115	.12	1: 1.82
Blue Shield of Rhode Island	1,161,370	24,640	.02	35,008	.03	1: 1.42
Metropolitan (KY)	1,742,618	(c)		(c)	(c)	(c)
Total		$1,829,780		$13,929,935		1: 7.61

a/Denials attributed to prepayment UR for computing cost/benefit ratios are net of certain amounts discussed below.

b/The Massachusetts and Maine portions were analyzed separately because, unlike the other multi-State carriers we reviewed, reviews of claims from providers in Maine were made by different personnel than those handling claims from Massachusetts providers. Also, the Maine work was being carried out under a contract that the carrier won through competitive bidding, while the Massachusetts work was being performed under a cost-reimbursement-type contract.

c/This carrier was not able to provide enough information for us to estimate its costs and benefits.

The amounts attributable to prepayment denials for computing cost/benefit ratios do not include certain amounts. First, prepayment denials associated with habitual overutilizers whose claims were identified for special handling were

excluded[1] because these denials could not reasonably be attributed to the routine prepayment UR edits. Second, denials do not include the 20-percent coinsurance amounts, which are the beneficiary's responsibility. Third, denials do not include reasonable charge reductions, on the assumption that if the charge for the claimed service had not been denied as medically unnecessary, it probably would have been reduced anyway to recognize Medicare's reasonable charge criteria, which for the carriers and periods analyzed ranged from 13 to 28 percent of the submitted charges.

Even after these adjustments, prepayment savings ranged from $1.42 to $11.35 for each $1 spent on prepayment utilization review at the carriers we analyzed. Also, the net amount of denials in terms of workload ranged from 3 to 98 cents per claim processed. Inconsistencies in carrier-provided data account for some of the performance differences. For example, many carriers were unable to segregate or identify cost elements we requested, and the information provided constituted their "best estimates," which may have varied in preciseness. Also, prepayment denial amounts shown for the carriers covering Massachusetts, Maine, Pennsylvania, and Maryland exclude any reversals due to appeals, whereas prepayment denial amounts shown for the remaining carriers do not take these reversals into account. We were able to compute the percentage of prepayment denials reversed after appeals by providers for three carriers and noted that reversals after appeals totaled only about 6 percent of the initial denials. Even after taking these inconsistencies into account, we believe that prepayment savings reported by the carriers we visited would vary greatly because of differences in the level of their UR activities and that at least some of the carriers have considerable room for improvement.

The following sections discuss (1) the number and types of the more effective automated UR edits used by the nine carriers visited, (2) the disincentives for prepayment UR contained in HCFA's contractor evaluation processes, and (3) the recent contractor budget cuts that focused on this cost-beneficial carrier activity.

PREPAYMENT REVIEW SHOULD SAVE MORE

Although all carriers must comply with the same basic HCFA prepayment UR requirements, the nine carriers we visited differed greatly in the number and type of edits used. To determine what the effects of maximizing the use of prepayment

---

[1]The cost of these denials, however, were not excluded in some cases because they could not be segregated.

edits would be, we compared the automated prepayment utilization edits used at each location and identified a core group of edits which at least one of the carriers used to make substantial denials.[2] A brief description of what each core group of edits does is contained in appendix I.

Denials attributable to the edits we identified totaled $17.7 million during a recent year for the carriers reviewed. Unlike the prepayment denial amounts shown on page 11, this total does not eliminate coinsurance or reasonable charge reductions. Also, because more recent information on denials for some of the carriers was available than was available in compiling our cost/benefit analysis, the same years were not necessarily used for both that analysis and the denials attributed to specific edits. The following table shows the carriers that used the core edits, the amounts they denied for various 1-year periods between October 1979 and September 1981, and that only 5 of the 20 edits we identified were used by all carriers.

---

[2]We defined our core group of edits as the edits that were used to deny $100,000 or more before taking into account coinsurance and reasonable charge reductions, but after adjustment to offset differences in claims volume. For example, Indiana Blue Shield used its routine foot care edit to deny $45,945 which, after extrapolating to the carrier with the highest claims volume, would total $148,237. We, therefore, considered this edit as one which was used to make substantial denials.

Denials by Carriers During a Recent Year for Core Edits (note a)

Automated prepayment UR edits	Blue Shield carriers covering							Ct. Gen.	Metro-politan (KY)	Nation-wide (OH/WV)	Total
	Ind	Md	Mass	Maine	NH/VT	Pa	RI				
	(000 omitted)										
Hospital visits/time period	No	$126	$4,091	$254	b/	$ 614	c/	b/	$319	$ 86	$5,490
Concurrent care	$633	No	1,217	258	$ 62	1,577	b/	$186	2	No	3,935
Postoperative care	92	No	388	78	160	304	b/	b/	914	No	1,936
Hospital visits per claim	No	No	No	No	No	647	No	No	No	540	1,187
Chiropractic treatments	62	7	No	No	55	390	c/	c/	c/	437	951
Nursing home visits	b/	b/	171	23	60	186	$14	80	54	331	919
Medical charges	No	No	368	No	No	504	No	No	No	c/	872
Office visits	42	9	57	2	39	92	6	73	b/	40	360
Lab services	27	c/	1	No	No	234	No	No	b/	No	262
Chronic renal disease	b/	No	No	No	No	222	No	c/	c/	44	266
Physical exams	200	No	No	No	No	No	No	No	No	No	200
Injections/time period	58	No	1	No	No	82	No	No	b/	37	178
Home visits	4	4	21	3	22	40	1	28	b/	46	169
EKG services	No	No	No	No	No	13	1	136	No	No	150
Skilled nursing facility visits	b/	b/	5	1	6	112	1	b/	b/	14	139
Foot care	46	No	No	No	No	76	No	No	No	d/	122
Chest X-rays	66	No	No	No	No	No	No	55	No	No	121
Procedures of questionable usefulness	29	e/	No	No	No	102	No	No	No	e/	131
Outpatient physical vs. in-hospital	48	No	No	No	No	No	No	No	No	No	48
B-12 injections	17	c/	c/	1	14	c/	1	9	b/	3	45
Total	$1,324	$146	$6,320	$620	$418	$5,195	$24	$567	$1,289	$1,578	$17,481
Number of No's	4	11	9	12	11	3	10	8	8	7	

a/This table covers the most recent 1-year period available at the time of our visit to each carrier. A "No" denotes that the carrier neither had an automated edit nor reported the use of a manual edit.

b/The carriers had an automated edit but could not identify the amount of savings attributable to it.

c/The carrier reported that it has a manual edit that is similar to the described automated edit.

d/The carrier reported that its foot care edit is combined with another UR edit.

e/The carrier reported that it has manual edits for some procedures of questionable usefulness.

Based on the experiences of the carriers using each core edit, we estimated the amount that might be saved if all carriers we visited used them. We computed a low and a high estimate of anticipated denials, adjusted for claims volumes, for each carrier that did not use these edits. The low estimate was based on the experience of the least successful carrier using the edit, while the high estimate was based on the experience of the most successful carrier using the edit. If only one carrier was using an edit, only that carrier's experience was used in computing both the low and the high estimate. Some edits, such as those for postoperative care and concurrent care, identify some of the same problems; thus, in some instances part of our estimate of anticipated savings attributed to one edit could have been attributed to the other, similar edit.

On the basis of the analysis, we calculated in terms of possible additional gross denials a low estimate of $6 million (see app. II) and a high estimate of $18 million (see app. III) for the nine carriers. The specific UR edits producing the largest potential savings in the low estimate were (1) the edit used only by Indiana Blue Shield to identify claims involving stated numbers of complete medical histories and nonroutine physical examinations associated with the same beneficiary and the same physician within a stated time period, (2) the edits used only by Pennsylvania Blue Shield and Nationwide to identify claims involving more than a specific number of doctor visits with a hospitalized beneficiary, and (3) the edits used by Pennsylvania Blue Shield and Massachusetts Blue Shield (in Massachusetts) to identify claims for which the total charges for medical services exceed stated dollar amounts.

The high estimate consisted principally of the above edits plus significant amounts applicable to the concurrent care[3] and postoperative care[4] edits used by all the carriers except Maryland Blue Shield and Nationwide.[5]

Based on the estimated additional gross denials, we estimate that the additional net Medicare savings these carriers could achieve would total another $3 million to $9 million a year. Estimated gross denials were adjusted downward to account for (1) the increased costs attributable to the additional workload and (2) probable reasonable charge reductions and the 20-percent coinsurance paid by beneficiaries. Because we were unable to include in our estimates all the factors that might influence the savings, our estimates are not precise. For example, we recognize that:

--Edits may overlap to some degree. A concurrent care edit, for example, may suspend for review some of the same physician services that would be suspended by an edit for postoperative care. Consequently, the savings attributable to these edits may not be additive in every case.

--Medical practice can vary by geographical area; thus, some edits may vary in productivity from one area to another.

The nine carriers we visited represent only about 20 percent of the carriers operating nationwide. Consequently, if the core edits were implemented nationwide, we would expect total program savings to be substantially higher.

---

[3]Identifies claims in which more than one doctor bills as the attending physician for a hospitalized beneficiary.

[4]Identifies claims for visits that should have been included in the fee for surgery.

[5]In commenting on our report, Nationwide stated that its concurrent care edit is included in its hospital visits edits. However, this carrier might have identified additional medically unnecessary services if it had separate edits for concurrent care and hospital visits. Morever, this carrier's denials under the latter edit were so low in comparison with other carriers having a distinct concurrent care edit that we believe Nationwide probably would generate substantial additional denials with a distinct concurrent care edit. (See pp. 79 and 80.)

Since the above edits produced the most savings to the program, we believe that HCFA should require that all carriers test their applicability and implement them where appropriate, unless carriers have a reasonable basis for believing that the implementation of a particular edit would not be cost beneficial for them. We recognize that:

--Carriers we did not visit may be using other effective edits that may warrant consideration.

--Differences exist in the individual edit parameters used by various carriers. These differences affect the number of services suspended by the edits and may affect total denials. An effective edit parameter should maximize the identification of medically unnecessary services and minimize the workload.

No matter how many automated edits are implemented, savings will not result unless carrier personnel effectively use them. The computer only identifies suspect situations. The amount of savings derived from any prepayment edit is a direct result of the commitment of the reviewing personnel to identify and deny medically unnecessary services from the suspended claims. The process for reviewing suspended claims must therefore include appropriate decision guidelines, which are applied by adequate numbers of trained staff under the supervision of medical consultants from various specialties. There have been disincentives for carriers to have such a process.

DISINCENTIVES TO PERFORMING EFFECTIVE UR

HCFA requires carriers to have UR programs, but its own policies and practices not only lacked incentives for carriers to perform effective UR but actually tended to act as disincentives to effective UR programs. HCFA's evaluations of carriers' UR programs were focused on verifying the existence of processes that were assumed to be worthwhile, rather than determining whether the programs are cost beneficial. The disincentives were that HCFA has

--placed significant emphasis on reducing administrative claims processing costs without adequately considering the extent to which these reductions would result in increased payments for unnecessary medical services and

--traditionally judged carriers' performance on how well they minimize claims processing costs and claims processing time and not on how they strive to save program dollars.

Carrier officials were aware of HCFA's priorities and tried to tailor their prepayment review programs accordingly. For example, a Blue Shield of Maryland official stated that there was no incentive for performing UR, because HCFA emphasized keeping the cost per claim processed low and paying claims quickly. He added that Maryland had not expanded its UR program because HCFA has not given carriers credit for increased savings in benefit payments when the savings are accompanied by increased administrative costs. A Pennsylvania Blue Shield official echoed these sentiments--the carrier was studying ways to reduce the cost and perhaps the number of prepayment edits because (1) the carrier does not get recognition for saving benefit dollars and (2) HCFA emphasizes administrative cost reductions.

In October 1982, HCFA modified the performance standards to be applied for fiscal year 1983. For the first time, the standards emphasized the cost effectiveness of carrier UR activities in evaluating performance. An objective of the modification was to change the overall focus of carrier evaluations from a system of performance criteria and statistical standards to outcome-oriented standards that measure essential aspects of carrier performance. Although it is too early to tell how the new standards will eventually be applied, the change in emphasis could result in giving the carriers an incentive for performing effective UR.

Also, nearly all of the carriers' officials agreed that the apprehensions surrounding Medicare competitive bidding for carrier contracts, where a low claims processing cost could still be the overriding factor, acts as an incentive to cut UR activities to the lowest acceptable level. If HCFA continues to use this method of awarding carrier contracts, carriers will likely look harder to find ways to minimize UR.

Minimum requirements for prepayment utilization edits were reduced

HCFA has established minimum requirements for prepayment UR. Before 1980, carriers were required to have edits for five categories of physicians' service: office, home, hospital, skilled nursing facility, and nursing home visits. Additional edits could be employed at each carrier's discretion. Also, carriers were required to (1) periodically evaluate the validity of each UR edit parameter, (2) have qualified

medical staff manually review questionable services, and (3) determine whether provider flags[6] should be discontinued.

In 1980, HCFA revised its functional UR requirements and provided more detailed instructions in several areas. For example, each carrier's system must now be capable of applying specified consistency edits to ensure that medical services are appropriate considering various factors, such as the patient's age, sex, or diagnosis. However, the revised requirements reduced the number of categories required to have edits from five to one (nursing home visits). Instead of requiring other categories of edits, the instructions state:

> "Your prepayment utilization review system must screen services identified through your knowledge of service area problems and your analysis of the postpayment review data."

Although HCFA regional offices must be notified when prepayment edits are eliminated or changed, basically HCFA has left it up to each carrier to determine the number and nature of the prepayment UR edits it wishes to employ.

An important improvement in the 1980 instructions was the requirement for quarterly reports on the results of individual edits. By collecting data on the dollar amount and number of services suspended and denied for each prepayment edit, a carrier can evaluate its effectiveness and determine whether continued use is worthwhile.

HCFA performance evaluations do not address cost savings of prepayment UR

HCFA performance evaluations of the carriers we visited did not compare the monetary benefits of the prepayment UR systems with the costs of operating them. Carriers such as Massachusetts Blue Shield and Pennsylvania Blue Shield, whose UR systems generated substantial net savings to the program, were rated as satisfactory, as was Rhode Island Blue Shield, whose UR program generated relatively small savings. Thus, carriers have little incentive to do more than meet the minimum requirements.

---

[6]This refers to situations in which a particular physician has been identified as a chronic overutilizer or misutilizer and all or certain types of claims involving this provider are subject to special prepayment review.

HCFA's review of Blue Shield of Rhode Island is a good example of the cursory nature of these evaluations. Both the fiscal year 1979 and 1980 Annual Contract Evaluation Report (ACER) rated the carrier's performance "satisfactory" in meeting HCFA requirements for prepayment controls.

These evaluations did not mention that Rhode Island's prepayment UR program was marginally cost beneficial and represented the least effective UR performance of any carrier we visited. In addition, one of the computer edits the carrier used had not functioned for over 3 years until, according to a carrier official, corrective action was taken in October 1982. The official said the problem had not been corrected sooner because it had a low priority. Finally, HCFA did not report that from fiscal year 1979 to fiscal year 1980, the dollar denials generated by Rhode Island's prepayment edits dropped from $35,000 to $19,500 in program savings (total denials less reasonable charge reductions and the 20-percent coinsurance).

