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MEDICARE

HCFA Monitoring of the Quality of Part B Claims Processing

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Mr. Chairman and Members of the Committee:

It is a pleasure to be here today to share with you the preliminary findings of our ongoing work on the methodological quality of the Health Care Financing Administration's (HCFA's) review of Medicare carrier performance. Concerned that private insurance carriers that process Medicare claims may be inappropriately denying, underpaying, or overpaying beneficiaries' claims, you asked us to assess the methods being used to approve or deny claims, and whether they are being applied correctly and equitably. In our testimony today, we present a description and an interim assessment of the methods HCFA uses to monitor the quality of carriers' processing of Medicare Part B claims. To develop this information, we met with HCFA officials, examined HCFA documentation, reviewed the literature, and interviewed experts in the field, including representatives from one carrier.

BACKGROUND

Medicare was authorized by title XVIII of the Social Security Act to provide health care benefits to (1) most Americans 65 years of age or older and (2) certain Americans under 65 years of age who are disabled or who have end-stage renal disease. The Health Care Financing Administration, within the Department of Health and Human Services, administers Medicare and establishes the regulations and policies under which the program operates.

The Medicare program has two distinct parts: Part A (Hospital Insurance Benefits for the Aged and Disabled) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities; Part B (Supplementary Medical Insurance for the Aged and Disabled) covers physician services and a range of other noninstitutional supplies and services, such as durable medical equipment, diagnostic laboratory tests, and X-rays.

HCFA has contracted with 34 private carriers to process and issue payment on Part B claims. The carriers are required to process these claims in a timely, efficient, effective, and accurate manner. During fiscal year 1991, these 34 carriers processed about 500 million claims submitted by nearly 900,000 physicians and suppliers.

Carrier prepayment reviews begin with a computer analysis of all claims in order to process valid claims and to identify questionable claims for manual review prior to payment or denial. More specifically, prepayment reviews (1) detect problems with individual beneficiary claims, (2) identify claims for services not covered by Medicare, (3) identify claims for types of services associated with overuse, and (4) identify claims from

physicians or suppliers known to have questionable practice patterns.

The computer program provides 20 prompts for information requests--called "screens"--as part of the initial review of claims. These screens include, for example, checks that no payment will be made for an unusually large number of routine foot care treatments, comprehensive physical examinations and office visits, or physiatric visits to a patient in a rehabilitation facility.

Carriers are required to pay only for services or supplies that are medically necessary. HCFA allows the carrier to develop and use its own criteria for determining medical necessity. For example, a carrier may decide that payment will not be made for more than one comprehensive physical examination in a 6-month period without justification. HCFA also allows the carrier to develop screens that identify unreasonable and unnecessary medical services based on the local medical community's customary health care needs. HCFA officials told us that carriers are allowed to develop these screens with input from the medical community on local health care patterns and from the feedback carriers receive when the criteria are published for public comment.

Two results of this process are that the number and sophistication of prepayment screens vary greatly among the carriers and that each carrier has a unique set of criteria on which they assess medical necessity. What this means is that although Medicare is a national program, its actual health coverage varies by carrier and by geographical region. Even the so-called "national" screens are not standardized screens but are standardized topics that carriers must translate into screens.

Upon receipt of a claim, the carrier is required to assess whether it is complete, accurate, and submitted according to Medicare guidelines. The carrier reviews the claim to determine whether (1) the beneficiary is eligible for Medicare benefits, (2) the claim is submitted within the limited number of days from the date of medical service or item delivery, (3) the service or supply is covered by Medicare, and (4) if so, the documentation on patient condition supports the claim.

On the basis of this review, the carrier determines whether the claim should be paid or denied or whether more information is needed to make a decision. For approved claims, the carrier determines Medicare's allowable charge for the service or supplies, and then makes payment to the physician, supplier, or Medicare beneficiary.

If a carrier determines that a request for payment is a duplicate or does not properly reflect the kind and amount of

services furnished, or if it determines that a request for payment has been submitted for services that are not medically necessary, then the carrier either rejects or adjusts the request for payment. The carrier notifies the beneficiary and provider of the action taken, using an "Explanation of Medicare Benefits" letter for beneficiaries and a summary voucher form for the providers.

For a claim that has been denied, the beneficiary or the provider has the option either to provide additional information to the carrier (with the expectation that denial will be reversed), to initiate an appeal (whereby the first step is a carrier review of the claim), or to accept the carrier's decision.

The carriers are obligated under their contract with HCFA to safeguard against unnecessary utilization of services and to conduct audits to ensure that payments are made properly. In return for providing these Medicare claims administrative functions, HCFA pays the carriers the administrative costs they incur by processing Medicare Part B claims.

