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Report to the Acting Administrator, Health Care Financing Administration, Department of Health and Human Services

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MEDICARE

Internal Controls Over Electronic Claims for Anesthesia Services Are Inadequate

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GAO

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Human Resources Division

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December 18, 1989

Mr. Louis B. Hays
Acting Administrator
Health Care Financing Administration
Department of Health and
Human Services

Dear Mr. Hays:

During our review of Medicare payments to anesthesiologists, we found that internal controls were inadequate for claims for anesthesia services submitted by electronic media, such as magnetic tape or disk. Controls over electronic claims at seven of eight carriers in our review were not as effective as controls used in paying paper claims. When we sampled electronic claims at three of these carriers, we found computational errors that could have been detected had the controls for reviewing paper claims been employed. A subsequent audit by one of these carriers disclosed net overpayments to an anesthesiology group of about $117,000. The Health Care Financing Administration (HCFA) needs to improve its electronic media claims control policies and review carrier compliance with such policies.

Background

Providers of Medicare services submit claims in either paper or electronic form. In fiscal year 1988, about 34 percent of part B claims (which are primarily for physician services) processed by Medicare carriers were received electronically. During fiscal year 1988, part B benefit payments totaled $33.7 billion, of which $1.2 billion was for physician anesthesia services.

Medicare payments are based primarily on the "reasonable charge" concept and, for anesthesia claims, the amount of time it takes the physician to provide the service or to furnish medical direction to nurse anesthetists.[1] To determine the reasonable charge for an anesthesia claim, the carrier calculates the number of anesthesia units allowed for the service and multiplies those units by a dollar conversion factor for

[1]Nurse anesthetists may also submit claims for providing anesthesia services. Medicare payments to anesthetists are determined in a manner similar to the one used for physicians. In this report, the processes and problems described for physician claims for anesthesia services also apply to anesthetists.

controls used for verifying computation of time units on paper and electronic anesthesia claims that they process.[3]

Our work on this segment of the overall study was performed at HCFA headquarters in Baltimore, HCFA's regional office in Kansas City, and eight carriers. We verified the anesthesia times reported on electronic media claims at hospitals in California, Missouri, and Pennsylvania.

We discussed this report with HCFA officials and incorporated their comments where appropriate. Our field work was performed between January and August 1989 in accordance with generally accepted government auditing standards.

Carriers Not Following Medicare Procedures in Processing Anesthesia Claims

Medicare carriers are not following Medicare Carriers' Manual policies that (1) anesthesia times be shown on all claims for anesthesia services and (2) carriers subject electronic media claims to the same prepayment reviews as paper claims. As a result, seven of the eight carriers we contacted lacked adequate assurance that providers billing electronically had correctly computed the anesthesia time units they were claiming. In addition, HCFA is not assuring that organizations, such as Medicare carriers, adopt internal control systems to ensure proper use of federal funds, in accordance with the Federal Managers' Financial Integrity Act of 1982 (31 U.S.C. 3512(b)).[4]

The eight Medicare carriers we contacted said that they require anesthesia times on all paper claims for anesthesia services and that paper claims are not processed for payment until such times are furnished. But for electronic media claims, only one of these carriers followed the same policy. The other seven pay electronic claims for services that do not show anesthesia times.

[3]We did not contact Prudential because the company ceased operating as a Medicare carrier for North Carolina on January 1, 1989.

[4]The act requires agencies to establish internal control systems that assure agency expenditures are consistent with laws, regulations, and policies. When an agency's major function involves monitoring the activities of private organizations, the agency should make reasonable efforts to assure that the organization adopts adequate internal control systems. The Comptroller General has prescribed specific internal control standards for agency use in implementing the Financial Integrity Act. For example, transactions must be documented so managers can use them in controlling and auditors in evaluating operations.

A HCFA official told us that the agency's annual contractor evaluations do not determine whether carriers subject electronic claims to the same prepayment reviews as paper claims. Furthermore, HCFA regional officials overseeing the Missouri carrier said the region had never conducted reviews to determine carrier compliance with this requirement.

Conclusions

HCFA lacks reasonable assurance that payments for anesthesia services based on electronic claims are accurate. Medicare carriers' internal controls should include independent verification of physicians' computations of time units for anesthesia services. Independent verification requires that physicians show on each claim the time spent in providing the service and that carriers systematically reconcile this information with claimed time units. However, carriers are paying electronically submitted claims that lack data on anesthesia times or, when time data are submitted, they are not reconciling these data with the time units claimed. As a result, computational errors have gone undetected and overpayments have occurred.

Recommendations

We recommend that you

- reemphasize to carriers that electronic media claims for anesthesia services must show anesthesia times and receive the same prepayment reviews as paper claims,
- require that carriers systematically reconcile time units claimed with anesthesia times reported on the claims, and
- include periodic assessment of compliance with electronic media processing requirements in HCFA's contractor evaluations.