Another evaluation, one of New Hampshire-Vermont Blue Shield, was also cursory. In the fiscal year 1979 ACER, the carrier's performance was judged satisfactory based, in part, on HCFA's belief that the carrier denied a total of $703,646 as a result of applying prepayment utilization edits. However, according to the carrier's monthly Prepayment Screen Monitoring Reports submitted to the regional office, the fiscal year 1979 savings totaled only $133,477. Upon analyzing the carrier's prepayment statistics, we found that the monthly reports did not include the results of several edits and that the denials reported for other edits were overstated because of inaccurate recordkeeping. We estimated that fiscal year 1979 denials were actually about $240,000. The HCFA representative was not aware of the huge difference between the ACER and the actual denials.

Although the Medicare Carriers Manual states that prepayment screening should be cost effective, HCFA does not evaluate using this criterion and, in fact, does not even require carriers to develop and report prepayment and postpayment UR costs separately. Carriers are instructed to report total utilization review costs, together with the cost of reasonable charge reviews, as one line item on their administrative cost reports. However, most carriers report some or all of their prepayment UR costs under other line items, and HCFA officials were not aware of this.

In September 1980, HCFA published new performance standards for fiscal year 1981. These standards, which are part of the Contractor Performance Evaluation Program (CPEP), did not address the quality or the cost savings of carriers'

prepayment UR programs. In addition, those standards and related evaluation criteria that do relate specifically to prepayment UR were stated in a way that allowed a wide range of performance in terms of cost and benefits to be considered acceptable. Carriers were merely required to (1) develop prepayment edits, (2) provide written review guidelines and procedures, (3) apply the edits to all claims, (4) review the suspended claims, and (5) prepare quarterly reports analyzing edit results and submit them timely to the regional office.

A September 1981 revision to the standards allowed the awarding of a bonus point to carriers if all of their quarterly management reports were completed in accordance with HCFA requirements and at least one report addressed administrative costs of prepayment UR edits in relation to program savings.

The performance standards were revised again in October 1982. This revision, which will apply to carrier activities for fiscal year 1983, was intended to refocus CPEP from a system of performance criteria and statistical standards to outcome-oriented standards which measure only essential aspects of carrier performance. The new CPEP requires that overall performance scores awarded to carriers include scoring of UR cost/benefit ratios and the appropriateness of medical necessity UR decisions.

RECENT CONTRACTOR BUDGET CUTS FOCUS ON UR

Further disincentives for carrier UR activities surfaced when HCFA's fiscal year 1982 budget was cut. One step taken to implement the cuts was to reduce postpayment UR efforts by 20 percent. When further reductions were required, HCFA directed the carriers' UR budgets to be cut a total of 50 percent. After discussions with HCFA officials in which we expressed concern about the effects of these actions, HCFA tempered its previous directive by telling the regional offices:

> "If the contractors can meet the performance standards and functional requirements and still achieve targeted budget savings through management efficiencies and national abatements, they do not have to reduce their * * * UR line items to the 50 percent level. The 50 percent level is a floor and not a target. To the extent possible, those screens and procedures which have proven to be most cost effective should be retained."

Although HCFA officials believed that carrier UR activities were saving program dollars, they said they had no choice but to direct that administrative costs be reduced in this area during the recent budget cuts. They said that they had

already eliminated planned new initiatives and certain beneficiary services activities during prior cuts and that the most recent round of cuts required them to reduce budgets for UR and other ongoing program operations. In contrast, an Office of Management and Budget (OMB) official said that OMB never intended for HCFA to cut UR activities. He believed that HCFA could absorb the cuts in other areas and agreed to discuss the matter with HCFA officials. We were later told that this discussion was held, but that HCFA officials maintained that they had no choice but to cut the administrative costs of performing UR.

HCFA's action to cut UR budgets appears to be counter to the intent of a May 1980 report by the President's Management Improvement Council on Medicare contracting, which discussed the need for increased emphasis on UR. According to the Council's report, the administrative dollars spent on UR can be far outweighed by their cost containment impact on program benefit dollars.

Further, the President's 1983 Budget included a reduction of $330 million in benefit payments as a cost-saving regulatory initiative aimed at giving the Medicare intermediaries and carriers greater responsibility for identifying and denying payment for unnecessary services. However, there was no increase for 1983 in the contractors' 1982 funding level to implement this UR initiative. On the other hand, section 118 of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), approved on September 3, 1982, did address UR funding levels by providing that, in addition to any funds otherwise provided for fiscal years 1983, 1984, and 1985 for payments to Medicare contractors, an additional $45 million for each year is to be transferred from the Medicare Trust Funds to be used exclusively for institutional provider cost audits and reviews of medical necessity.

CONCLUSIONS

The program savings generated by carriers' prepayment UR edits generally are much more than the related costs, and there is potential for further increasing these savings. We identified a number of effective utilization edits which, if adopted by just the nine carriers reviewed, could increase savings by millions of dollars annually.

In the past, HCFA's performance standards have not gone far enough in addressing the cost savings of carriers' prepayment controls, and its evaluations have not identified the more and less effective prepayment UR systems. Its emphasis on minimizing administrative costs has acted as a disincentive

to carriers' operating more effective UR programs, thus lowering program safeguards against paying for medically unnecessary services.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

--compare the prepayment utilization edits used by Medicare carriers, identify the more effective ones in terms of valid denials, and require their implementation (at least on a test basis) by all carriers, except where a carrier has a reasonable basis for believing that the implementation of a particular edit would not be cost beneficial; and

--require that prepayment UR costs be reported separately from other claims processing costs to allow for valid analysis of carrier costs and related benefits in conducting prepayment UR.

AGENCY ACTION, COMMENTS, AND OUR EVALUATION

HHS generally concurred with our recommendations and, as previously noted, in October 1982 modified its performance standards for evaluating carrier performance for fiscal year 1983 to give consideration to the cost effectiveness of overall UR activities. Although it is too early to tell how these new standards will actually be applied, in view of the agency's action, we have deleted our proposal to develop performance standards and evaluation criteria for identifying effective and ineffective prepayment UR systems, and to incorporate these standards in CPEP.

However, although HHS stated that it was acting to obtain better cost data on carrier UR activities, it did not believe that costs should be segregated between prepayment and postpayment activities because the activities are interrelated and many carriers would have difficulty in breaking out these costs. On the other hand, HHS said that it is revising the Medicare Carriers Manual to require carriers to identify cost savings resulting from postpayment reviews as well as to estimate expenses in connection with conducting such reviews. We believe that, while a precise breakout of costs between prepayment and postpayment activities might be difficult, reasonable cost estimates can be made for each activity and comparisons of the estimated costs with the related benefits could help to identify profitable activities that could be expanded and unprofitable activities that could be curtailed.

In commenting on our report, the Medicare carriers supported the thrust of our recommendations, but emphasized the need for flexibility in requiring specific prepayment UR edits to give recognition to local conditions. The Blue Shield Association, commenting on behalf of the Blue Shield carriers, suggested that "HCFA require contractors to report separately, pre and postutilization review administrative costs, as well as prepayment denial amounts, which would render the reported savings valid."

CHAPTER 3

MEDICARE POSTPAYMENT UTILIZATION REVIEW-- OPPORTUNITIES FOR INCREASED EFFECTIVENESS

In contrast with the prepayment UR program, which was a positive cost-beneficial activity at all nine carriers reviewed, the Medicare part B postpayment review programs were not cost beneficial at most of the nine carriers. Postpayment UR undoubtedly has a deterrent effect and can be used to identify overutilizers that could go undetected even when the most effective prepayment UR techniques are used. Because extensive manual effort can be required to identify and recoup payments that have already been made, postpayment UR may never be a uniformly cost-beneficial program. Nevertheless, we identified a number of correctable conditions at these carriers that contributed to the relatively low cost/benefit ratios experienced. Specifically:

--Three carriers selected physicians or suppliers for review even though there was little potential for identifying and recovering sizable overpayments. We believe that such costly but unproductive reviews could be curtailed.

--Five carriers failed to calculate overpayments although overutilization had been identified, did not calculate them appropriately, or did not try to collect the calculated overpayments. We believe that after overutilizers have been identified, overpayments should be calculated and recovery action initiated when the amounts of the overpayments exceed the recovery tolerances under HCFA guidelines.[1]

--A cumbersome and unproductive fraud referral system and/or its implementation was hampering the recovery of overpayments.

--Interest charges have not been assessed for the period of time providers have had to repay the overpayments after they were identified even though these providers usually have had the use of the money for years before the overpayments are detected. We believe that the free use of Federal funds is inappropriate and tends to delay timely recoveries. Section 117 of the Tax Equity

---

[1]HCFA guidelines state that the carrier should attempt to recoup overpayments determined to be $50 or more.

and Fiscal Responsibility Act of 1982 (Public Law 97-248) requires that interest shall accrue on unrecovered overpayments and underpayments after 30 days of the date an overpayment or underpayment is determined to exist. This act was passed after we completed our review.

Further, we believe that HCFA evaluations of the carriers' postpayment UR programs (1) have been misdirected to focus on the processes and timeliness of carrier activities and (2) needed to be expanded to emphasize the costs and tangible benefits of the postpayment UR programs. In this regard, HCFA developed standards in October 1982 with an objective of expanding the emphasis of these evaluations to include consideration of the results of carrier activities.

The basis and results of our cost/benefit analysis of the carriers' postpayment UR programs and a discussion of our findings follow.

THE COSTS AND BENEFITS OF POSTPAYMENT REVIEW

The cost/benefit information for the nine carriers we visited shows that postpayment UR was not cost beneficial for six of the carriers and was about breaking even for the other three. Since HCFA does not require carriers to report cost data for postpayment UR reviews, we asked the carriers we visited for information so that we could compute cost/benefit ratios. Our analysis showed that the carriers' performance varied; however, precise comparisons could not be made because the carriers did not supply us with exactly the same kind of information.

For example, the 1-year time periods covering the overpayments reported to us varied. Also, the amounts of overpayment reported by the five carriers in HCFA's Boston region represent claims on which recovery had been sought, while the amount from Pennsylvania Blue Shield and from Nationwide represents actual recoveries. Recovery amounts from Blue Shield of Maryland, Indiana Blue Shield, and Metropolitan (Kentucky) represent overpayments identified and recovered as the result of reviews of providers' claims submitted during a recent year.

Carrier postpayment review staff have several responsibilities other than postpayment UR, including fraud investigations, program integrity reviews, and responses to HCFA regional office special requests. These ad hoc activities result from beneficiary complaints and regional office instructions to which the carriers must respond. Our efforts

were primarily concerned with their postpayment UR activity, which requires them to routinely determine which providers should be reviewed and to determine appropriate corrective actions to be taken against abusive providers--for example, overpayment recovery, educational contact, prepayment screening, or recommendations for removal from the program. We, therefore, asked the carriers to provide us with cost/benefit estimates that relate specifically to their routine postpayment UR activities that take place in response to instructions in the Medicare Carriers Manual which are summarized on pages 5 and 6.

The following table shows the costs and quantifiable benefits of the postpayment UR activities of the carriers we reviewed during various 1-year periods between October 1978 and June 1981.

Cost/Benefit Analysis of Carriers' Postpayment UR Operations

Medicare carrier	Postpayment UR costs	Potential or actual recoveries	Cost/benefit ratio
Blue Shield of Massachusetts (Mass)	$121,651	$130,558	$1:$1.07
Connecticut General	59,475	58,864	1: .99
Pennsylvania Blue Shield	233,711	217,286	1: .93
Massachusetts Blue Shield (Maine)	24,930	17,884	1: .72
New Hampshire-Vermont Blue Shield	31,797	23,024	1: .72
Blue Shield of Rhode Island	53,206	33,425	1: .63
Nationwide (OH/WV)	136,705	52,323	1: .38
Indiana Blue Shield	77,642	7,641	1: .10
Blue Shield of Maryland	60,411	3,838	1: .06
Metropolitan (KY)	a/19,666	0	1: .00
Total	$819,194	$544,843	1: .67

a/Carrier provided personnel costs only.

Although the carriers' routine postpayment UR operations were not generally cost beneficial,[2] they often provided a valuable adjunct to their prepayment operations. An example of the value of postpayment review is a Medicare carrier's ability to identify a common inappropriate practice called "upcoding." If a physician routinely bills the program for comprehensive office visits at $30 each when in fact a brief office visit at $15 is all that is medically necessary, Medicare should reimburse the beneficiary or provider only for a brief visit.

Typical prepayment edits only identify office visits provided in excess of an established parameter, often four or five per month per beneficiary. Consequently, these services will be reviewed before payment only when a Medicare carrier is billed by or on behalf of a beneficiary for more than four or five office visits to a physician within a 30-day period. However, when this physician is compared with his or her peer group (physicians of the same specialty in the same basic locality) under the Medicare postpayment UR program, the practice of routinely billing for comprehensive office visits whenever the physician sees a patient will probably appear aberrant and will be identified and reviewed.

Benefits not included in our cost/benefit analysis

We recognize that postpayment UR has some nonquantifiable benefits. For example, if a carrier is known to identify and aggressively recover overpayments, physicians in its area may be deterred from abusing the program. One carrier, Pennsylvania Blue Shield, notifies providers when the number of a service they provide exceeds the "norm" for their peer group. Carrier officials believe that such a routine mailout is an inexpensive way of deterring abuse since it puts the providers on notice that their practices are being monitored for potential abuse. However, because we could not quantify the impact of the "deterrent value" of postpayment review on curbing overutilization, it was excluded from our computations.

---

[2]In commenting on our report, officials at Nationwide agreed that their overpayment recoveries in fiscal year 1980 as the result of routine postpayment URs required by HCFA were relatively modest. However, they stated that special postpayment reviews they have conducted have contributed to savings incurred through their prepayment review efforts. They credited their postpayment URs of chiropractors with identifying problems resulting in the initiation of a number of prepayment flags and subsequent prepayment denials totaling $541,657 in fiscal year 1980, or about one-fourth of their total prepayment denials for that year.

Postpayment reviews of providers' practices also can be important in identifying overutilizers whose claims should be manually reviewed before payment. Officials at Nationwide, for example, credited their postpayment review activities with identifying many of the providers that had been placed on prepayment review. Prepayment denials involving "flagged" providers totaled over $1 million in a recent year for eight of the carriers we visited. However, we could not determine from the information supplied by the carriers how much of this amount was attributable directly to postpayment UR activities.

The following sections discuss some of the reasons for the relatively poor cost/benefit ratios of carrier postpayment programs and some steps that can be taken to improve them.

SOME CARRIERS DID NOT ASSESS THE POTENTIAL FOR IDENTIFYING OVERPAYMENTS BEFORE MAKING EXTENSIVE REVIEWS

Three of the nine carriers we visited selected cases for extensive review that they knew or should have known had little potential for identifying program overpayments large enough to offset the cost of review. For example, in 1980 Blue Shield of Maryland identified 41 providers suspected of overutilization and had completed its reviews in 22 of these cases. We reviewed the files for 19 of the completed cases--all of those readily available at the time of our review. In 5 of the cases a physician medical consultant had reviewed patient medical records to determine whether the providers were "upcoding" when the payment for the unnecessary higher level of care was the same as that which would have been allowed for the appropriate lower level of care. Since no quantifiable overpayments could have been established, the cost of these reviews could not have been recovered.

