



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

24/24

HUMAN RESOURCES  
DIVISION

August 17, 1984



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

Dear Dr. Davis:

Subject: Proposal to Improve Identification and Collection  
of Medicare Part B Duplicate Payments (GAO/HRD-84-88)

Duplicate payments are one of the principal causes of overpayments in Medicare Part B. Our work at selected Medicare claims processing contractors showed that computer screening of paid claims can be a cost beneficial way to identify duplicate payments so that recovery action can be taken. This report summarizes our work and proposes that the carriers screen their paid claims annually for duplicate payments until the process ceases to be cost beneficial.

BACKGROUND

Medicare is a health insurance program which covers (1) most Americans who are age 65 or older and (2) certain individuals under 65 who are disabled or who have chronic kidney disease. The program is authorized under title XVIII of the Social Security Act (42 U.S.C. 1395) and provides protection under two parts. Part A covers the services of institutional health care providers. Part B covers physician services, outpatient hospital care, and other medical and health services. Part B benefit payments for fiscal year 1983 were \$17.5 billion. This report deals only with part B claims.

The Health Care Financing Administration (HCFA) administers part B with the assistance of 49 contractors--called carriers. The carriers process and pay part B claims, which can be submitted by either the providers of medical services or the beneficiaries who receive them.

Some claims list services which have been billed to the carrier previously. HCFA requires carriers to have prepayment controls to prevent paying for the same medical services more than once. Generally, information describing each medical service is coded by carrier personnel and entered in the carrier's computer system as a line item. The computer compares

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new line items to one another and to those entered previously. If the line items match in enough respects, the computer can automatically deny payment for the new line item. If the line items match in certain respects but not in others, the computer is supposed to identify them for manual review.

The carriers reported that in calendar year 1982 prepayment controls prevented about \$930 million in duplicate payments. Still, HCFA statistics show that year after year duplicate payments are one of the principal causes of part B overpayments. In fiscal year 1983 duplicate payments were estimated to amount to \$69.8 million. A HCFA quality control official attributed the duplicate payments to errors made during the manual examination of claims that the carriers' automated screening processes had identified as potential duplicates.

#### OBJECTIVE, SCOPE, AND METHODOLOGY

Our objective was to determine whether it would be cost beneficial for carriers to periodically screen their claims on a postpayment basis to recover duplicate payments.

Our work was done at HCFA's central office in Baltimore, Maryland, and at Blue Shield carriers in Kansas City, Missouri, (Kansas City Blue Shield) and in Timonium, Maryland, (Maryland Blue Shield). Our selection of those carriers was based upon HCFA statistics which showed that Kansas City Blue Shield had a lower-than-average overpayment error rate and Maryland Blue Shield had a higher-than-average overpayment error rate. Prior to selecting Kansas City Blue Shield, we had identified a duplicate payment problem at the carrier in Illinois, Electronic Data Systems Federal Corporation.<sup>1</sup> However, we were aware that conditions at that carrier were conducive to a high number of duplicate claims because of problems it encountered on taking over the claims processing contract. We selected Kansas City Blue Shield for a followup test to determine whether screening paid claims would be cost effective at a carrier with a relatively low overpayment error rate. To further test and refine our screening criteria, we chose Maryland Blue Shield, a carrier with a somewhat higher overpayment error rate and with a higher volume of claims. In terms of number of claims processed, Maryland Blue Shield is near the median of all carriers and Kansas City Blue Shield is one of the smaller carriers.

For our analysis, we used Kansas City Blue Shield's claims history file for the period October 1, 1980, through November 21, 1982. During that time, the carrier processed about 2.9 million claims and paid out about \$176 million in part B benefits. We used Maryland Blue Shield's claims history file for the period October 1, 1981, through August 16, 1983. During

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<sup>1</sup>"Need to Recover Medicare Part B Duplicate Payments in Illinois" (GAO/HRD-82-67, April 30, 1982).

that period, the carrier processed about 3.9 million claims and paid out about \$265 million. In addition, we followed up on the review we had made at the carrier in Illinois.

