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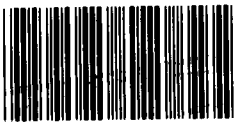
HUMAN RESOURCES
DIVISION



Carolyne K. Davis, Ph.D., Administrator
Health Care Financing Administration
Department of Health and Human Services

Dear Dr. Davis:

Subject: Inadequate Controls Over Medicare Payments for Once-In-A-Lifetime Physician Procedures (GAO/HRD-84-23)

Medicare carriers are required to have controls to prevent inappropriate payments involving once-in-a-lifetime procedures. Our review, however, showed that carrier controls were often nonexistent or inadequate and this resulted in Medicare overpayments. Medicare program requirements regarding once-in-a-lifetime procedures need to be enforced and should be strengthened.

As used in this report, the term once-in-a-lifetime procedure refers to two categories of physician procedures--surgical and "initial service" procedures. Certain surgical procedures can be performed only once in a beneficiary's lifetime. Initial service procedures, such as an initial comprehensive hospital visit, may be performed more than once during a beneficiary's lifetime but should not be routinely performed by the same physician.

OVERPAYMENTS HAVE BEEN MADE

Our work primarily covered the Albuquerque, New Mexico, office of the Equitable Life Assurance Society (Equitable), the Medicare carrier for New Mexico, and Blue Shield of New Hampshire-Vermont (NH/V Blue Shield), the Medicare carrier for those states. Neither carrier had specific controls for once-in-a-lifetime procedures.

The Health Care Financing Administration's (HCFA's) Medicare Carriers Manual states that claims processing systems:

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> ". . . will have the ability to identify once-in-a-lifetime procedures. . . . [The carrier] will keep a record of such services on the beneficiary's history for the 15 to 27 month processing history. . . . [Carriers should] not make payment without review of the medical necessity for the second performance of a service."

The manual does not further define once-in-a-lifetime procedures other than to say that initial service codes (such as initial office visit) should be included in the carriers' once-in-a-lifetime payment edits or screens.

Equitable's Medicare Director for New Mexico told us that Equitable did not have payment controls over once-in-a-lifetime procedures because of higher priority computer programming requirements and budget constraints imposed by HCFA. NH/V Blue Shield had developed a list of once-in-a-lifetime procedures; however, the Director of Medical Claims/Utilization Review for Medicare said that the necessary edits were not incorporated into the carrier's claims processing system, apparently because of oversight.

We reviewed multiple payments for selected once-in-a-lifetime procedures by analyzing the claims history files for the two carriers. In New Mexico, we screened the payment history for multiple payments for 79 once-in-a-lifetime procedures and identified overpayments of $24,677 and potential overpayments of about $14,800 during the approximately 16-month period from October 1, 1981, to January 12, 1983. In New Hampshire-Vermont, we screened for the three procedures most often having overpayments in New Mexico and identified about $3,660 in overpayments and about $13,700 in potential overpayments for the 1-year period July 1, 1981, to June 30, 1982. Two physician procedures accounted for approximately 93 percent of the total overpayments--(1) initial dialysis for acute renal failure and (2) transurethal resection of prostate. The potential overpayments involved initial comprehensive hospital visits. The amounts of overpayments and potential overpayments are Medicare program dollars, exclusive of deductibles and coinsurance paid by beneficiaries. The following describes in more detail the nature of our findings for these procedures.

New Mexico

In New Mexico, we identified overpayments of $13,562 that resulted from inappropriate charges for inpatient dialysis treatments. Equitable recognizes three procedures for hemodialysis for hospitalized patients: (1) initial dialysis for acute renal failure, (2) second through sixth treatment for

patients receiving initial stabilization treatments, and (3) hemodialysis for a chronic renal failure patient hospitalized for another illness or problem. Ten providers billed a total of 88 initial dialysis treatments when coding for subsequent treatment levels was appropriate. Overpayments were made for 59 out of 82 beneficiaries who received initial dialysis treatments. Payments of $13,562 could have been avoided if these 88 services had been paid at the appropriate less costly level of care. For the time period covered by our review, the average prevailing charge for the initial dialysis was $393, for the second through sixth treatment, it was $145; and for subsequent dialysis, it was $102. In one example a provider was overpaid $2,100 by charging for 11 initial acute dialysis treatments for a beneficiary during a 25-day hospital stay.

Carrier officials agreed that overpayments had been made. Further, they said they would attempt to collect from the provider who had received about half of the overpayments, but did not plan to attempt to collect from the other nine providers. We believe the carrier should collect all of the overpayments.

Overpayments of $11,115 were also made in New Mexico for 6 once-in-a-lifetime surgery procedures involving 25 patients. About 2,100 beneficiaries had 1 of the 6 surgery procedures during the 16-month period covered by our review. Most of the overpayments ($9,020) were for multiple billing for 18 patients for the transurethal resection of prostate procedure (removal of obstructive tissue from the prostate gland).