Two other carriers selected physicians for full-scale review whose annual income from the Medicare program was relatively small, thus making large dollar recoveries unlikely. Metropolitan (Kentucky) identified no overpayments for the 18 relatively low-volume Medicare providers it selected. Indiana Blue Shield selected 15 such providers for full-scale review and identified only $1,189 in overpayments. For 11 of these providers overpayments either were not established or were determined to be less than $100. While attempts to collect a $100 overpayment once it has been determined may well be appropriate, the benefits from these reviews seem meager in comparison to the possible cost of a full-scale review.

In commenting on our report, Blue Shield stated that the process of selecting cases for review by carriers is specified in the Medicare Carriers Manual. It also stated that a lengthy sampling, review, and analysis process may be necessary before a determination regarding further investigation and potential payback can be made. According to Blue Shield, the Government's attitudes regarding expenditures for fraud and abuse detection are that (1) Government policy has, in practice, always emphasized that the detection of fraud and abuse must be pursued because of the deterrent effect, and (2) preliminary postpayment UR activities are necessary even though they all will not result in fraud and abuse investigation and/or identification of overpayments.

Although we agree that the carriers' routine postpayment UR activities and the criteria for the preliminary selection of cases for review are spelled out in the Medicare Carriers Manual, we believe that the manual allows the use of carrier judgment in deciding whether to further develop cases when the potential amount to be recovered can readily be ascertained as negligible.

SOME CARRIERS DID NOT CALCULATE OVERPAYMENTS PROPERLY OR TRY TO RECOVER FROM OVERUTILIZERS

We reviewed postpayment UR cases at all nine carriers to determine how overpayments were calculated and if recovery actions were initiated. Three carriers identified overutilization and misutilization but did not calculate any overpayments. Another carrier calculated overpayments but did not attempt to recover them. A fifth carrier calculated overpayments using a method which usually understated overpayment amounts.

At Blue Shield of Maryland, Metropolitan, and Nationwide, when practitioners were identified as overutilizers, either they were placed on prepayment review or professional relations contacts were made in lieu of calculating and pursuing overpayments.

At Blue Shield of Maryland, which incurred over $60,000 in costs to identify less than $4,000 in overpayments involving medical necessity issues, in a number of situations the carrier identified improper physician billing practices, but did not calculate or recover overpayments. Of the 22 fiscal year 1980 case reviews which had been completed by the carrier at the time of our visit, the carrier's medical consultant determined that in 11 cases, the physicians were either upcoding or otherwise overutilizing medical services. However, no

overpayments were calculated, and none of the physicians were placed on prepayment review. Instead, professional relations contacts were made to "encourage them to change their practices."

We estimated that these 11 physicians were overpaid by more than $137,000 during the 3-year period 1978-80 because of consistent overutilization or misutilization of the kinds of services that the medical consultant had questioned. Our estimate of these overpayments could be low because in 10 of the 19 cases there were indications on the computerized profile reports that the physicians were also upcoding procedures that were not reviewed by the medical consultant. Nevertheless, the recovery of the overpayments we calculated would have made Maryland's postpayment UR program cost beneficial.

According to Blue Shield of Maryland officials, they did not have the time to calculate and recover the overpayments and still meet the timeliness standards for the initial review of 3 percent of the physicians and suppliers in their area.

At Metropolitan, which spent about $20,000 and identified no overpayments, in two cases physicians were reviewed several times, and each time the carrier's medical consultant concluded that they had billed and collected for medically unnecessary treatments. In both cases, no overpayment was calculated, and only a professional relations contact was made to discuss their billing practices. In one of the cases, the abuse was considered so serious that the carrier referred the case to the Jefferson County Peer Review Committee, which in turn referred it to the Kentucky State Board of Medical Licensure for peer review.

At Nationwide, which spent $137,000 to identify $52,000 in medical necessity overpayments, we noted two cases where physicians were overutilizing office visits and upcoding. The carrier placed the physicians on prepayment review, but did not calculate the overpayments.

Indiana Blue Shield, which recovered about 10 cents for every dollar spent on postpayment UR, had calculated overpayments for two physicians totaling about $2,500, but made "educational" visits in lieu of recovering the money.

Pennsylvania Blue Shield used an overpayment calculation method that tended to understate the amounts overpaid. Some other carriers calculated overpayments by reviewing statistical samples of claims and applying the results of their reviews to the total number of claims submitted by the provider

for the period being reviewed. However, to save time and review effort, Pennsylvania Blue Shield based overpayment computations on the differences between the number of times a provider performed a particular service and the "norm," which it defined as two standard deviations above the average (the 97.5th percentile of everyone in a provider's peer group with respect to the number of times the service was provided). Carrier officials said HCFA's Philadelphia Regional Office had approved the use of this method.

Use of this method may be acceptable for identifying the most aberrant providers, but when used as a basis for making overpayment computations, it assumes that all services rendered up to the level of the most aberrant 2.5 percent of a provider's peer group are medically necessary. Not only is this use of the "norm" method legally questionable, but the use of statistical sampling resulted in higher overpayment determinations in four of the five cases in which Pennsylvania Blue Shield was able to identify where it used both the "norm" method and statistical sampling techniques to compute overpayments. For the five cases combined, overpayment determinations totaled $95,663 using the "norm" method and $130,431 using sampling techniques.

The above examples suggest that some carriers are reluctant to take the time and effort to calculate and recover all the program overpayments made to the providers they review. We believe that this stems from various reasons, including a reluctance to alienate providers and inadequate staff to review the number of providers required by the Initial Three Percent Investigation List. In any event, carriers' failure to calculate overpayments properly or try to recover from overutilizers contributes to the poor cost/benefit ratios of postpayment UR programs. Given that only a small percentage of providers active in the Medicare program have been found to be substantial abusers, we believe that neither the carriers nor HCFA should hesitate to calculate and recover overpayments identified during postpayment UR.

RECOVERY OF OVERPAYMENTS WAS BEING HAMPERED BY AN UNPRODUCTIVE FRAUD REFERRAL SYSTEM

HCFA required carriers to refer cases of suspected fraud to a HCFA regional office and not attempt to collect overpayments until they were dropped as fraud cases. The overlapping of the Medicare fraud referral and investigation process involving the carriers, HCFA, and the HHS Office of Inspector General (OIG) has resulted in delays in completing

investigations. Also, the number of Medicare fraud convictions has declined markedly under this process. Most of the potential Medicare fraud cases are eventually dropped and returned to the carriers for overpayment collection action as overutilization cases. Often by this time years have passed since the overutilization was initially detected.

Carrier personnel told us that recovering overpayments in such cases has become more difficult and less productive in recent years. They said the passage of time increases the likelihood of records being lost or destroyed, beneficiaries or providers dying, or beneficiaries (often elderly) forgetting the services provided to them. Carrier officials gave us the files of several closed fraud cases as examples in which there was a link between lost overpayment recoveries and delayed recovery actions. Following is a summary of three of these cases.

Case 1: The carrier suspected a physician of fraudulently billing for $276 in services not rendered by him and for billing for another $38,702 for medically unnecessary services. In September 1976, the carrier referred the potential fraud case to the Social Security Administration's Office of Program Integrity, which later became part of HCFA. Responding to a comment by the carrier a year later about holding overpayment recovery action in abeyance, a HCFA regional official instructed the carrier to continue to hold all overpayment recovery action in abeyance until the fraud investigation was completed. In March 1978, 1-1/2 years after the case was initially referred to the Office of Program Integrity, it was dropped by HCFA as a fraud case because of the (1) unpromising prospects of developing a criminal fraud case against the provider, (2) low dollar amount of the suspected fraudulent activity, and (3) physician's advanced age. The carrier later proceeded with the overpayment recovery action, and the case was finally settled in May 1980 for $14,828. Overpayments totaling $24,150 were lost, according to a carrier official, primarily because of the age of the case.

Case 2: The carrier suspected a medical laboratory of billing for services not ordered by a physician, billing profile tests individually,[3] and billing for separate house calls for specimens collected from the same places on the same dates. The carrier referred the case to the then Bureau of

---

[3]This refers to several specific laboratory tests which are done as a group or combination. The price for the group is less than the total price for those billed as individual tests.

Health Insurance of the Social Security Administration, and in June 1980, over 4-1/2 years later, the case was dropped as a fraud case and returned to the carrier for overpayment recovery action. By this time, the laboratory's owner had sold the laboratory and moved. The carrier made several attempts to recover the amount it could substantiate (about $14,000 of a carrier-estimated $50,000 in overpayments) but was unsuccessful and referred the case back to HCFA. Later, HCFA made several attempts to recover money from the laboratory's former owner, but no recovery had been made as of August 1982.

Case 3: The carrier suspected a podiatrist of billing for services that were not performed and referred the case to HCFA in December 1977. In May 1979, 1-1/2 years after receiving the case, HCFA referred it to OIG. In July 1980, over 2-1/2 years after the case was initially referred to HCFA, it was declined as a fraud case by the U.S. attorney's office and was returned to the carrier for overpayment recovery action. Although the carrier estimated that overpayments totaled $9,700, it was able to recover only $2,535. The 2-1/2-year time lapse rendered the carrier unable to substantiate and recover the remaining $7,165.

During discussions with the Inspector General and other HHS officials, we had suggested that the Medicare fraud referral process be streamlined to eliminate the direct involvement in Medicare fraud case development of either HCFA or OIG. The Secretary of HHS subsequently approved an October 1982 proposal for the transfer of most of HCFA's program integrity and program validation functions to OIG, including accountability for the performance of these functions. According to OIG and HCFA personnel, the transfer, to be completed by January 1983, will place the total responsibility for the development of fraud and abuse cases in OIG.

INTEREST WAS NOT ASSESSED ON OVERPAYMENTS

HCFA has allowed interest-free repayment of overpayments over a period of months or years after the overpayments were identified even though the providers often had the money for years before the overpayments were detected. We believe interest charges should be collected to help encourage timely repayment of overpayments and improve the cost effectiveness of postpayment reviews. Legislation enacted in September 1982, after our review, now requires the collection of interest on overpayments.

An example of how long providers kept Medicare overpayments before they were repaid involved Pennsylvania Blue

Shield. Of providers we randomly picked for which overpayments had been established, four were allowed to make repayments in interest-free time payments. The following schedule shows that overpayments to the providers had been made years before the initiation of collection action but that they were given from 1 to 3 years to repay them interest free.

Provider	Dates of overpayments	Date collection initiated	Repayment time (months)	Overpayment
A	1/01/70- 6/30/75	7/30/80	36	$17,117
B	1/01/76-12/31/78	4/15/80	12	5,258
C	1/01/77-12/31/79	3/25/80	24	11,232
D	1/01/77-12/31/78	2/04/80	12	4,336

OIG and HCFA personnel have recognized the need to collect interest on overpayments. In December 1981, OIG made a proposal with respect to collecting interest on debts involving institutional Medicare providers. A May 27, 1982, draft of a HCFA regulation stated

> "If interest is not assessed debtors often tend to place a very low priority on repaying debts. We believe assessment of interest on delinquent Medicare debts and installment payments will provide incentives for debtors to repay overpayments more promptly, improve the efficiency and effectiveness of agency collection, and reduce the number of cases that must be referred for civil litigation.
>
> "* * * The income derived from the collection of interest on overpayments would more than offset administrative costs of assessing and collecting the charge along with the overpaid amounts."

Although this draft is recent, a HCFA official told us that the need for such a regulation was recognized as early as July 1979. The HCFA draft regulation would have applied to overpayments outstanding for over 30 days and to all providers of Medicare services, not just those identified by postpayment UR. HCFA estimated that, on the basis of fiscal year 1981 average interest rates and total part A and B Medicare overpayments, the amount of interest subject to collection would total $25 million annually.

In our August 1982 draft report, we proposed that the Secretary of HHS direct the Administrator of HCFA to charge providers interest on overpayments. In September 1982, the Tax Equity and Fiscal Responsibility Act of 1982 was passed.

Section 117 (which amends section 1815 of the Social Security Act) requires that interest shall accrue on unrecovered overpayments and underpayments 30 days after the date of the determination, and implementing regulations were included in the December 6, 1982, publication of the Federal Register. We, therefore, did not include a recommendation on charging interest in our final report.

HCFA EVALUATIONS HAVE BEEN MISDIRECTED, BUT EVALUATION CRITERIA HAVE BEEN CHANGED

HCFA regional offices currently conduct annual onsite reviews of carrier prepayment and postpayment review operations and issue reports on carrier performance under the Contractor Performance and Evaluation Program (CPEP). This program's objective is to enhance the quality of carrier performance through a system of review and appraisal.

Before 1980, regional offices issued ACER reports on carrier performance under the Contractor Inspection and Evaluation Program. This program and CPEP are similar; the major difference is that CPEP introduces specific criteria, elements, and review methods that facilitate the uniformity of reviews and is to be applied for fiscal year 1981 and afterwards.

Our examination of the reports on the postpayment part of annual reviews made before 1980 showed that the programs were cursory and did not address most of the weaknesses discussed in this chapter. Further, CPEP performance standards for fiscal year 1982, while improved, tended to focus on processes and timeliness but did not emphasize the cost effectiveness of postpayment UR.

The performance standards to be applied for fiscal year 1983, however, represented a significant departure from the prior standards in that for the first time the cost effectiveness of carriers' UR activities will be emphasized in evaluating their performance. Although it is too early to tell how these new standards will actually be applied, this change in emphasis could improve the quality of regional office reviews.

Reports we reviewed of the regional office reviews made before the application of CPEP showed that HCFA has not emphasized the quality of case development or the calculation of overpayments, but instead has commented primarily on the processes used to select providers for review. Even in this area, HCFA criticisms of carrier processes were not particularly constructive since its regional offices did not suggest how improvements could be implemented.

CONCLUSIONS

The postpayment UR function, as carried out by most of the carriers we reviewed, was not cost beneficial. Although we do not support its elimination because of its deterrent effect on program abuse and its contributions to prepayment UR, we believe the postpayment UR program should be improved to increase its usefulness and effectiveness and to better assure that its tangible benefits (i.e., overpayment collections) at least cover operating costs. Whether the Medicare carriers' postpayment UR activities can be made into a uniformly cost-beneficial function is uncertain, but we believe that several steps should be taken to work toward this objective, which should be a criterion for measuring satisfactory performance.

First, HCFA should modify the way it measures or evaluates carrier programs. In the past, the system has emphasized processes and timeliness; however, it should be expanded to measure the quality and effectiveness of the identification and collection of overpayments. The performance standards to be applied for fiscal year 1983 have been modified in an effort to make the evaluations more effectiveness oriented. In this regard, carriers should be required to accumulate and report on postpayment UR costs to allow for comparison with the results of their efforts.

Second, the selection criteria for full-scale reviews should be examined. For example, reviews should not be undertaken when there is little likelihood of recouping enough in overpayments to cover review costs, such as would likely be the case when practitioners have low Medicare reimbursement.