Using our computer programs, we screened the carriers' part B claims history files to identify potential duplicate payments. These potential duplicates were based on matches in certain data fields, such as service dates, provider numbers, or procedure codes. Although we retained similarities in the screening criteria we used at each carrier, we refined it in each application to test different types of criteria and to increase cost effectiveness by eliminating types of cases which did not appear to be worthwhile for the carriers to investigate. Enclosure III shows the screening criteria we used at Maryland Blue Shield.

At both Kansas City Blue Shield and Maryland Blue Shield, we used two-stage stratified cluster samples to select the potential duplicates we had identified. At each carrier, we grouped the potential duplicates by payee and divided the payees into strata according to the dollar amounts in question. We selected the sample in two stages. First, we randomly selected payees from each of the strata. We then analyzed all or a sample of the matches for those payees. Generally, when the selected payees had a small number of matches, we analyzed all of them. However, when the payees had a larger number, we randomly selected a sample of their matches. We used microfilm and microfiche copies of the claims to analyze the selected matches. When the claims appeared to be duplicates, we discussed them with carrier officials.

In projecting our sample results for Kansas City Blue Shield and Maryland Blue Shield, we did not count as duplicate payments those cases in which (1) carrier officials were uncertain, without further investigation, whether a duplicate payment had been made; (2) the projected total overpayment for an individual payee was less than HCFA's overpayment recovery tolerance of \$50;<sup>2</sup> or (3) the carrier had already identified the duplicate payment through other means, such as quality assurance reviews or returned checks.

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

COMPUTER SCREENING FOR DUPLICATE  
PAYMENTS CAN BE COST BENEFICIAL

Our work at two carriers in this review as well as the work done previously at another carrier showed that screening paid claims to identify duplicate payments can be cost beneficial.

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<sup>2</sup>To reduce the carriers administrative costs, HCFA has instructed carriers not to try to recover overpayments of less than \$50.

For Kansas City Blue Shield and Maryland Blue Shield, our computer programs identified an estimated \$184,700 in duplicate payments which we believe the carrier should follow up on. The carriers estimated that their costs to investigate and take the necessary recovery steps will be about \$77,800. On December 22, 1983, we issued a letter report to the Kansas City Regional Administrator of HCFA recommending that Kansas City Blue Shield investigate the potential duplicates we had identified. The carrier began the followup in March 1984. We recently completed our review at Maryland Blue Shield. Our results are included in this report.

Although not exactly comparable to the duplicate payment situation, our prior work has shown that the carriers' programs to identify or recover overpayments for medically unnecessary services on an after the fact or postpayment basis had not been cost beneficial at six of the nine carriers reviewed and had about broken even at the other three.<sup>3</sup> Although we have supported the postpayment utilization review function because of the deterrant effect on program abuse and other nonquantifiable benefits, we believe that a postpayment duplicate payment detection effort offers opportunities for substantially more favorable cost benefit results than the carriers' postpayment utilization review activities.<sup>4</sup>

#### Kansas City Blue Shield

Our computer analyses identified 8,595 potential duplicates in the 2 year period studied at Kansas City Blue Shield. We randomly selected 381 for further examination, which showed that 141 of them were actual duplicate payments. The Carrier's Manager for Medicare Administration agreed that duplicate payments had been made in those cases. However, in analyzing the sample items, we identified some types of potential duplicates that may not be worthwhile for the carrier to pursue. (See enc. I.) Eliminating them left 3,826 matches that we believe the carrier should investigate. We estimate, with 95 percent confidence, that the 3,826 matches include about 1,700 duplicate payments (plus or minus 660) amounting to about \$93,900 (plus or minus \$38,100.)

The Manager for Medicare Administration estimated that it would take 2,071 staff hours and cost about \$21,600 for the carrier to investigate 3,826 matches and take the necessary recovery steps. He said this cost estimate of \$5.65 per match does not include the time required to initially train additional personnel who would be needed to do the work.

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<sup>3</sup>Improving Medicare and Medicaid System to Control Payments for Unnecessary Physicians' Service (GAO/HRD 83-16, Feb. 8, 1983)

<sup>4</sup>For fiscal year 1980 Maryland Blue Shield spent \$60,411 on postpayment utilization review and recovered \$3,838.