Equitable used three procedure codes in connection with the prostate operation: (1) the initial procedure code (which is supposed to cover services during a 90-day aftercare period), (2) a procedure code for removal of residual tissue more than 90 days but less than 1 year after the original procedure, and (3) a procedure code for the removal of obstructive tissue more than 1 year after the original procedure. In 13 of the cases we identified, the provider charged the initial procedure code a second time rather than providing free care during the aftercare period or charging one of the subsequent care codes. In five cases duplicate payments were made for a single service. Equitable officials have initiated action to recover the $9,020 in overpayments for the prostate procedures as well as the overpayments for the other five surgery procedures.

Potential overpayments of about $14,800 were identified for billings for initial comprehensive hospital visits.[1] For

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[1]The $14,800 is an estimate based on the difference between the average amount paid for an initial comprehensive hospital visit and the prevailing rate for physician specialists (less coinsurance) for an intermediate hospital visit.

physician hospital visits related to admissions, Equitable uses three procedure codes representing three levels of care: (1) brief admission; (2) initial limited or intermediate visit; and (3) initial comprehensive, complex, or extensive visit. The code for comprehensive care involves a complete physicial examination and obtaining a patient's complete medical history. According to the medical officer of HCFA's Division of Medical Services Coverage Policy, this procedure could be justified more than once in a beneficiary's lifetime; however, because of the extensive nature of the procedure, it should be used by a physician for the same patient infrequently--possibly once every 6 months. Equitable's routine utilization screen allowed one comprehensive hospital visit in 1 month and two comprehensive hospital visits in 3 months.

Using a one visit per 6 month criteria, we screened 16 months of claims payment history to identify cases where the same provider billed for more than one initial comprehensive hospital visit to a beneficiary and where Equitable's routine utilization screen did not subject the claims to review. We identified 1,762 visits which met this criteria. Carrier officials were reluctant to review the 1,762 visits because its established practice was not to question them. Equitable did, however, revise its utilization screen to allow no more than one bill for this procedure within 3 months.

New Hampshire/Vermont

In New Hampshire and Vermont for the period July 1, 1981, through June 30, 1982, we identified about $3,660 in overpayments for transurethal resection of the prostate and $13,700 in potential overpayments for charges for initial comprehensive hospital visits. No overpayments were identified for the third screened procedure--dialysis for acute renal failure--which was billed for 56 beneficiaries.

Providers billed and were paid for performing transurethal resection of prostate more than once for 9 beneficiaries out of the 1,021 beneficiaries who had this surgery during the year covered by our review. The overpayments for these cases--which included one duplicate claim--were about $3,660. This procedure is on NH/V Blue Shield's list of once-in-a-lifetime procedures, but the once-in-a-lifetime edits were not operative. A carrier official said that those claims should have been suspended from processing and priced individually; however, this was not done. Carrier officials said the overpayments would be recovered.

For physician hospital visits related to admissions, NH/V Blue Shield uses two codes to represent different levels of care: (1) limited or primary admission and (2) comprehensive visit. The carrier did not use a prepayment screen for overuse of the comprehensive visit procedure. For the 12-month period reviewed,

we identified about $13,700 in potential overpayments from overuse of the comprehensive hospital visit code.[2] We found 2,014 cases where a provider billed a beneficiary for more than one comprehensive initial hospital visit within a 6-month period (nearly three-quarters of the 2,014 cases involved a second change within 3 months). Carrier officials agreed that some of the charges we identified may be excessive and agreed to review the cases. Also, the carrier said it would (1) inform providers about the proper use of the comprehensive hospital visit code and (2) establish a prepayment screen to prevent future overpayments.

CARRIER SURVEY

We contacted 15 other carriers by telephone to find out what controls they had for once-in-a-lifetime procedures. Only eight carriers said they had controls.[3] Six of the eight were able to tell us the amount of savings they attributed to their once-in-a-lifetime screens. This data is summarized in the table below.

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[2]The $13,700 is the difference between the amount paid for a comprehensive visit and the prevailing rate (less coinsurance) for a limited or primary visit.

[3]Of these eight carriers, three included initial acute hemodialysis, one included initial comprehensive hospital visits, and one included transurethal resection of prostate on their lists of once-in-a-lifetime procedures.

Number of Procedures Screened
and Savings Attributed to
Once-in-a-Lifetime Screens

Carrier	Number of procedures screened	Savings	Time period covered by savings
Transamerica Occidental Life Insurance Company (southern California)	475	$ 157,000	January-March 1983
California Physicians' Service (northern California)	132	1,046,000	October 1982-March 1983
Blue Cross and Blue Shield of Florida	111	58,000	January-March 1983
Arkansas Blue Shield	8	77	October-December 1982
Connecticut General Life Insurance Company	67	a/	a/
Rocky Mountain Hospital and Medical Service (Colorado)	131	a/	a/
Group Medical and Surgical Service (Texas)	41	17,000	January-March 1983
Aetna Life and Casualty (Oklahoma)	29	37,000	October-December 1982

a/Carrier did not have savings reports specifically for these screens.