Third, overpayments should be computed and recovered when overutilization or misutilization has occurred and reasonable recovery efforts would not cost more than the identified overpayment.

Although HCFA instructions to the carriers have been modified to recognize the desirability of these latter steps, it is not clear that they will be considered in making performance evaluations.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

--require that the costs and benefits (overpayments collected) associated with carrier postpayment UR be reported separately from claims processing costs for use in determining the effectiveness of postpayment UR operations and

--ensure that the HCFA regional offices evaluate carrier effectiveness on postpayment utilization reviews regarding (1) the appropriateness of the selection criteria used for full-scale reviews and (2) whether overpayments are computed and recovered when overutilization is identified.

AGENCY ACTION, COMMENTS, AND OUR EVALUATION

HHS generally concurred with our recommendations and, as previously noted, in October 1982 modified its performance standards for evaluating carrier performance for fiscal year 1983 to give consideration to the cost effectiveness of overall UR activities. Although it is too early to tell how these new standards will actually be applied, in view of the agency's action, we have deleted our proposal to modify the performance standards in our final report. However, as we discussed on page 23, the Department did not believe that prepayment and postpayment UR costs should be segregated. We continue to believe that reasonable cost estimates can be made for each activity and that comparisons of the estimated costs with the related benefits could help to identify unproductive or unprofitable activities.

CHAPTER 4

HABITUAL OVERUTILIZERS SHOULD BE EXCLUDED FROM MEDICARE

The carriers we visited were spending thousands of dollars year after year to review and recoup overpayments from a relatively few practitioners who were judged to have repeatedly billed the Medicare program for medically unnecessary services. Although HCFA has excluded providers for reasons such as outright fraud or poor quality of care, it has made little use of its authority to exclude providers for repeatedly billing for medically unnecessary services. We believe that prepayment UR costs would be reduced, fewer overpayments would go unrecovered, and the cost of collecting overpayments would be reduced if HCFA excluded chronic or habitual overutilizers from participating in the Medicare program.

HABITUAL OVERUTILIZERS CAN BE EXCLUDED

Part B of Medicare is an indemnity program that either directly or indirectly reimburses the beneficiary for medical expenses incurred; thus, specific contractual agreements between the Medicare program and physicians and suppliers are not made. The program, therefore, pays for covered medical services by any licensed practitioner or provider that the Medicare beneficiary chooses, unless the provider has been excluded from participation in Medicare. The law authorizes the exclusion of providers as long as certain due process requirements are met; however, providers convicted of Medicare or Medicaid related crimes such as fraud are automatically excluded--the presumption is that the due process requirements were met as part of the criminal proceedings.

The Social Security Act also provides for excluding providers if HHS determines that they have (1) submitted fraudulent claims, (2) habitually overutilized or otherwise abused the Medicare program, or (3) failed to provide care of a quality meeting professionally recognized standards of health care. Following are specific sections of the act that provide the authority to exclude habitual overutilizers from the program.

--Section 1862(d) allows HHS to exclude from the Medicare program for the time period it deems appropriate providers who have furnished services that are determined

to be substantially in excess of the needs of beneficiaries or to be of a quality that fails to meet professionally recognized standards of health care.

--Section 1160 allows HHS to exclude from the Medicare program for the time period it deems appropriate providers who have been found by a Professional Standards Review Organization (PSRO)[1] to have, in a substantial number of cases, provided medically unnecessary services or services that do not meet professionally recognized standards of health care.

Medicare regulations outline the procedures for excluding overutilizers. According to regulations implementing section 1862(d), HCFA's determination of whether a provider is overutilizing or providing services of an unacceptable quality are to be made on the basis of reports from a PSRO, State or local licensing or certification authorities, peer review committees of Medicare contractors, State or local professional societies, or other sources deemed appropriate by HCFA. The provider has 30 days to submit his or her case to a HCFA official after being notified of an exclusion determination. If, after considering the provider's response, HCFA continues to believe that exclusion is warranted, it notifies the provider 15 days before the decision becomes effective. An excluded provider can get a hearing by a Social Security Administration administrative law judge and, if dissatisfied with the hearing decision, a review by the Social Security Administration Appeals Council. A judicial review of that decision is available to the provider. Similar procedures for excluding providers are discussed in the regulations that implement section 1160 of the Social Security Act.

COSTS ARE BEING INCURRED TO CONDUCT SPECIAL REVIEWS OF HABITUAL OVERUTILIZERS

Carriers we visited were incurring thousands of dollars in program costs to identify and conduct manual reviews of

---

[1]PSROs promote the effective, efficient, and economical delivery of health care services under the Medicare, Medicaid, and maternal child health programs. The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) repealed the existing PSRO program and replaced it with a utilization and quality control peer review program having many of the characteristics of the PSRO program. The exclusion authority discussed above is now contained in section 1156 of the Social Security Act.

claims from providers whose practices have been questioned, usually during postpayment investigations. The carriers attempt to prevent payment to these providers for medically unnecessary services through the use of provider flags. The computer is instructed to suspend all claims submitted by that provider or claims for those types of services that were questionable in the past. In either case, the review is much the same as that given claims suspended by other prepayment utilization edits, i.e., a determination of medical necessity.

Provider flags are supposed to be a temporary control to be used until an identified billing problem has been corrected. However, we noted some instances in which reviews of flagged providers had continued for long periods. In general, these appear to be providers who refuse to alter their billing practices and who continue to cost the program scarce administrative dollars to manually review their claims.

For example, for the last quarter of calendar year 1980, Pennsylvania Blue Shield had 98 providers on prepayment review, of which 14 had been subject to review for from 1 to 10 years and each had over $1,000 of denials in both of the quarters we examined. In the last half of 1980 alone, we estimate that it cost the Medicare program about $13,000 for the prepayment review of the 14,226 claims submitted by these 14 providers. The average cost of reviewing these claims was $0.91 per claim, over 10 times the overall average cost of routine prepayment claims review for this carrier in 1980.

Blue Shield of Maryland had 22 providers on prepayment review as of June 30, 1981. Of these, 10 had been subject to monitoring for 2 years or more and had denials totaling $51,513 for the year ended June 30, 1981. One physician who had been flagged since November 1974 and still had not corrected his billing practices accounted over for $20,000 of the $53,513.

Connecticut General had 82 physicians on prepayment review as of December 1980. Of these, 30 percent had been on review 2 to 5 years, according to a carrier official. In Massachusetts a physician had been on prepayment review for over 9 years. During the year ended June 1981, denials for this provider amounted to over $50,000.

With respect to flagging providers, HCFA's instructions in the Medicare Carriers Manual state in part that

> "In your review of physicians/suppliers you will identify those which must be placed on prepayment review either for all claims received or for claims containing services in specific categories.

"Place these physicians/suppliers in a Physician/ Supplier Action File (PSAF). Monitor the performance of physicians on the PSAF on both the prepayment level and through subsequent post payment review."

HCFA has not provided guidance in the Manual on how long an overutilizer should be tolerated on prepayment review.

We believe that after 1 or 2 years of experience with a provider, it should be evident whether that person intends to alter his or her practice. If no improvement is evident, we believe that the process should be begun to exclude the provider from the Medicare program. Doing so would result in the provider either correcting his or her practices or being excluded from the program. In either case, Medicare would not have to continue expending the administrative resources to monitor the problem providers.

HCFA DOES NOT EXCLUDE OVERUTILIZERS

HCFA has excluded providers for unnecessarily endangering the health of beneficiaries and for other reasons, but as of August 1981, it had excluded only a few providers at most for overutilization alone. The following table summarizes information supplied by HCFA on providers excluded from the Medicare program since 1975 (when Medicare received such authority) through August 1981 and the reasons for the exclusion actions.

Reason for exclusion	Number of providers
Convicted for fraud	a/238
Filing false claims	4
Quality of care failed to meet professionally recognized standards	2
Quality of care failed to meet professionally recognized standards and overutilization	b/6
	250

a/Under section 1862(e) of the Social Security Act, a physician or practitioner convicted of Medicare or Medicaid fraud is automatically excluded.

b/Although it appeared that overutilization was a secondary reason in these cases, we could not conclusively determine whether these providers would have been excluded solely because they were overutilizers.

In September 1982, HCFA officials provided us a list including 12 providers that had been excluded since August 1981 because they had provided excessive care that failed to meet professionally recognized standards. One of these providers had been excluded solely for overutilization.

One reason why there has been a lack of action to exclude habitual overutilizers may have been confusion on the part of HCFA personnel as to the proper procedures for sanctioning a provider. In an October 17, 1980, letter to the regional Program Integrity Directors, HCFA's Director of the Office of Program Validation suggested that regional offices become "more aggressive in identifying and developing cases for administrative sanction action." However, this directive stated that in the case of medically unnecessary services or services that fail to meet professionally recognized standards of care, the case should be referred to a PSRO.

Carriers, however, did not routinely deal with PSROs. Consequently, regional office requests for sanction action usually include a peer review opinion of abuse, but not a PSRO opinion. This confusion has come about perhaps because the original PSRO legislation in 1972 assumed that PSROs would be ultimately responsible for making all medical necessity decisions for both part A and part B of Medicare, but this has not come to pass.

Carriers have relied on their own in-house medical review groups and/or made agreements with State or private peer review societies or groups to perform this function for the program. Consequently, we believe that requiring PSRO review of part B abuse determinations is impractical, since PSROs have played little or no role in this function. Officials at HCFA's Office of Program Validation said that they had never taken exclusion action against a carrier-referred provider. They expressed doubts about how well the carriers develop cases referred for exclusion and about excluding providers based on the findings of individual medical advisors and State medical societies. (Carriers frequently base their cases for exclusion action on such findings.)

We do not believe that a PSRO review is necessary to exclude overutilizers--particularly since HCFA was phasing out the PSROs in many areas. Instead, we believe that regional office requests for exclusion should be judged on the merits of the cases as presented as long as they include a review by some recognized peer group.

A second part of the exclusion problem is HCFA's apparent reluctance to use its authority to exclude overutilizers. We found the following examples of physicians who consistently billed for medically unnecessary services, yet were not excluded. The carriers and regional offices had experienced problems with these physicians for years and believed the physicians' practice patterns were serious enough to propose that they be excluded.

--A Connecticut physician was investigated and a $35,000 overpayment calculated for medically unnecessary services rendered during 1975 and 1976. Since 1976, the carrier manually reviewed the physician's claims for medical necessity before payment. Estimated prepayment denials have amounted to over $200,000 through fiscal year 1982. HCFA's central office declined to exclude this physician on the basis that there had never been a review of the provider's medical practice by a PSRO, peer review committee, or other recognized medical authority.

  Carrier officials told us that they were reluctant to obtain peer review because the review required by HCFA would be costly. They explained that the physician always requests a fair hearing to appeal prepayment denials, and they estimated that the cost of these hearings plus the cost of manually reviewing the provider's claims is about $2,000 per month.

However, in commenting on this report, the carrier stated that it did proceed to obtain the outside physician peer review requested by HCFA, that the cost of the peer review was about $3,000, and that HCFA is further considering the exclusion of this provider. In January 1983, HCFA personnel told us that the case had been forwarded to headquarters, that the provider had presented his side of the case to a HCFA official, but that a final exclusion determination has not yet been made.

--In a similar case involving a Massachusetts physician, the Medicare carrier identified $64,000 in overpayments covering the period January 1969 through March 1972. The physician has been on prepayment review for at least 9 years. The level of abuse continues to be significant--prepayment denials during the 12-month period ended June 1981 amounted to over $50,000. In July 1980 HCFA decided it could not proceed with an exclusion action without additional documentation; at that point the proposal had been pending over 2 years.

  The carrier told us that the physician is using the appeals process in an attempt to obtain additional payments. One carrier official told us that the carrier's budget includes $15,000 specifically related to the cost of conducting the hearings for this physician.

--In response to beneficiary complaints involving services claimed to have been provided as early as 1972 and other information provided by the carrier, a State peer review committee determined from a review of the practice of a Pennsylvania physician that he had been overutilizing laboratory and other procedures, and $7,044 was recovered. The carrier later found that this physician's individual statistics no longer represented a problem but that he was ordering medically unnecessary tests from an outside laboratory, where he was director, and which was owned by his wife. The doctor was later indicted in his capacity as the director of this laboratory. In November 1978, HCFA suspended payments to him from the Medicare program because of this indictment and because of complaints involving his Medicare billings as a physician in private practice. The suspension of payments was technically in effect for about 7 months. However, about a month after payments were suspended, an application was approved which allowed him to continue billing the Medicare program as

the head of a group practice which involved him and another physician. In 1980, a State peer review committee attempted to make an analysis of the medical necessity of services billed by the laboratory. However, this time the doctor refused to cooperate in a peer review and the carrier referred the case to HCFA.

Notwithstanding all of the foregoing, HCFA declined to take exclusion action, stating that a relationship between the doctor and the laboratory should be established so that an exclusion case could be developed against both parties.

In 1981, a carrier official told us it had confirmed that the physician's wife held 98 percent ownership in this laboratory but that they were dropping the case because (1) they had been told by the doctor's attorney that the laboratory is no longer in business, (2) they believe that they had already shown a clear link between the doctor and the laboratory, (3) they are confused as to what additional information HCFA wants, and (4) this practitioner has stopped accepting assignment for claims submitted under his name, thus making additional review impractical since they cannot attempt to recoup overpayments on unassigned claims.

CONCLUSIONS

Extraordinary review costs are being incurred because of extended special monitoring of the claims of habitual overutilizers. HCFA has instructed carriers on prepayment and postpayment monitoring of suspect providers but has not stated how long chronic overutilizers should be tolerated before their cases are submitted to HCFA for exclusion action. Instructions from HCFA headquarters suggesting that PSROs are the only acceptable groups of peer reviewers whose overutilization determinations can be used as a basis for sanction action indicate that those involved in sanctioning have been too restrictive in implementing procedures for excluding habitual overutilizers. Finally, although we noted cases of habitual overutilization referred to HCFA in which exclusion appeared warranted, HCFA did not exclude them, and we could find very few exclusion cases in which the primary reason for exclusion action could have been habitual overutilization.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to:

--In accordance with due process requirements, exclude providers who remain on prepayment review for over a specified period of time because they refuse to correct their abusive billing practices.

--Make it clear to carriers which peer review mechanisms besides PSROs are acceptable for initiating exclusion procedures.

AGENCY COMMENTS AND OUR EVALUATION

HHS, in concurring with our recommendations, stated that HCFA has conducted a training session with carrier personnel on administrative sanctions and that more sessions are planned. An expansion of the instructions in the Medicare Carriers Manual on referring cases to HCFA regional offices for potential administrative sanctions is also planned. The actions proposed should help alleviate some of the confusion with the administrative sanctions process; however, the tangible results of such actions measured in terms of the number of habitual overutilizers actually excluded will depend on HCFA's aggressive followup action on carrier referrals.