## Maryland Blue Shield

We identified 12,943 potential duplicates at Maryland Blue Shield in the 23 month period studied and randomly selected 331 of them for examination. The Manager for Medicare Services agreed that duplicate payments had been made in 47 of those cases. As at Kansas City Blue Shield, we identified some types of potential duplicates that may not be worthwhile for Maryland Blue Shield to pursue. (See enc. II.) Eliminating them left 6,130 matches that we believe should be investigated. We estimate, with 95 percent confidence, that the 6,130 matches include 1,660 duplicate payments (plus or minus 560) amounting to about \$90,800 (plus or minus \$45,700). The carrier's Director of Government Programs estimated that investigation and recovery would cost about \$56,200 or about \$9.17 per match.

## Electronic Data Systems Federal Corporation--Illinois

Our computer programs identified 24,552 potential duplicates made during the 22 month period studied at Electronic Data Systems Federal Corporation's Illinois operation. In response to our recommendation, the carrier identified an additional 7,522 potential duplicates that had not been correctly processed against claims history. The carrier's contract expired in April 1984. HCFA terminated the carrier's review of the potential duplicate payments on September 30, 1983. At that time, the carrier had researched 11,177 of the potential duplicates and had tried to collect the duplicate payments of more than \$50. The carrier had recovered \$218,970 and collection was pending on another \$78,608. According to the carrier, the cost of its effort was \$156,000 or \$13.96 per match.

We did not determine the reasons why the carriers estimated cost per match to investigate and recover the overpayment varied from \$5.65 to \$13.96. However, in comparing HCFA's overpayment recovery tolerance of \$50 to the individual carrier cost, we found that in all three cases the recovery efforts would be cost beneficial.

## CONCLUSIONS

Carrier prepayment controls are effective in identifying and denying payment on most duplicate claims. Although only a relatively small proportion of them slip through the carriers' controls, they represent a loss to the program of millions of dollars each year.

We believe that periodically screening paid claims to identify duplicate payments would be cost beneficial. Carriers purge older claims from their computerized beneficiary claims file annually. So that all claims can be matched, we believe

carriers should screen the file each year before purging the older claims. The first year, they will need to match all of the claims in the file against one another. However, in subsequent years, only the claims received in the last year would have to be matched against one another and against the older claims still in the file.

We believe the carriers should use criteria similar to what we found to be cost beneficial at Maryland Blue Shield. (See enc. III.) HCFA will need to monitor the results achieved by the carriers so that the screening criteria can be modified as necessary and the reasonableness of the carriers' costs can be evaluated.

Detecting and denying duplicate claims before payment is far better than identifying and attempting to recover an erroneous payment. We believe that, in the long run, the most important benefit of screening paid claims may be that carriers will be better able to identify and correct the billing or processing problems that allowed the duplicate payments to be made. If so, duplicate payments may be reduced to the point that screening paid claims will not be worthwhile.

#### RECOMMENDATIONS


We recommend that you:

- require Maryland Blue Shield to follow up on the 6,130 potential duplicates we identified,
- require carriers to screen their paid claims computer records at least once a year and to recover the duplicate payments they identify, and
- monitor the results achieved by the carriers so that the screening criteria (1) can be modified as necessary and (2) can be discontinued for any carriers that reduce their duplicate payments enough that screening paid claims is no longer cost beneficial.

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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  
Group Director

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KANSAS CITY BLUE SHIELD SAMPLE RESULTS

The following table shows the sample sizes and sample results in each of eight groups of matched line items at Kansas City Blue Shield.