HCFA has left to the discretion of the carriers which procedures to screen as once-in-a-lifetime services and, as can be seen, the number of once-in-a-lifetime procedures screened varied widely. Transamerica Occidental Life Insurance Company, California Physicians' Service, Blue Cross and Blue Shield of Florida and Rocky Mountain Hospital and Medical Service had relatively extensive lists while Arkansas Blue Shield screened only eight procedures.

California Physicians' Service reported the greatest amount of savings by far. About half of the savings was attributed to the carrier's practice with respect to charges for initial comprehensive hospital visits. Second and subsequent charges by a physician during a beneficiary's 15- to 27-month payment history are automatically reduced to a lower level of care. If a physician believes that he provided a comprehensive level of care, he has the right to appeal the cutback and furnish documentation supporting a higher charge.

The seven carriers that said they did not have once-in-a-lifetime screens were Equitable Life Assurance Society in Tennessee and Wyoming, Pan-American Life Insurance Company in Louisiana, Blue Shield of Massachusetts, Pennsylvania Blue Shield, Blue Cross-Blue Shield of Greater New York, and Washington Physicians Service. These carriers said they did not screen for once-in-a-lifetime procedures because this option was not available in their computer system or because they believed such controls were unnecessary or not cost-effective.

OPPORTUNITIES TO STRENGTHEN SCREENS FOR ONCE-IN-A-LIFETIME PROCEDURES

We believe that our review shows a need for HCFA to insure that its existing requirements concerning once-in-a-lifetime procedures are enforced. We also identified two areas in which we believe HCFA's requirements could be strengthened to prevent overpayments.

First, HCFA is in the process of requiring all carriers to use a common coding system, called the HCFA Common Procedure Coding System. This coding system is due to be phased-in at all carriers by July 1985. A common list of procedures would make it easy for HCFA to mandate a core list of once-in-a-lifetime procedures which all carriers should, as a minimum, control.

Second, an official at California Physicians' Service told us that they retain in the paid claims file a permanent record of 130 once-in-a-lifetime surgical procedures performed on beneficiaries, rather than only 15 to 27 months as required by HCFA. An official at Rocky Mountain Hospital and Medical Service told us they will be able to maintain a permanent record of once-in-a-lifetime procedures in their new claims processing system which became operational in August 1983. This particular feature appears to be a desirable one because it allows carriers to exert control over such procedures during a beneficiary's lifetime, rather than only the most recent 15 to 27 months.

CONCLUSIONS

There is fairly widespread lack of compliance with HCFA's requirement to control payments for once-in-a-lifetime procedures. The overpayments at the two relatively small volume carriers we reviewed indicates that overpayments are probably substantial nationwide given that half of the carriers we contacted did not have such controls. HCFA should enforce the once-in-a-lifetime control requirement.

We also believe Equitable should collect overpayments for all of the cases we identified.

Beyond the compliance problem, HCFA should strengthen controls over payments for once-in-a-lifetime procedures by requiring a minimum core of codes to be controlled as once-in-a-lifetime procedures. This would establish minimum standards for carrier performance related to once-in-a-lifetime procedures and help assure such procedures are only paid for when appropriate. Also, we believe the practice of making permanent records of procedures that can only be performed once, as in California and Colorado, has merit. We believe HCFA should consider requiring carriers to add such capability to their claims processing systems.

RECOMMENDATIONS

We recommend that you:

--enforce the requirement that carriers implement controls for once-in-a-lifetime procedures,

--require Equitable to collect all of the overpayments for dialysis treatments that we identified,

--develop a core list of codes to be controlled as once-in-a-lifetime procedures while implementing the HCFA Common Procedure Coding System and require carriers to have edits for these procedures, and

--examine the desirability of requiring carriers to make the use of procedures that can only be performed once on a beneficiary a permanent part of beneficiaries' records.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objective was to assess carrier payment controls for once-in-a-lifetime procedures.

When we began our work at Equitable, it was apparent that a variety of physician services could be considered once-in-a-lifetime procedures. Consequently, with the assistance of Equitable medical review staff and through contacts with other Medicare carriers and one state Medicaid program, we compiled a listing of 79 once-in-a-lifetime procedures. We then checked Equitable's payment record history to see if these procedures were billed more than once.

Three procedures were associated with about 95 percent of the overpayments and potential overpayments in New Mexico. We also checked those procedures against the payment records for beneficiaries in New Hampshire and Vermont. This carrier was selected primarily because we already had its payment records for the period July 1, 1981, to June 30, 1982, in connection with other work we had performed there.

The 15 carriers contacted by telephone were selected primarily because they (1) were in the Department of Health and Human Services' Dallas region, (2) processed a high number of Medicare claims, (3) were in states covered by Equitable, or (4) were carriers from whom we had obtained payment records in connection with other work and we anticipated performing some analyses of their controls. (We did not take the additional time needed to perform those analyses.) For those carriers who had once-in-a-lifetime controls, we obtained a list of the procedures controlled and the carriers' reports of savings from their once-in-a-lifetime controls.

Our work was done in accordance with generally accepted government audit standards.

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We would appreciate hearing from you within 30 days on whatever action you take or plan on our recommendations.

Sincerely yours,

Thomas Dowdal

Thomas Dowdal
Group Director