The Blue Shield Association and the commercial carriers commenting on this report all agreed that HCFA should act aggressively to exclude habitual overutilizers and that carriers are incurring excessive review costs to monitor the relatively few providers in this category. Blue Shield stated that, in the absence of PSRO input, HCFA should act to exclude habitual overutilizers on approved documentation provided by carriers from their UR process and peer review or other group recommendations. Connecticut General, in providing us information on a habitual overutilizer whose case had recently been resubmitted to HCFA's Boston Regional Office for exclusion action, stated that if HCFA excludes this provider, it would be the first time to its knowledge that HCFA has ever excluded a provider solely for overutilization. Nationwide commented that establishing a specific period of time for providers to correct abusive billing practices before they are excluded from the program would provide a uniform tool for the carrier to use in addressing this problem. Nationwide added that the exclusion of habitual overutilizers from the Medicare program would minimize the excessive review costs incurred by all carriers in monitoring the low percentage of providers in this category.

CHAPTER 5

MOST MEDICAID PROGRAMS SHOWED LITTLE TANGIBLE RESULTS FROM UTILIZATION REVIEW

Only 3 of the 11 States we visited used automated prepayment edits to identify and prevent payments for unnecessary Medicaid services, and only 1 had data that indicated the cost effectiveness of its prepayment UR activities. This State (Indiana) experienced a cost/benefit ratio of about 5 to 1, which was close to the overall ratio experienced by the Medicare carriers discussed in chapter 2. Officials in the other eight States said that prepayment UR had not been demonstrated to be cost beneficial or that, while they supported the concept of prepayment UR, limitations in their claims processing systems prevented them from implementing automated UR edits.

Regarding postpayment UR, many States generated reports through their Medicaid Management Information System (MMIS) or other claims processing systems which identified instances of possible overutilization, but the States did not accumulate information on, nor could we identify many tangible benefits resulting from, medical necessity issues raised through this activity.

We believe that States should have cost-beneficial prepayment and postpayment UR programs to (1) help assure that payment is made only for medically necessary services and (2) qualify for the special 75-percent Federal funding for operating their MMIS. To accomplish this HCFA should

--require States seeking continued funding for their MMIS to develop and report on the costs and tangible savings or other measurable benefits associated with their UR activities and

--facilitate communications among States attempting to establish automated edits and Medicare carriers which operate cost-beneficial prepayment UR edits.

LEGISLATIVE INCENTIVES TO CONDUCT UR

Section 1902(a)(30) of the Social Security Act requires States to provide necessary methods and procedures to safeguard the Medicaid program against unnecessary utilization of care and services. In October 1972, section 1903 of the act was amended by section 235 of Public Law 92-603 to provide financial incentives for State Medicaid programs to implement and operate efficient, economical, and effective automated

claims processing and information retrieval system--called MMIS. Such systems were intended to control program costs through more effective claims processing and utilization control. This law provided that instead of the normal 50-percent administrative cost-sharing ratio, the Federal Government would finance 90 percent of the design, development, and implementation costs of such systems and 75 percent of their operational costs.

Because of dissatisfaction with the States' progress in installing approved systems and as a further incentive for implementing MMIS, the Congress amended section 1903 in October 1980 by section 901 of Public Law 96-398. This amendment (known as the "Schweiker Amendment") provided that, except for certain small Medicaid programs, the Federal percentage of reimbursement for salaries of skilled medical personnel and other administrative costs would be reduced in States that have not implemented an MMIS by September 30, 1982 (except that a different date was to apply in certain instances specified in the amendment). The amendment also authorized HHS to reduce the Federal share of the costs to operate such a system if an MMIS subsystem fails to meet established performance standards. Disapproval can result in a reduction of the Federal share to between 50 and 70 percent of the quarterly costs to operate the system, except that the reduction cannot exceed 10 percentage points for any 4-quarter period. An objective of this amendment was to save money by minimizing unnecessary benefit payments.

While section 901 of Public Law 96-398 could provide a basis for encouraging States to make more effective use of their MMIS, the regulations describing how this provision is to be administered have not been published. The HCFA coordinator for drafting these regulations said that her office has given a high priority to completing them and that as of January 4, 1983, the draft regulations had been signed by the Secretary of HHS and had been forwarded to the Office of Management and Budget for approval.

More recent legislation (section 2161 of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35) has given the States an added incentive to demonstrate monetary results from their UR efforts. This legislation allows the States to receive a 1-percent offset to reductions that would otherwise total 3 percent of Federal Medicaid payments in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984 if their recoveries from third-party

liability programs[1] and from fraud and abuse activities total at least 1 percent of the total Federal payment.

Under September 1981 regulations to implement section 2161 of the Omnibus legislation, HHS required that the State fraud and abuse recoveries

--be documented by the State and

--include diverted funds or funds recovered as a result of State determinations of overutilization or furnishing of unnecessary care.

In defining "diverted funds," the regulations referred to

> "those amounts saved from claims that are denied or reduced in amount (1) as a result of applying prepayment screens to all or a particular portion of claims submitted by a specifically identified provider, and (2) by the application of special prepayment utilization screens in a mechanized or automated claims processing system, designed to detect fraud and abuse, to all claims submitted for payment from all providers or from a general category of providers * * *."

Although the HHS regulation seemed to include both documented cost avoidances and recoveries associated with prepayment and postpayment utilization review, a HCFA official said that, as a matter of practice, HCFA only had recognized cash collections in granting the 1-percent fraud and abuse offset under section 2161 of the Omnibus legislation. However, in commenting on our report (see app. IV) HHS stated that amended final regulations which will recognize cost avoidances as well as cash collections should be published in the near future (they were published on September 30, 1982) and that States that have not qualified for the 1-percent offset on the basis of cash collection alone will be reevaluated on the basis of criteria in the amended regulations.

---

[1]This refers to programs required under section 1902(a)(25) whereby States recover or avoid medical care costs which are the legal responsibility of third parties under private health, disability, and accident insurance policies.

THE MEDICAID MANAGEMENT INFORMATION SYSTEM

As of October 1982, 41 States or other jurisdictions were operating a federally approved MMIS. Another three States were anticipating the implementation and operation of an MMIS in fiscal year 1983, and another two States were planning, designing, or developing an MMIS. The eight remaining jurisdictions with Medicaid programs at that time do not have plans for installing such a system.

MMIS is designed to detect and report on various billing irregularities, such as duplicate claims, billing errors, ineligible beneficiaries, and ineligible providers.[2] It includes two subsystems which deal specifically with utilization review. The Claims Processing Subsystem provides for a prepayment UR function through required consistency checks among procedures and diagnoses. The Surveillance and Utilization Review Subsystem (SURS) provides for a postpayment UR function through required computerized development of provider and patient profiles on the utilization of covered services and items. This postpayment subsystem is to be used to identify providers who are abusing the program so that corrective action, such as computing and recouping overpayments, can be initiated.

Of the 11 States included in our review, 6 were operating MMISs at the time of our visits. Another two States (Connecticut and Kentucky) began to operate an MMIS after our visit. The other three States had claims processing systems that were at least partially automated but were less sophisticated than an MMIS. Of the three States, two (Maryland and Massachusetts) were planning to implement an MMIS. Rhode Island had no such plans because State officials concluded, and HCFA concurred, that the State's claims volume is too small to justify implementing an automated system as large and complicated as would be required to comply with the MMIS design.[3] Maryland had unsuccessfully attempted through a contractor to develop an MMIS plan, but in August 1982, a State official informed us

---

[2]Since Medicaid is a vendor payment program, institutional and noninstitutional providers that meet certain requirements can elect to participate in the program and enter into agreements with the States. Nonparticipating providers are not eligible to receive payment for services provided to Medicaid recipients.

[3]In September 1982, a HCFA official said that Rhode Island was one of four States that had been granted a waiver regarding implementing an MMIS.

that it was in the process of developing an "in-house" system, had made considerable progress, and had been granted a 6-month extension, until March 1983, to implement its MMIS.

The following table shows information applicable to each State's claims processing system.

	Benefits paid (fiscal year 1980)		MMIS processing system as of October 1982
	Institutional	Noninstitutional (note a)	
	(millions)		
Connecticut	$ 295	$ 54	Yes
Indiana	297	57	Yes
Kentucky	216	79	Yes
Maine	99	25	Yes
Maryland	271	48	No
Massachusetts	847	151	No
New Hampshire	62	10	Yes
Ohio	663	146	Yes
Rhode Island	141	19	No
Vermont	46	13	Yes
West Virginia	71	33	Yes
	$3,008	$635	

a/Includes physician, dental, other practitioner, clinic, laboratory, X-ray, prescribed drugs, family planning, and other care.

Noninstitutional services, the subject of this report, represent about 17 percent of total payments made by the State Medicaid programs we reviewed. One State Medicaid official said that the relatively low percentage of total payments for these services was one reason why States had not given controls over the utilization of these services a higher priority.

AUTOMATED PREPAYMENT UR EDITS ARE NOT GENERALLY USED

Although Medicare carriers we reviewed generally realized substantial savings through the use of automated prepayment UR edits, most State Medicaid programs did not use their computers to identify medically unnecessary services before payment.

In fact, only one State we visited (Indiana) could specifically identify amounts denied through its automated prepayment UR activity. Another State (Ohio) used automated UR

prepayment edits, but we were unable to develop information as to their cost effectiveness. A third State (Vermont) had automated UR edits, but their cost effectiveness appeared minimal.

However, all States visited had established prior authorization programs to provide prepayment controls over certain kinds of medical services. These programs required providers to obtain authorization from the State before the delivery of particular services. In general, for vision care, dental services, and some other routine services, the States require providers to furnish information on the patient's diagnosis and the specific services to be provided. The requests are subject to review for coverage issues, such as checks to determine if a beneficiary has already received the maximum number of eyeglasses that State law allows, as well as for medical necessity. Information on the number and amount of prior authorization denials applicable to medical necessity determinations was generally not available at the States we visited. However, Maryland officials judged from their records that most of their prior authorization denials related primarily to coverage or other issues, rather than to medical necessity questions.

HCFA has not required that State systems be capable of conducting cost-beneficial prepayment UR before certifying that their systems meet MMIS criteria and qualify to receive Federal funds for 75 percent of the cost of operating the systems. Regarding prepayment UR, 42 CFR 447.45(f)(1)(ii) of the Medicaid Regulations states only that consistency checks be made to see that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, sex, and location where the services were provided. No specific UR edits are required by the regulations.

Evaluations of the MMIS programs usually do not include assessments of prepayment UR because HCFA evaluators are not instructed on how it should be assessed. Concerning prepayment UR, evaluators are instructed only to compare the consistency/utilization edits in use with the requirements of

42 CFR 447.45(f)(1)(ii). However, as stated above, this regulation does not provide any specifics to measure against.[4]

States that used automated prepayment UR edits

The Medicaid programs in Indiana, Ohio, and Vermont were using automated prepayment UR edits to aid in detecting claims for medically unnecessary services. Information provided by Indiana officials shows that during calendar year 1980, its 35 automated medical necessity edits resulted in about $504,000 in denials at a cost of about $104,000.[5] Ohio did not keep its records in such a way that enabled us to develop comparable statistics for that State.

Vermont's claims processing system included automated prepayment UR edits, but apparently few claims denials involved medical necessity issues. A Vermont Medicaid official expressed doubts as to the extent to which it should question a physician for overutilization. Further, the State had not issued guidelines to reviewers who make medical necessity determinations. Information on the amount of medical necessity denials was not routinely kept, but according to State personnel and information available from a special project conducted for the year ended March 31, 1979, only about $42,000 in denials was attributable to automated UR edits. However, even this amount appears to be overstated because (1) it is based on amounts billed rather than allowable amounts; (2) it does not take into account the eventual reversals of the initial denials which program personnel said amounted to as much as 50 percent in this category; and (3) program personnel said that

---

[4]In commenting on our report, West Virginia's Assistant Commissioner for Medical Services stated that, if States are to adequately review for appropriateness of payment and medical necessity, Federal agencies responsible for the programs must not only require that review be accomplished but provide the incentives to encourage that it be done properly. He suggested that those incentives include a favorable matching ratio for the administration of the review programs along with mandatory guidelines for the proper staffing of those programs.

[5]Using fiscal year 1980 expenditures and savings for comparison purposes, if Indiana had been permitted to apply the net $403,000 savings to the fraud and abuse savings to be computed under section 2161 of the Omnibus Budget Reconciliation Act of 1981, it would have represented almost one-fifth of the savings the State needed to qualify for a 1-percent offset to the reduction in Federal payments.

it includes denials due to noncovered services and other non-UR issues.

The experience of the Indiana Medicaid program and the Medicare carriers we visited (see ch. 2) shows that savings can accrue to programs that effectively use automated prepayment UR edits. Many of the edits that are successfully used by Medicare carriers likely can also be used by State Medicaid agencies. In Indiana, where the Medicare carrier (Indiana Blue Shield) was also the State's fiscal agent, 13 of the 20 most productive edits being used by the Medicare carriers we visited were also being used by Medicaid. Also, Indiana had Medicaid UR edits for dental services, family planning, and eye care services covered by Medicaid but not by Medicare. While the Medicare carriers probably could save more through increased prepayment UR, they averaged over $7 saved per $1 spent on this activity through their current efforts. Indiana Medicaid saved about $5 per $1 spent on prepayment UR.

States which did not use automated prepayment UR edits

While officials in most States not using such edits agreed with the concept of automated prepayment UR, officials in three States expressed doubts about or had no experience with its benefits.

New Hampshire had an approved MMIS, but the State's Bureau of Medical Care Administrator doubted the usefulness of UR edits for several reasons, including (1) review costs would be increased since more people would be needed to handle the increase in suspended claims and (2) SURS identifies providers with heavy utilization for further review on a postpayment basis, thus reducing the need for prepayment UR edits. However, our review indicates that denying a claim for unnecessary services is much more cost beneficial than trying to recoup a payment already made.

Maine also had an MMIS,[6] but its computer was not programmed to keep track of the number of services that had been provided to a particular recipient. Therefore, screening to detect basic utilization problems--such as excessive numbers of procedures, tests, or office visits--could not be done.

---

[6]Our review of Maine's system was conducted between the time HCFA began to allow that State 75-percent Federal preferential funding for having an operating MMIS, but before the system was officially approved by HCFA.

In commenting on our report, Maine stated that, since our review, it has added computer edits to recognize overutilization of hospital and office visits associated with surgical procedures. Moreover, the State's Medical Director for Claims Review, like the New Hampshire official, did not consider the implementation of UR edits to be crucial because of the belief that overpayments can be identified and recovered through postpayment investigations.

In Kentucky few medical necessity determinations were made because the Medicaid agency did not have a physician on its staff until mid-1981 and officials there told us that no one had been willing to pursue questions of medical need without the support of a licensed physician.

Although Rhode Island does not use automated prepayment UR edits, personnel in that State believe in prepayment UR and routinely conduct manual prepayment reviews of claims to determine the medical necessity of services. State officials said that it is not necessary for them to use automated UR edits since the low volume of claims enables them to conduct the reviews on a manual basis, but they believed the early identification and denial of claims for medically unnecessary services is more cost beneficial than looking for overpayments and then attempting to recover them. They shared the desire of other State officials we contacted to pay claims as quickly as possible, but were unwilling to process claims quickly where unnecessary or excessive utilization is suspected. However, while the State officials believed their efforts to be beneficial on the basis of their study indicating that denials for medically unnecessary services claimed by private practitioners totaled about $55,000 in calendar year 1980, they do not collect data on the costs and benefits of their prepayment UR process.