Group	Matches in the universe	Sample results			Projections of <sup>a</sup> actual duplicates	
		Matches in the sample	Duplicates Identified	Percent	Dollars	Number
1. The matched line items had the same provider number, a matching service date, and the same amount was charged per service. The potentially duplicate payment was made to a beneficiary.	1,009	148	82	55.4	\$49,816	593
2. Same as group 1 except that the potentially duplicate payment was made to a provider.	2,669	62	31	50.0	39,388	1,073
3. The matched line items had the same procedure codes and provider numbers and a matching service date. However, the amount charged per service was different. The amount paid was \$50 or more. Group practice provider numbers and supplemental payments were excluded.	<u>148</u>	<u>50</u>	<u>12</u>	24.0	<u>4,685</u>	<u>36</u>
Subtotal	<u>3,826<sup>b</sup></u>	<u>260</u>	<u>125</u>	48.1	<u>\$93,889<sup>b</sup></u>	<u>1,702<sup>b</sup></u>
4. The line items matched in some respects, but had different provider numbers.	1,213 <sup>c</sup>	58	4	6.9	\$ 3,229	115
5. The provider was a group practice for which we identified an especially large number of potentially duplicate matches.	1,708 <sup>c</sup>	15	0	0	0	0
6. The Medicare payment for each service was less than \$5.	1,113 <sup>c</sup>	25	10	40.0	1,448	294
7. Ambulance claims	288 <sup>c</sup>	6	0	0	0	0
8. Purchase of medical supplies or durable medical equipment	<u>447<sup>c</sup></u>	<u>17</u>	<u>2</u>	11.8	<u>2,844</u>	<u>150</u>
Subtotal	<u>4,769</u>	<u>121</u>	<u>16</u>	13.2	<u>\$ 7,521</u>	<u>559</u>
Total	8,595 =====	381 ===	141 ===	37.0	\$101,409 <sup>d</sup> =====	2,261 =====

<sup>a</sup>We did not count as a duplicate payment or include in our projection, overpayments which were less than HCFA's \$50 overpayment recovery tolerance.

<sup>b</sup>We estimate, with 95 percent confidence, that the 3,826 matches include about 1,700 duplicate payments (plus or minus 660) amounting to about \$93,900 (plus or minus \$38,100).

<sup>c</sup>Our sample results indicated it may not be worthwhile for the carrier to pursue the potential duplicates in these groups.

<sup>d</sup>This is a projection of the overall sample results and, because of rounding, is slightly different from the sum of the projections for each of the eight groups.

MARYLAND BLUE SHIELD SAMPLE RESULTS

The following table shows the results of our sample at Maryland Blue Shield. The sample was designed to be projected on an overall basis rather than category by category. However, to identify the categories which may not be worthwhile for the carrier to pursue, we made separate projections of the sample results for each category. The overall projections and the combined projections for categories 1 through 7 are accurate. However, because of the small sample sizes in individual categories and because some categories comprised a disproportionate share of the sample, the projections are somewhat understated for some individual categories and overstated for others. Still, in our judgment, the projections indicate that categories 8 through 13 probably would not be worthwhile for the carrier to pursue. (Enc. 111 shows the screening criteria for each category.)

Category	<u>Matches in the universe</u>		<u>Sample results</u>				
	<u>Total</u>	<u>After excluding certain payees<sup>a</sup></u>	<u>Matches in the sample</u>	<u>Duplicates Identified</u>	<u>Percent</u>	<u>Projections of actual duplicates<sup>b</sup></u>	
						<u>Dollars</u>	<u>Number</u>
1	1,792	1,013	21	6	28.6	\$ 8,782	291
2	4,010	2,854	77	17	22.1	22,485	516
3	212	172	4	3	75.0	18,067	49
4	168	166	14	7	50.0	22,413	159 <sup>c</sup>
5	402	351	5	4	80.0	3,447	346
6	676	404	20	2	10.0	7,445	94
7	<u>1,881</u>	<u>1,170</u>	<u>34</u>	<u>5</u>	<u>14.7</u>	<u>8,171</u>	<u>175</u>
Subtotal	<u>9,141</u>	<u>6,130</u>	<u>175</u>	<u>44</u>	<u>25.1</u>	<u>\$90,809<sup>d</sup></u>	<u>1,660<sup>d</sup></u>
8	151	124	2	0	0	\$ 0	0
9	2,127	1,734	92	2	2.2	2,427	41
10	204	198	13	0	0	0	0
11	816	811	26	0	0	0	0
12	438	287	18	1	5.6	493	41
13	<u>66</u>	<u>60</u>	<u>5</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Subtotal	<u>3,802</u>	<u>3,214</u>	<u>156</u>	<u>3</u>	<u>1.9</u>	<u>\$2,920</u>	<u>82</u>
Total	12,943	9,344	331	47	14.2	\$93,729 <sup>d</sup>	1,742 <sup>d</sup>
	*****	*****	***	**		*****	*****