Major Contributors to This Report

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Anesthesia Claims Reviewed by GAO

Carrier	No. of claims reviewed			No. of providers who submitted the claims
	Paper	Electronic	Total	
Blue Cross and Blue Shield of Massachusetts, Inc.	191	0	191	1
The Travelers Insurance Company (Connecticut)	144	0	144	1
Prudential Insurance Company (North Carolina)	33	0	33	1
Blue Cross and Blue Shield of Florida, Inc.	269	0	269	14
Pennsylvania Blue Shield	290	99	389	4
Blue Shield of Iowa	194	0	194	1
General American Life Insurance Company (Missouri)	1	93	94	1
Aetna Life and Casualty Company (Arizona)	34	0	34	5
Blue Shield of California	147	39	186	14
Total	**1,303**	**231**	**1,534**	**42**

We are sending copies of this report to interested congressional committees and subcommittees, the Secretary of Health and Human Services, and other interested parties.

We would appreciate your informing us within 60 days of the action taken or planned in response to our recommendations. Please call me on (202) 275-5451 if you have any questions about this report. Other major contributors to this report are listed in appendix II.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

As a prepayment review measure for all paper claims, the carriers independently compute anesthesia time units using the anesthesia times reported on the claim. For electronic claims, seven of the eight carriers do not use this prepayment control:

- One carrier makes independent computations on electronic claims that show anesthesia times but accepts as correct the number of units claimed by the physician when anesthesia times are not reported.
- Six carriers pay claims according to whatever number of units the provider shows on the claim.

The carriers for Missouri, northern California, and Pennsylvania processed the electronic claims included in our sample. When we tested the accuracy of electronic media billings, we found high error rates at the Missouri (24.7 percent) and northern California (30.7 percent) carriers; the Pennsylvania carrier's error rate was only 2 percent for electronic billings. For example, at the Missouri carrier we examined 94 claims, including 93 electronic claims, submitted by one group. On the sole paper claim, the anesthesiology group claimed 6 units more than allowable but because of the prepayment review process, the overbilling was detected and the excess units were disallowed. On the electronic claims, 23 of 93 had errors in the units claimed that the carrier did not detect. On 9 of the 23 claims, the carrier allowed too many units (30 total), and on the other 14 claims, the anesthesiology group was entitled to additional units (16 total). Had this carrier used the review process it uses for paper claims, it would have detected these errors. After we discussed our findings with carrier officials, they audited the anesthesiology group's claims. Preliminary results of that audit show net overpayments, during an 11-month period, of about $117,000, due largely to the carrier's inability to detect physicians' computational errors involving anesthesia time units.

Carrier officials offered several reasons why information and review requirements were different for electronic and paper claims. Some were concerned that requiring anesthesia time and performing prepayment reviews on electronic claims would slow processing time. Because the independent computation of anesthesia time could be done electronically by computer, we do not believe this concern is valid. Other carriers were unaware that electronic and paper claims had to receive the same treatment. One such carrier, after our inquiry, instituted a control to suspend payment on electronic media claims that do not contain anesthesia time.

the geographic area in which the service was furnished. Anesthesia units have two components:[2]

- Base units. These reflect the complexity of different anesthesia procedures. For example, 4 base units are allowed for anesthesia services provided in conjunction with a hernia repair, while 15 are allowed for procedures involving heart surgery.
- Time units. Medicare allows one time unit for (1) each 15-minute interval that the physician spent personally in providing anesthesia service and (2) each 30-minute interval spent in furnishing medical direction to others. HCFA requires providers to show anesthesia times on each claim. This enables Medicare carriers to compute the allowable time units independently.

If an anesthesiologist spent 50 minutes providing anesthesia for a hernia repair, the carrier would allow 8 anesthesia units—4 base units for the procedure and 4 time units (50 minutes divided by 15 minutes per unit, rounded up).

Objectives, Scope, and Methodology

Section 4048(d) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) required us to review Medicare payments to anesthesiologists and verify anesthesia times claimed by comparing them with patient medical records. We reviewed 1,534 randomly selected claims for physician anesthesia services provided at 11 hospitals between July 1 and December 31, 1987. We judgmentally selected the hospitals, located in nine states, to provide geographic representation. The claims were submitted by 42 physicians or anesthesiology groups and processed by the nine carriers shown in appendix I. Of the 1,534 claims, 231 (15 percent) were in electronic form.

To verify the accuracy of anesthesia time units on electronic media claims, we compared the time units reported to the three carriers in our sample that had electronic claims, with the time recorded in patient medical records. After finding computational errors on these claims, we contacted officials at eight of the nine carriers to determine the internal

[2]HCFA limited anesthesia units to these two components effective March 1, 1989. Before that time, including the claims covered by our review, carriers could allow additional anesthesia units, called modifier units, for circumstances such as when a patient was over 70 years old or in poor physical condition.