Connecticut, Maryland, Massachusetts, and West Virginia lacked automated prepayment UR edits at the time of our visits, but their officials believed that prepayment UR is a desirable activity. Connecticut began to operate an MMIS since our visit which, according to officials in that State, had some prepayment UR edits. West Virginia's MMIS was just getting underway at the time of our visit, and officials in that State were working on the implementation of automated prepayment UR edits. Officials in Maryland and Massachusetts said they hope to have automated prepayment UR edits when they implement their MMISs.

NEED FOR SHARING INFORMATION ON EFFECTIVE PREPAYMENT UR EDITS AMONG HCFA, MEDICARE CARRIERS, AND THE STATES

As described in chapter 2, the Medicare carriers visited had implemented cost-beneficial prepayment UR programs to varying degrees. The only State we visited that could demonstrate the cost-effective use of automated edits under its Medicaid program (Indiana) used as its fiscal agent the same organization that was the Medicare carrier in the State. Thus, to the extent the States desire to develop cost-beneficial prepayment UR edits, the Medicare carriers that are already successfully operating these edits should be able to provide valuable technical assistance. For example, carriers with successful edits could help the States by providing them the parameters used for the Medicare edits and procedures for manually reviewing claims suspended by the automated edits.

HCFA could help identify carriers with successful edits and facilitate the exchange of information from the carriers to the States.[7] For example, Medicare carriers report quarterly to HCFA regional offices on services suspended and denied as the result of prepayment utilization edits. HCFA could use these reports to help identify edits being used successfully by Medicare carriers. Also, HCFA does periodically bring together State personnel to share their positive and negative experiences with MMIS. This same forum could be used to bring the carriers' experience with automated prepayment UR edits to the States' attention.

FEW TANGIBLE BENEFITS IDENTIFIED WITH POSTPAYMENT UR ACTIVITIES

States we visited were incurring the cost of implementing and operating federally supported postpayment UR systems, but medical necessity questions raised through the operation of the automated systems usually were ignored during later manual reviews. States have not been required to demonstrate that their SURSs are cost beneficial. However, the authority to establish performance standards and to carry out postcertification reviews under section 901 of Public Law 96-398 gives HCFA a basis for reducing the special 75-percent funding for postpayment UR systems that are not cost beneficial. In this regard, the SURS performance standards for evaluating the previously certified MMIS do not include any measure of operational economy. Simply stated, significant questions relating

[7]Section 1903(r)(6)(G) requires HHS to assist States in developing and improving their MMIS.

to MMIS' cost effectiveness go unanswered because States do not develop or report on the costs or related benefits.

Regarding tangible benefits, the fact that SURS is of limited value is not a new issue. In a September 1978 report[8] covering Ohio and two other State programs, we pointed out that (1) SURS reports did not readily identify overutilizers, (2) little use was made of SURS reports, and (3) there was inadequate staffing to effectively use much of the information SURS produced.

Existing postpayment UR programs

Of the 11 States we visited, 6 (Indiana, Maine, New Hampshire, Ohio, Vermont, and West Virginia) were being funded at the time of our visit to operate a SURS. This subsystem is similar to the postpayment UR approach used by Medicare carriers. It is designed to detect possible fraud and abuse by identifying unusual utilization patterns by providers and recipients. It generates utilization profiles for each physician and supplier billing the State, including the number and types of medical procedures they perform. It then identifies providers with abnormal practice patterns in comparison with their peer groups (all providers of the same specialty in the same locality). On the basis of these data, SURS personnel are to select for review the providers who appear to be overutilizing or misutilizing the Medicaid program.

Although Connecticut did not have an approved SURS at the time of our visit, it also used an automated system that identified providers with aberrant practice patterns in ways similar to those required under the SURS. The four other States without a SURS at the time of our visits (Kentucky, Maryland, Massachusetts, and Rhode Island) selected providers for review on the basis of complaints or allegations from providers and recipients, and inquiries by State or Federal personnel.

Postpayment UR systems are not being effectively used

Reports that identify aberrant providers form an important basis for achieving the goals of SURS, which are to (1) control improper or illegal utilization patterns and (2) assure the quality of care delivered to Medicaid beneficiaries. We found few instances in any of the five SURS operations we

---

[8]"Attainable Benefits of the Medicaid Management Information System Are Not Being Realized" (HRD-78-151, Sept. 26, 1978).

reviewed[9] in which utilization questions raised by these reports were investigated. The reports were being put to little use or were not being used for their intended purpose.

New Hampshire makes little use of information from its SURS to identify aberrant providers because, according to State officials, (1) more providers are excepted by the system than can be reviewed with the limited available staff, (2) providers who exceed peer norms are listed even if they treat only a few Medicaid patients, and (3) the information is presented in a way that makes it difficult to use. Reviews are usually started through referrals or special projects aimed at reviewing certain procedures or certain provider groups, such as podiatrists or anesthesiologists. Information was not available on the extent to which medical necessity determinations are made, but in the 15 cases we randomly selected from a list of 75 cases where overpayments had been identified, it appeared that the majority of overpayment findings related to duplicate payments or other billing problems that could have been detected through an effective prepayment review system.

Ohio's SURS generates data which could not be effectively used by its small postpayment UR staff. For this reason they usually do not use the SURS for identifying providers for review, but sometimes use it in investigating providers that have been identified on the basis of referrals or other means.

Vermont's Medicaid Division Director said the State uses its SURS to give providers feedback on the utilization of health care services. Vermont Medicaid officials considered this to be an alternative approach to making medical necessity determinations and recouping any overpayments. The officials could not provide information on the effectiveness of their approach in deterring medically unnecessary services. However, their approach does not result in the identification or recovery of overpayments.

Indiana started some postpayment reviews on the basis of data from its SURS, but officials in that State said that almost none of their investigations are designed to determine whether or not payments were being made for medically unnecessary services. The officials explained that such determinations require judgments by medical consultants. They believed

---

[9]We did not review the SURS operation in West Virginia since it was not operational until after we completed our work in that State.

that even with the support of these judgments, their chances of recovering any money would not be high if such a case were to go to litigation.

Maine was attempting to review the medical necessity of some of the providers identified through its profiling system. State officials were using their local PSRO to review cases for which the postpayment staff raised questions about the medical necessity of services already paid for. However, Maine identified only about $7,000 in overpayments from December 1979 to July 1980, and no more than $1,900 of this amount involved medical necessity issues. The other $5,100 involved payments for noncovered services.[10]

Connecticut, which used an automated postpayment review system with characteristics similar to those required under SURS, was using its system to identify and investigate some cases in which payments were thought to have been made for medically unnecessary services. State Medicaid officials did not know how much in medical necessity overpayments had been identified or recovered. Our review of 16 randomly selected cases from a list of 84 cases where overpayment determinations had been made showed that 2 involved medical necessity issues, but the other 14 involved duplicate claims, use of incorrect procedure codes, or other billing problems that probably could have been detected before payment with effective prepayment edits.

CONCLUSIONS

The Congress has given the States incentives to develop UR programs. One incentive provides special additional funding for operating a qualified MMIS. However, HCFA does not require that the States operate cost-beneficial UR programs in order to qualify for the additional Federal funding. Another incentive, contained in section 2161 of the Omnibus Budget Reconciliation Act of 1981, provides for increased payments to States that can demonstrate tangible monetary results from their UR efforts; in September 1982 HHS modified its regulations to give the States credit for such savings. Only 1 of the 11 States we visited was able to identify the costs and benefits associated with its UR activities, a capability that we believe is necessary to qualify for the increased payments authorized by section 2161.

---

[10] In commenting on our report, Maine said that its MMIS was new and in a fledgling state at the time of our review. It noted that recoveries resulting from its postpayment reviews have increased since that time (see pp. 82 and 83).

The experience of the Indiana Medicaid program (and the Medicare carriers we reviewed) demonstrates that automated prepayment UR edits of claims can be cost beneficial and can result in substantial program savings. Few State Medicaid programs, however, edit claims for medical necessity, and except for "consistency checks," HCFA does not require prepayment UR editing under MMIS. Also, HCFA does not require States receiving additional funding to develop and report information on the costs and benefits of their UR functions. Such information could significantly aid in judging the effectiveness of these functions.

RECOMMENDATIONS

To encourage State Medicaid programs to establish efficient and effective utilization review programs, we recommend that the Secretary of HHS direct the Administrator of HCFA to:

--Add to 42 CFR 447.45(f)(1)(ii) a requirement that a minimum number of automated medical necessity edits similar to those listed in chapter 2 be tested and, where cost effective, implemented in all States with MMIS.

--Develop guidelines for State Medicaid programs seeking reapproval of their MMIS to use in reporting costs and benefits of their UR efforts. The guidelines should detail the cost and benefit categories to be reported and provide that they be associated with specific prepayment screening and SURS reviews.

--Provide State Medicaid programs information on prepayment UR edits that are being successfully used by Medicare carriers and encourage the exchange of information on the edits between carriers and State agencies.

AGENCY COMMENTS AND OUR EVALUATION

HHS concurred with the intent of our recommendations. The Department said it is establishing a reapproval standard for a cost-effective SURS. It also plans to strengthen its effort to exchange information on prepayment utilization edits between carriers and State agencies.

HHS agreed that States should be encouraged to implement medical necessity edits that have been shown to be effective but said that adding a specific number of automated medical necessity edits to 42 CFR 447.45(f)(1)(ii) would be inappropriate for a regulatory provision because it would deprive HCFA and the States of needed flexibility in responding to

local patterns of utilization abuse and that any specific fixed requirements would conflict with the administration initiative to reduce the burden on States. However, HHS stated it would, through its MMIS Systems Performance Review and MMIS requirements, make revisions that will encourage the cost-effective application of prepayment screens.

The objective of our recommendation for modifying the regulatory requirements for the State prepayment claims reviews was to provide more specificity in the evaluations of such systems because the MMIS Performance Review Guide simply refers to the regulation. To the extent that this problem can be resolved by revising the guide itself, we believe that such proposed action is fully in accord with the intent of the recommendation.

APPENDIX I

DESCRIPTION OF CORE PREPAYMENT EDITS USED BY MEDICARE CARRIERS TO MAKE SUBSTANTIAL DENIALS

Edit	What it does
Hospital visits per time period	Identifies for manual review claims in which a hospitalized beneficiary is visited by a doctor more than a specified number of times within a given time period.
Concurrent care	Identifies claims in which more than one doctor bills as the attending physician for a hospitalized beneficiary.
Postoperative care	Because the fee for surgery can include postoperative care, this edit identifies claims for visits after the date of the operation.
Hospital visits per claim	Identifies a claim involving more than a specified number of doctors' visits with a hospitalized beneficiary.
Chiropractic treatments	Identifies claims involving more than a specified number of manipulations of a beneficiary's spine per time period.
Nursing home visits	Identifies claims involving more than one nursing home visit to a beneficiary within a month.
Medical charges	Identifies a claim in which total medical charges are in excess of a specified dollar amount.
Office visits	Identifies claims for more than a specified number of doctors' office visits by a beneficiary within a stated time period.

APPENDIX I

Edit	What it does
Lab services	Identifies all claims involving more than a specified dollar amount or number of laboratory services on behalf of a beneficiary within a stated time period.
Chronic renal disease	Identifies physician claims relating to kidney dialysis and certain other services provided to renal patients. Reviewers determine if a patient's medical condition warrants the kind of services for which payment is claimed and if the physician is billing for services that are supposed to be provided at no additional charge if he/she has elected to be paid a monthly maintenance fee to provide services to dialysis patients.
Physical exams	Identifies claims involving more than a specified number of complete histories and nonroutine physical exams of a beneficiary by the same provider within a stated time period.
Injections/time period	Identifies all claims involving more than a specified number of injections for a beneficiary within a stated time period.
Home visits	Identifies all claims involving more than a specified number of visits by a provider to a beneficiary's home within a stated time period.
EKG services	Identifies all claims involving more than a specified number of electrocardiogram (EKG) services to a patient within a stated time period.

APPENDIX I

Edit	What it does
Skilled nursing facility visits	Identifies all claims involving more than a specified number of visits to a beneficiary in a skilled nursing facility within a stated time period.
Foot care	Identifies all claims involving more than a specified number of foot care treatments per time period when a beneficiary has been diagnosed as having diabetes or other medical problems qualifying him/her to be covered for routine foot care.
Chest X-rays	Identifies all claims involving more than a specified number of X-rays of a beneficiary's chest within a stated time period.
Procedures of questionable usefulness	Identifies all claims involving the use of a number of medical procedures that the carrier or HCFA considers to be of questionable usefulness.
Outpatient physical vs. in-hospital	Identifies situations in which a beneficiary was provided a physical exam as an outpatient and was admitted to the hospital. Depending on which claim was paid first, either the claim for the physical exam or the physician's claim for the hospital admission day may be denied for payment.
B-12 injections	Identifies all claims involving more than a specified number of vitamin B-12 injections for a beneficiary within a stated time period.

LOW ESTIMATE OF ANTICIPATED DENIALS FOR CARRIERS BY ADDING THE CORE PREPAYMENT EDITS THEY DO NOT HAVE

Automated prepayment UR edits (note a)	Blue Shield carriers covering							Conn. Gen.	Metro. (Ky)	Nation-wide (OH/WV)	Total
	Ind	Md	Mass	Maine	NH/VT	Pa	RI				
	(000 omitted)										
Hospital visits/time period	$ 18										$ 18
Concurrent care		$ 2								$ 10	12
Postoperative care		55								259	314
Hospital visits per claim	187	114	$ 392	$ 59	$ 78		$ 91	$169	$123		1,213
Chiropractic treatments			25	4							29
Medical charges	161	96		50	66		81	146	106		706
Lab services				8	11		13	24		76	132
Chronic renal disease		9	32	5	6		7				59
Physical exams		120	413	62	82	$625	96	180	128	563	2,269
Injections/time period		7		3	5		5	10			30
EKG services	4	3	9	1	2				3	12	34
Foot care		14	50	8	10		12	22	16		132
Chest X-rays		37	126	19	25	190	29		39	172	637
Procedures of questionable usefulness			61	9	12		14	26	19		141
Outpatient physical vs. in-hospital		29	100	15	20	151	23	43	31	136	548
Total	$370	$486	$1,208	$243	$317	$966	$371	$620	$465	$1,228	$6,274

a/The difference between the 20 core edits shown on page 14 and the 15 edits shown on this table is that all carriers visited had used 5 of the 20 core edits.

Source: GAO calculations based on information provided by Medicare carriers.