<sup>a</sup>We selected our sample in two stages. First, we randomly selected 112 payees from a universe of 1,783 payees which we had stratified according to the dollar amount of their potential duplicates. The payees had from 1 to 546 potential duplicates. We then randomly selected potential duplicates for each of the 112 payees. For some payees with a relatively large number of matches, our sample results indicated that investigation of all of their potential duplicates would probably not be worthwhile. Eliminating them would substantially reduce the number of potential duplicates to be investigated by the carrier but, according to our sample results, would not significantly reduce the actual duplicate payments detected. The projections in this table do not include any duplicate payments for the excluded payees.

<sup>b</sup>We estimate, with 95 percent confidence, that the 6,130 matches in categories 1 through 7 include 1,660 duplicate payments (plus or minus about 560) amounting to about \$90,800 (plus or minus \$45,700). We did not count as a duplicate payment or include in our projection overpayments which were less than HCFA's \$50 overpayment recovery tolerance.

<sup>c</sup>Our projection for this category was 188 and the sample error was large. Seven of the 14 matches included in our sample were not duplicates. Therefore, the maximum number of duplicates possible would be 159 (166-7=159).

<sup>d</sup>This is a projection of the overall sample results for a group of categories and is somewhat different from the sum of the projections for each of the individual categories.



MARYLAND BLUE SHIELD SCREENING CRITERIA

We used Maryland Blue Shield's claims history file for the period October 1, 1981, through August 16, 1983. We eliminated from our analysis any line items which did not involve a benefit payment or which were not applied against the deductible. Also, we required that the amount paid for each service be (1) at least \$50 for ambulance and durable medical equipment claims and (2) at least \$5 for all other claims. We did not match line items from within the same claim.

Except as noted above, each beneficiary's line items were compared to one another. The following table shows (1) the data fields that we compared and (2) other requirements that had to be met in order for line items to be identified as potential duplicates in one of our screening categories. "YES" means that the line items had to match, "NO" means that they had to be different, and "---" means that the screening criteria did not include this factor.

Data fields compared										Other requirements			
A													
matching	provider	Same	Same	billed	Same	Specialty	Same	Amt. paid	per service	visit	procedure	adjustment	line item?
service	number?	procedure	amt. per	amt. per	type of	type of	type of	was \$25	was \$25	code?	code?	code?	code?
date?	code?	code?	code?	code?	code?	code?	code?	code?	code?	code?	code?	code?	code?

1	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	---
2	YES	YES	NO	YES	NO	YES	YES	---	---	---	---	---	---
3	YES	YES	YES	YES	NO	YES	YES	---	---	---	---	---	NO
4	YES	NO	YES	YES	YES	---	---	---	---	---	---	---	---
5	YES	NO	YES	YES	YES	---	---	---	---	---	---	---	---
6	YES	NO	NO	YES	YES	---	---	---	---	---	---	---	---
7	NO b	YES	YES	YES	YES	---	---	---	---	---	---	---	---
8	YES	YES	YES	NO	NO	---	---	---	---	---	---	---	---
9	YES	YES	NO	NO	---	---	---	---	---	---	---	---	---
10	YES	NO	YES	YES	NO	---	---	---	---	---	---	---	NO
11	YES	NO	YES	NO	YES	---	---	---	---	---	---	---	NO
12	NO b	YES	YES	NO	---	---	---	---	---	---	---	---	---
13	NO b	NO	YES	YES	YES	---	---	---	---	---	---	---	---

Type of service means similar service such as surgery, ambulance service, durable medical equipment etc. Each line item showed the beginning and ending dates of the treatment period. The potential duplicates we identified in these categories did not have matching service dates, but had overlapping treatment periods. To help assure that the line items could potentially have a service date in common, we required that at least one of the line items had to involve three or more services. Also, whenever the other line involved just two services, we required that at least one of the dates for those services be between the service dates on the line with three or more services.