APPENDIX II

HIGH ESTIMATE OF ANTICIPATED DENIALS FOR CARRIERS BY ADDING THE CORE PREPAYMENT EDITS THEY DO NOT HAVE

Automated prepayment UR edits (note a)	Blue Shield carriers covering							Conn. Gen.	Metro. (Ky)	Nation-wide (Oh/WV)	Total
	Ind	Md	Mass	Me	NH/VT	Pa	RI				
	(000 omitted)										
Hospital visits/time period	$1,964										$ 1,964
Concurrent care		$ 500								$2,345	2,845
Postoperative care		859								4,011	4,870
Hospital visits per claim	207	123	$ 427	$ 65	$ 84		$104	$188	$136		1,334
Chiropractic treatments			1,325	197							1,522
Medical charges	176	107		55	74		85	158	114		769
Lab services				23	30		37	68		210	368
Chronic renal disease		42	147	22	29		36				276
Physical exams		120	413	62	82	$625	96	180	128	563	2,269
Injections/time period		35		18	24		28	52			157
EKG services	44	26	91	14	18				28	125	346
Foot care		28	95	14	19		22	41	29		248
Chest X-rays		40	137	21	27	208	32		42	187	694
Procedures of questionable usefulness			67	10	13		16	30	21		157
Outpatient physical vs. in-hospital		29	100	15	20	151	23	43	31	136	548
Total	$2,391	$1,909	$2,802	$516	$420	$984	$479	$760	$529	$7,577	$18,367

a/The difference between the 20 core edits shown on page 14 and the 15 edits shown on this table is that all carriers visited had used 5 of the 20 core edits.

Source: GAO calculations based on information provided by Medicare carriers.

APPENDIX III

APPENDIX IV

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

10 SEP 1982

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft of a proposed report "Medicare and Medicaid Systems to Identify, Prevent or Recover Payments for Unnecessary Physicians' Services Should Be Improved." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

APPENDIX IV

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Medicare and Medicaid Systems to Identify, Prevent or Recover
Payments for Unnecessary Physicians' Services Should be Improved"

GAO Recommendation

That the Secretary direct the Administrator of HCFA to:

- develop performance standards and evaluation criteria for identifying effective and ineffective prepayment utilization review (UR) systems, that encourage cost beneficial performance, and incorporate these standards and criteria into the Contractor Performance Evaluation Program (CPEP); [See GAO note a.]

Department Comment

We concur.
We have been working on this project for some months and, by mid-September, we will issue instructions to the regional offices to implement a strengthened cost-benefit approach to prepayment screening. The instructions, to be implemented nationally on October 1, 1982, establish more uniform reporting guidelines which will allow for ongoing monitoring of this area. In addition, the CPEP has been greatly modified in this area. For example, we have eliminated the process monitoring requirements and replaced them with performance measurements and performance-related requirements. These new measures will be tested nationally during FY 1983.

GAO Recommendation

- compare the prepayment utilization edits used by Medicare carriers, identify the more effective ones in terms of valid denials and require their implementation (at least on a test basis) by all carriers;

Department Comment

We concur.
The improved data identification and reporting instructions noted in our comments to the previous recommendation, especially in the areas of cost identification, will allow us to identify the truly effective screens. These will then be tested by all carriers to determine their cost-effectiveness in the various service areas. We anticipate that this could be done by mid-1984.

GAO Recommendation

- require that prepayment UR costs be reported separately from other claims processing costs to allow for valid analysis of carriers' costs and related benefits in conducting prepayment UR;

GAO note a: Because, in October 1982, HCFA incorporated GAO's proposal in performance standards to be used for fiscal year 1983, this proposal was deleted from the final report.

APPENDIX IV

Department Comment

We concur in part.
A major part of our revised instructions is devoted to isolating costs associated with screening. At present, many carriers are reporting screen related costs under claims review. Our initiative should give us much better cost data. However, we believe that an effective screening program requires the integration of prepayment and postpayment activities; there are three reasons for not segregating these activities. First, since most carriers do not budget separately and many do not have separate units for prepayment and postpayment utilization review, it is difficult to segregate the administrative costs of these activities. Second, in many carriers, claims examiners and medical personnel perform some prepayment, as well as some postpayment, activities. Separation of administrative costs would entail a workload analysis to determine the percentage of individual employee time expended on each activity. Third, in the case of physicians and suppliers who are placed on special prepayment review, most of the administrative costs of identifying the physician or supplier and placing him/her on review are incurred in the postpayment area, while the savings appear as prepayment savings. The data on utilization review costs, combining both prepayment and postpayment costs, should be available in FY 1983. [See GAO note b.]

GAO Recommendation

- require that the costs and benefits (overpayments collected) associated with carrier postpayment UR be reported separately from claims processing costs for use in determining the effectiveness of postpayment UR operations;

Department Comment

We concur in part.
As discussed in our comments to the previous recommendation, screening costs should be isolated from claims review costs. We do not, however, feel it is appropriate to segregate the costs associated with the prepayment - postpayment UR activity.

GAO Recommendation

- expand current performance standards to ensure that the HCFA regional offices evaluate carrier effectiveness on postpayment utilization reviews with regard to (1) the appropriateness of the selection criteria used for full-scale reviews, (2) whether overpayments are computed and recovered when overutilization is identified, and (3) cost/benefit ratios for carrier UR operations; [See GAO note c.]

Department Comment

We concur and have already begun or completed actions to implement this recommendation. Our specific comments to the three aspects of this recommendation are presented below and are similarly numbered.

(1) Revisions to Medicare Carriers Manual Sections 7512, 7514, and new Section 7599 (Transmittal 906 dated March, 1982) further refine the postpayment process requirements. Section 7512 F.4 allows the contractors, with regional office concurrence, to reduce the size of the universe used for calculating the 3 percent

GAO note b: As stated on pages 11 and 12, these denials and, where possible, the associated administrative costs were excluded from our cost/benefit analysis partly for the reason pointed out by HCFA.

GAO note c: Because, in October 1982, HCFA modified its performance standards to be used for fiscal year 1983, the portion of the proposal relating to expanding the performance standard was deleted from the final report.

list by eliminating categories of comparison which have been found to be unproductive sources of postpayment investigation using a peer norm approach. Section 7514 has been expanded and explains the steps for postpayment utilization review in greater detail and directs when development should be curtailed when there is little likelihood of correcting a problem or collecting an overpayment. Section 7599 outlines the format and content to be followed by the carriers in preparing their annual postpayment utilization review activity report. Sections of this report require the contractors to identify their most effective procedures and screens. They are also required to identify cost savings resulting from their postpayment review activity as well as estimate expenses incurred in conducting their reviews.

(2) Due to the reduced funding for the Part B carriers' UR activity for FY 1982 and FY 1983, adjustments to the Postpayment Process Requirements were made. The initial 3 percent investigation list was reduced to 2 percent. Also, carriers are encouraged to make additional reductions by eliminating certain medical specialties which were found to be unproductive leads. Documentation of the screening process does not have to be done on an individual case-by-case review. It can be done by listing the parameters used. Methods for selecting cases for indepth/full scale review are to be prioritized using the following criteria: (1) highest dollar amount; (2) highest aberrancy; (3) highest number of keys (parameters) failed; (4) recurring problem with previously reviewed physicians/suppliers; (5) prior complaints received on a particular physicians/supplier; (6) regional office referrals; and, (7) personal knowledge of carrier UR staff.

Carriers are also expected to calculate and recover overpayments and to correct operational deficiencies identified by these reviews. In those instances where a carrier exceeds the postpayment requirements, bonus points will be awarded under the CPEP evaluation guides. The main objectives of these revisions are to encourage increased carrier efficiency and to obtain higher cost benefit ratio for dollars expended in the postpayment reviews.

(3) For FY 1983, HCFA is combining the prepayment and postpayment CPEP review process under one criterion. Within this criterion--"Develop and maintain a utilization review process"--the carrier will be required: (1) to submit to the regional office management reports which analyze the cost effectiveness of UR activity, and (2) to maintain a cost effective UR system. This will be measured by examining a cost-benefit ratio on a fiscal year basis by examining the four quarterly reports submitted. Due to the newness of this approach, this criterion will be scored for monitoring purposes only in FY 1983.

GAO Recommendation

- charge providers interest on the overpayments from the date collection action is initiated to the date the overpayments are repaid in full; [See GAO note d.]

Department Comment

We agree that interest should be charged to providers relative to overpayments and HCFA has already drafted a Notice of Proposed Rule Making (NPRM) which will require that interest be charged accordingly. However, we do not agree that interest should be charged from the date collection action is initiated. The NPRM

GAO note d: This proposal was not included in our final report because the Tax Equity and Fiscal Reform Act, enacted September 3, 1982, requires HHS to charge providers interest on overpayments.

presently drafted requires interest to be charged as of the date of the demand letter unless the provider makes payment in full within 30 days. This procedure is in accord with Treasury Department regulations and established business practice.

GAO Recommendation

- take steps to exclude providers who remain on prepayment review for over a specified period of time because they refuse to correct their abusive billing practices;

Department Comment

We concur.

The Bureau of Quality Control (BQC) within HCFA is responsible for imposing administrative sanctions on physicians or providers who have furnished services or supplies which are excessive or of a quality which does not meet professionally recognized standards for health care. GAO, in its report, stated that HCFA has never excluded a single provider for furnishing and billing for unnecessary services (p. iii). Actually, HCFA has excluded 11 physicians or suppliers from program participation since November, 1977, wholly or partially because they furnished excessive services. The confusion regarding this point seems to result from the fact that when BQC makes a determination that a physician has furnished unnecessary services, this determination usually means that the quality of care furnished does not meet professionally recognized standards of health care. Consequently, in all but one of the 11 cases cited above, the letter to the party explaining the reasons for our exclusion stated that the party has furnished unnecessary services, as well as services which did not meet professionally recognized standards for health care.

[See GAO note e.]

[See GAO note f.]

Existing carrier manual instructions require that whenever the carrier takes a corrective action to resolve a case of suspected abuse (i.e., overpayment, educational contact, or prepayment review) that any correspondence with the party must inform him/her that continuation of the practice could result in the party's exclusion from the Medicare program. The manual also states that carriers should refer cases which do not respond to this corrective action to the HCFA regional office for potential administrative sanction.

We recognize, however, that certain carriers have not submitted, for sanction action, cases which should have been submitted. Other carriers have submitted cases which needed extensive additional development in order for HCFA to impose a sanction which would be sustained through subsequent hearings and reviews. As a result, BQC conducted a training session on administrative sanctions with carrier personnel. In addition, more comprehensive carrier instructions and additional training sessions are being planned to resolve these problems.

GAO Recommendation

- make it clear to carriers which peer review mechanisms in addition to the Professional Standards Review Organizations are acceptable for initiating exclusion procedures.

GAO note e: Page numbers have been changed to correspond to the final version of the report.

GAO note f: We met with HCFA personnel and reconciled the information presented in this paragraph with our statement on page iii and our related statements in chapter 4. This report was adjusted to reflect this reconciliation.

APPENDIX IV

Department Comment

We concur.
We are aware that confusion exists among carriers concerning their responsibilities with respect to obtaining external peer review on potential sanction cases. It is our position that carriers should submit to the HCFA regional office for sanctions action, all cases in which corrective action attempted by the carrier has not been successful in resolving the suspected abuse and the carriers' medical staff believes the party has furnished unnecessary or poor quality services. We do not require that the carrier obtain external medical review of these cases before the case is submitted. The decision concerning additional peer review will be made by the HCFA regional office. We intend to make this point clear in our revised instructions discussed in our response to the previous recommendation.

GAO Recommendation

To encourage State Medicaid programs to establish efficient and effective utilization review programs, we recommend that the Secretary of HHS direct the Administrator of HCFA to:

- give States credit for net prepayment UR savings which can be documented in implementing section 2161 of the Omnibus Budget Reconciliation Act of 1981; [See GAO note g.]

Department Comment

We concur.
The guidelines implementing section 2161 already provide such credit. The GAO report states (page 70) that GAO was told "by a HCFA official that as a matter of practice, HCFA only has recognized cash collections in granting the 1 percent fraud and abuse offset under section 2161."

The Third Party Liability/Fraud and Abuse (TPL/FA) one percent offset is based on the collections and diversions reported by a State. Where a State qualifies for the 1 percent offset on the basis of its cash collections alone, HCFA has already approved the 1 percent offset (this is the situation referred to by the HCFA official referenced in the GAO report). Final regulations covering the TPL portion of the offset have not been published and the provisions related to diversion of funds are being refined.

A draft final regulation is currentiy under review within the Department and should be published in the near future. We intend to permit the States to submit revised expenditure reports for the last quarter of fiscal year 1981 and each quarter of fiscal year 1982, and to reevaluate States' eligibility for the offset based on the criteria contained in the final regulation. Also, we are revising our expenditure reporting forms to facilitate State reporting of the TPL/FA information. Issuance of these revised instructions is contingent upon Executive Office of Management and Budget approval and we anticipate that approval to coincide with the publication of the final regulation.

GAO note g: Because regulations, established in September 1982, in effect implemented this proposal, the recommendation was deleted from the final report.

APPENDIX IV

GAO Recommendation

- add to 42 CFR 447.45(f)(1)(ii) a requirement that a minimum number of automated medical necessity edits similar to those listed in chapter 2 be tested and where cost beneficial, implemented in all States with a Medicaid Management Information System (MMIS);

Department Comment

We concur with the objective of the recommendation, however, the specificity of change put forward in the recommendation is inappropriate for a regulatory provision and would deprive HCFA and the States of needed flexibility in responding to local patterns of utilization abuse. Any specific fixed requirements would be in conflict with the administration initiatives to reduce burden on States. We will, through our MMIS Systems Performance Review, develop standards for application of cost effective utilization screens. In addition, we will revise the MMIS requirements to link prepayment screens to aberrancies identified through post payment analysis and other sources of abuse information. Such new requirements will be published in the Federal Register in accordance with 42 CFR 433, Subpart C, by mid 1984. We intend to encourage information exchange between carriers and States on local problems, but do not plan to require specific screens.

Because of its selection of States for review, the GAO findings do not show the State-of-the-Art of a number of State systems which already contain prepayment edits similar to those recommended.

GAO Recommendation

- develop guidelines for use by State Medicaid programs seeking approval or recertification of their MMIS for reporting costs and benefits of their utilization review efforts. The guidelines should detail the cost and benefit categories to be reported and provide that they be associated with specific prepayment screening and Surveillance and Utilization Review Subsystem (SURS) reviews;

Department Comment

We concur in part.
In line with our response to the previous recommendation, we will establish a recertification (reapproval) standard for a cost-effective SURS. However, it does not appear appropriate to do the same for initial approval given the difficulties of establishing an operations SURS and the paucity of data available at the time of initial certification review. Again, this activity must take place within the requirements for State flexibility and burden reduction. [See GAO note h.]

GAO Recommendation

- provide State Medicaid programs information on prepayment utilization review edits that are being successfully used by Medicare carriers and encourage the exchange of information on the edits between carriers and State agencies.

GAO note h: We modified this recommendation to clarify our intention that it be applied only to those seeking reapproval of their MMIS.

Department Comment

We concur.
We believe, however, that the exchange will be in both directions. Some of our MMIS operations are technologically far in advance over many Medicare carrier systems. This effort to assure information exchange has long been in place; but, will be strengthened.

Technical Comment

Page 7 — The last sentence of the first paragraph is incorrect. Medicare does not routinely "waive the beneficiaries liability for services." Carriers are supposed to waive it only once. Also, waiver of liability is not applicable in unassigned claims. [See GAO note 1.]

GAO note 1: We clarified this sentence in recognition of the Department's comments.

SUMMARY OF COMMENTS BY MEDICARE CARRIERS AND GAO'S EVALUATION

We received comments from the Blue Shield Association, the Connecticut General Life Insurance Company, and the Nationwide Mutual Insurance Company. We requested but did not receive comments from the Metropolitan Life Insurance Company which, effective October 1, 1982, was replaced by Blue Cross and Blue Shield of Kentucky as the Medicare carrier for that State. Some of the comments related to specific parts of our report and were incorporated in the report. Other comments and our evaluations are summarized below.

BLUE SHIELD

Blue Shield said it is aware of the potential savings in benefit payments to be obtained from the development and enhancement of carriers' UR programs and is concerned that the current emphasis on reduction in administrative funding will further inhibit the efforts of carriers to carry out these programs effectively. In Blue Shield's opinion, we have done a creditable job in examining a most important subject which needs continual attention. It agreed that:

--The proper incentives for carriers to effectively perform either their prepayment/postpayment or sanction activities have not been provided. It specifically mentioned the emphasis on low administrative cost and timeliness of claims processing activities as not creating the proper incentives.

--HCFA's evaluations of carriers' postpayment UR programs, which also focus on the processes and timeliness of carrier activities, should be modified to measure the results obtained from the postpayment UR programs in use. It stated that an emphasis on identifying and collecting overpayments would give HCFA a method of measurement. Also, it stated that priority action directed to cases with a potential for high dollar payback would certainly maximize the return on this effort.

--The exclusion of habitual overutilizers from the Medicare program would reduce UR costs and the costs of

collecting overpayments. It believed that in the absence of PSRO input, HCFA should act to exclude habitual overutilizers on approved documentation provided by carriers from their UR process and peer review or other group recommendations.

Contrary to the HHS comments, Blue Shield suggested that HCFA require contractors to report separately prepayment and postpayment UR administrative costs, as well as prepayment denial amounts. It believed that the UR cost/benefit estimates in our report are of limited validity for the reasons we cited and pointed out that these limitations make any comparison of carriers' performance difficult.

Blue Shield also expressed reservations about the methodology we employed with respect to (1) the selection of carriers located in the Northeastern, Midwestern, and Mid-Atlantic sections of the country instead of a more representative sample and (2) the failure to address the variations in the types of claims processing systems used and the related cost of system changes.

In our opinion, Blue Shield places too much emphasis on the preciseness of the data we collected and the relatively minor inconsistencies in the data among the carriers. Simply stated, a change of 10 percent one way or the other in either the costs or the benefits would have no effect on our overall conclusions and a relatively minor effect on the relative ranking of the carriers in terms of costs and benefits. Further, we did not merely accept the carriers' estimates of costs but spent considerable effort in validating them for reasonableness by verifying the numbers and types of carrier employees actually engaged in prepayment and postpayment UR activities during our onsite visits.

Regarding our selection of carriers, we had planned to obtain information on the prepayment UR capabilities at all carriers through the use of test claims. We had developed 10 test claims involving various common types of overutilization which HCFA had agreed to submit to Medicare carriers. However, in response to budget cuts by OMB late in fiscal year 1981, HCFA decided not to submit our test claims to the carriers as originally agreed.

Regarding the variations in the claims processing systems, we noted that four of the five carriers that ranked highest in terms of prepayment UR cost/benefit ratios employed

the same data processing subcontractor (Electronic Data Systems Federal Corporation). According to an official at this subcontractor's headquarters, it generally would take little effort to adapt edits used by one carrier using its system to another carrier using its system. On the other hand, the costs associated with prepayment UR are principally expended in the labor-intensive manual review of claims suspended by the systems. Thus, we believe variations in performance are more attributable to a carrier's willingness to spend the time and effort to review questionable claims than to variations in the systems themselves.

Blue Shield officials expressed concern that our report would lead to (1) a requirement that all carriers implement certain UR edits and (2) limited flexibility of individual carriers to implement edits to respond to local conditions. They stated that variances in medical practice by geographical area and between rural and metropolitan areas might greatly influence the savings generated by certain edits and that effective professional relations and beneficiary education affect the need for and cost effectiveness of certain edits. We agree that certain variables can influence the productivity of a given edit. As indicated in the report, we intended that (1) discretion be used in requiring the use of edits that are found to be generally productive and (2) carriers should be encouraged to try new edits that they believe would be productive for them. We modified our final report in an effort to clarify our intent in this regard.

Blue Shield also stated that HCFA has drafted proposed changes to CPEP since our report was prepared and that these changes attempt to measure a carrier's ability to develop and maintain a UR process by (1) monitoring carriers' quarterly management reports, which analyze the cost effectiveness of UR activity; (2) requiring carriers to review quarterly UR reports to determine the actual cost efficiency of the UR system; and (3) requiring that carriers prepare an annual analysis of all prepayment and postpayment screens and make appropriate adjustments to them. It stated that these changes appear to respond to our concerns, but it is not convinced that the evaluation process, in itself, will provide the proper incentives to carriers to enhance or develop their UR systems. While this may be true, we believe the changes constitute a step in the right direction with respect to providing the proper incentives to carriers to perform cost beneficial UR.

CONNECTICUT GENERAL

Connecticut General stated that the report represented a very thorough and accurate analysis of the Medicare part B prepayment and postpayment UR process. It (1) stated that cost/benefit goals will be difficult to achieve if carriers are required to follow nonproductive protocols established by HCFA directives and (2) suggested we include in our recommendations that carriers be permitted some flexibility in designing their own processes to maximize program savings. Because of this comment and similar comments by Blue Shield and others, we modified our final report to clarify our intent that a carrier should not be required to implement a generally productive edit if there is a reasonable and supportable basis for believing that its implementation would not be cost beneficial for that carrier.

NATIONWIDE

Nationwide agreed with our overall findings of Medicare UR activities and our recommendations for program improvement. It agreed that HCFA performance evaluations provide little incentive to expand UR initiatives if a "satisfactory" performance in meeting HCFA requirements for prepayment controls is given for either minimum or maximum effort in developing and monitoring parameters.

It stated that our recommendation to consider UR cost/benefit ratios is a major criterion in evaluating parameter effectiveness and would provide carriers with an incentive to initiate more effective prepayment edits, that incorporating some uniform cost/savings credit into the CPEP evaluation would help to encourage all carriers to expand cost-effective utilization controls, and that carriers should receive credit for establishing cost-effective parameters in addition to any that are required to correct abusive practices in their service area.

However, in commenting on the charts on pages 11 and 14 and appendixes II and III, Nationwide said that all of the anticipated savings assigned to it for full implementation of the core edits we identified were overstated. We adjusted our charts on the basis of its comments. But we did not make adjustments on the basis of the following comments because we

could not quantify the adjustments, nor do we believe the results shown in our charts would be significantly affected.

Nationwide stated that its hospital visits per time period and per claim edits include concurrent care. However, we noted that Massachusetts Blue Shield, which had less than two-thirds of the claims volume of Nationwide and both a concurrent care and a hospital visit edit, reported denials totaling $5.2 million for these edits as compared with only $626,000 for Nationwide's hospital visit edits. Pennsylvania Blue Shield, which also had separate concurrent care and hospital visits edits, but about 15 percent higher claims volume than did Nationwide, reported over four times more in denials for these edits than did Nationwide for its hospital visit edits. Although we could not determine the specific reasons for these differences, we believe that having specific edits for hospital visits and concurrent care affected the differences in the amounts of denials reported by these carriers.

Nationwide officials also stated that they control the overutilization of physical exams, chest X-rays, laboratory services, and electrocardiogram services by provider flags where providers are on prepayment review. For this reason the carrier believed that the anticipated savings of implementing these edits would be lower than our estimates indicate. However, we question whether this factor would materially affect our estimates. First, all carriers we visited used provider flags to control identified overutilizers. Second, Nationwide and other carriers were using provider flags to monitor only a small percentage of their total provider population.

SUMMARY OF COMMENTS BY STATE

MEDICAID PROGRAMS AND GAO'S EVALUATION

We received comments from 7 of the 11 State Medicaid programs visited. We requested but did not receive comments from Indiana, New Hampshire, Ohio, or Vermont. Some of the comments received were discussed in the body of the final report. Other comments from the States and our evaluations, where appropriate, are summarized below.

CONNECTICUT

Connecticut reported that it had put its MMIS into operation since our visit. It stated that audits and edits have been built into its MMIS and are used to conduct prepayment utilization reviews. It also stated that SURS reports are used to place questionable providers on prepayment review. However, Connecticut provided no quantitative data to assess or measure the impact of these changes.

KENTUCKY

Kentucky stated that its staff was interested in the potential impact of our recommendations and that the exchange of prepayment edits would be most beneficial. It noted that, naturally, postpayment edits should be exchanged as well. It also provided the following additional proposals which it believed could strengthen our recommendations and their effect on utilization activities.

"(1) Medical Necessity Issues:

One of the key issues which seemed to come out of the Audit was the question of medical necessity. As the report indicates, the majority of states in the Audit tend not to deal with this issue, even when SUR reports clearly identify its existence.

"It would appear that pre-pay and post-pay activity will continue to fall short of its potential until this issue is effectively dealt with by both the states and the Federal Government.

"One suggestion which might assist all concerns involved would be collection and review of standards which are currently in place through the various state Lock-In Programs. By collecting

and categorizing what is considered medically necessary for the individual recipient, perhaps some standard could be extrapolated as a general model for treatment of all recipients. This could then be applied to practitioners for reviewing medical necessity as a whole. It is recognized that the government cannot dictate the practice of medicine, but some basic standards must be agreed upon to add credence to UR activity in this area.

"Furthermore, it could remove medical necessity from the area of one professional opinion versus a second professional opinion and strengthen the entire process.

"(2) S/UR Staffing:

"The second issue which was noted was a shortage of staff in S/UR Units among the states reviewed. This precipitated the production of reports which were not utilized and not cost effective.

"Perhaps this issue could be resolved by increasing the Federal match level for S/URS or requiring minimum staffing levels."

The "Lock-In" programs mentioned by Kentucky refer to section 2175 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35, approved Aug. 13, 1981), which in effect authorized a State to restrict Medicaid recipients who have been found to have been overutilizing the program to a specific provider or providers to curb program abuse. We agree with the State that this recent authority could add a new dimension to enhancing the effectiveness of postpayment UR under Medicaid by identifying such recipients. With respect to increasing the Federal match for SURS, as indicated in the report, we believe that the Congress has already provided the States with strong financial incentives to develop effective UR programs.

MAINE

Maine stated that it encouraged our efforts to increase information sharing among States, fiscal agents, and Medicare carriers with demonstrated cost-effective UR edits. It also stated that while our assessment that the State had limited

capability in the performance of prepayment and postpayment medical necessity review was accurate at the time of our visit, it is no longer accurate.

According to Maine, it was in the process of implementing its MMIS at the time of our visit and its SURS was not fully operational then. The State reported that actual recoveries as the result of its postpayment medical necessity review program have increased from about $3,000 in State fiscal year 1980, to $72,000 in 1981, and to $184,000 in 1982.

Maine said its medical necessity review approach has been to identify utilization problems on a postpayment basis and, where practicable, to enhance the system to handle identified problem areas on a prepayment basis. The State believed this to be the most cost effective and efficient method of implementing and operating an automated claims processing and information retrieval system.

MARYLAND

Maryland generally agreed with the substance of our report and the recommendations regarding the implementation of automated prepayment edits. It also agreed that postpayment UR systems are not being effectively used and that this weakness must be corrected. According to Maryland, its planned MMIS will incorporate the features necessary to make postpayment and prepayment UR effective tools for the administration of the Maryland Medicaid Program.

Maryland expressed the view that any conclusion that prepayment reviews are more cost beneficial than postpayment reviews in reducing payment for medically unnecessary services may be premature. It further stated that (1) concentrating on correcting individual cases of misutilization or overutilization, any one of which may be medically necessary given a patient's particular health needs, diverts valuable, scarce resources from the systematic detection and elimination of providers who routinely misutilize or overutilize and (2) the latter is best performed on a postpayment basis and leads just as surely to the same result--avoiding payment for medically unnecessary services.

We did not intend to suggest that prepayment UR is a substitute for postpayment UR, or vice versa. We believe that the levels of review conducted before and after payment complement each other in that one identifies specific unnecessary services while the other identifies aberrant provider practice patterns. Also, we did not conclude that postpayment UR could

not be cost beneficial and cited a number of correctable conditions that contributed to the situation as we found it. In addition, we noted that Maryland has been quite aggressive in pursuing identified fraud and abuse situations with the view toward removing chronic overutilizers from its program. For example, through March 1981, Maryland had suspended or terminated 10 providers for reasons other than fraud convictions. As discussed in chapter 4, Medicare has not taken such an aggressive approach, thus one of the potential benefits cited by Maryland of a postpayment UR system has not been realized under Medicare.

MASSACHUSETTS

Massachusetts stated that it does not yet have automated prepayment UR edits or a functioning SURS, and that it relies on manual efforts to operate its prior authorization program and in the postpayment review mechanism operated by its professional review unit. The State estimated that its prior authorization program saved over $600,000 in the first quarter of 1982 by identifying unnecessary services. Further, it stated that under its postpayment review mechanism, suspension from the program is generally emphasized in cases where it has been determined that the provider's overall pattern of practice fails to meet professionally recognized standards of health care. Five physician cases were recommended for suspension in fiscal year 1982, and $19,600 in overpayments was identified solely on the basis of the medical necessity of the services.

As indicated in chapter 5, all the States we visited had prior authorization programs covering various types of services, which is one of the differences between Medicaid and Medicare. However, these prior authorization programs did not cover services associated with some of the more productive automated prepayment UR edits used by the Medicare carriers--particularly those focusing on inpatient hospital care, such as the concurrent care edit.

RHODE ISLAND

Rhode Island concurred generally with our report but stated that one of the paragraphs contained some inaccuracies. We adjusted this paragraph accordingly.

APPENDIX VI

WEST VIRGINIA

West Virginia generally concurred with our findings and recommendations and agreed that postpayment UR efforts to date have been largely ineffective. It stated, however, that while it is probably more cost effective and more beneficial to identify and deny payment of a medically unnecessary service than to attempt recovery after payment, review for and resolution of misutilization is a labor-extensive, time-consuming process which requires considerable medical expertise and, therefore, rather expensive staff. Further, it stated that current requirements on timeliness of payment are inconsistent with extensive prepayment UR.[1]

The State further commented that, upon further consideration, if States are to effectively review the appropriateness of payment (including decisions of medical necessity), Federal agencies responsible for the programs must not only require that reviews be accomplished, but also provide the incentives to encourage that they be done properly. Among those incentives, it suggested "a favorable matching ratio for administration of the review programs along with mandatory guidelines for proper staffing of those programs because "in this age of cost containment and fiscal constraints, the UR programs have been the first to suffer."

---

[1]The timeliness of payment standard contained in section 1902 (a)(37) of the Social Security Act refers to "clean claims"; that is, those not requiring further substantiation. In our opinion, the standard does not apply to claims suspended for review because of questionable medical necessity.

(106179)

*U.S. GOVERNMENT PRINTING OFFICE : 1983 0-381-843/29

24229

AN EQUAL OPPORTUNITY EMPLOYER

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

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE,$300

POSTAGE AND FEES PAID
U. S. GENERAL ACCOUNTING OFFICE

U.S.MAIL

SPECIAL FOURTH CLASS RATE
BOOK