The accuracy with which carriers assess Medicare claims has an impact on the federal government, the medical community, and the public. Overpayment of claims adversely affects the size of the federal budget, while underpayment has a negative impact on medical providers and beneficiaries. Because you were concerned with the lack of information on the accuracy with which claims are resolved, you asked us to describe HCFA's methods of monitoring carriers' performance in claims processing.

WHAT METHODS ARE USED BY HCFA TO MONITOR THE QUALITY OF CARRIERS' CLAIMS PROCESSING?

HCFA is required to develop criteria, standards, and procedures to evaluate a carrier's performance under its contract with the agency. A carrier's failure to meet these standards can result in the termination of the contract. HCFA officials told us that they use the Quality Assurance (QA) Program and the Contractor Performance Evaluation Program (CPEP) to monitor the quality of carriers' claims processing.

Quality Assurance Program

The Quality Assurance Program calculates two types of errors. First is the number and type of processing errors or "occurrence errors"; that is, the number of errors made by the carrier in the following categories: (1) entitlement, (2) coverage, (3) reasonable charge, (4) payment, (5) documentation, and (6) coding or data entry. The second calculation is the dollar amount corresponding with the sum of the errors in the six categories called "payment/deductible errors," made by each

carrier in processing its claims.

Processing errors may occur, for example, because the carrier incorrectly paid a claim for a beneficiary who was not entitled to Medicare coverage, payment was made for services that were not covered, payment was not made for services that were covered, overpayments or underpayments were made, or a data entry error resulted in an incorrect identification of the type of service.

Calculations of the processing errors and payment/deductible errors are made in a two-step process. First, the carrier, using a HCFA-developed computer program, selects a random sample of claims that were processed during the preceding quarter. The carrier then reviews these claims to determine the accuracy of its initial claims processing. Each carrier uses its unique set of national and local screens to reprocess a claim and compares how the claim should have been handled against the way the claim was actually handled.

Second, HCFA's regional staff select a 9-percent subsample from the carrier's sample of claims, and using the carrier's unique set of screens, HCFA independently calculates the error rates. Findings from the carrier's sample review are combined with findings from the regional office's subsample review to produce final error rates. The carrier is notified of the findings of the QA reviews, and if deficiencies are identified, the carrier is expected to take the necessary corrective actions.

It is important to note that the QA Program is limited to assessing the reliability of whether the criteria (or screens) were applied appropriately, and it cannot be used to assess the validity or "goodness" of the criteria. Specifically, because carriers and HCFA's regional staff use the same screens in calculating the processing error rate, HCFA's QA Program measures only the reliability; that is, interrater agreement, but not the validity of the criteria; that is, whether in fact the criteria measure what they are intended to measure. For example, a carrier may use a screen that denies more than a single routine foot care treatment during any 6-month period. A reviewer, using the same screen, would likely conclude that the denial was warranted. However, the reviewer's conclusion may be erroneous because it may be that two routine foot care treatments are warranted in any 6-month period. In our judgment, this is a serious limitation in the QA Program because HCFA gives much flexibility to carriers in developing their own set of medical screens. Without knowing the validity of the screens, the QA Program cannot independently determine whether the carrier could have inaccurately denied or improperly approved a claim.

We found that the QA Program does not provide a direct measure of the extent of underpayment of Medicare Part B claims.

The payment/deductible error rate is the sum of underpayments, overpayments, and misapplied deductible payments. HCFA officials told us that they do have separate data on underpayment, and we will explore this issue further.

Contractor Performance Evaluation Program

A second method that HCFA uses to monitor the quality of carriers' claims processing is called the Contractor Performance Evaluation Program. HCFA's regional staff annually conduct CPEPs to evaluate each carrier's performance. The results of these evaluations are considered whenever HCFA enters into, renews, or terminates a carrier contract.

Carriers are rated on a 100-point scale that contains the following five criteria:[1]

1. claims processing, which measures the extent to which claims are processed in a timely and accurate manner (29 points);

2. payment safeguards, which prevent inappropriate program expenditures (27 points);

3. services, which ensure that beneficiaries and providers are treated in accordance with the law, regulations, and general instructions (7 points);

4. administrative management, which ensures that the Medicare program is effectively administered (12 points); and

5. program efficiency, which ensures that the contractors operate the program in the most efficient and effective manner possible (25 points).

CPEP ratings include points for the payment/deductible error rate, which in part operationalize the first two criteria. However, based on our preliminary work, we note two aspects of carrier performance are not included as criteria in calculating CPEP scores. First, CPEP does not incorporate the number of claims that carriers inaccurately processed (which is available from the QA Program). Second, there is no measure of the validity of carriers' medical screens (which affect decisions on medical necessity and appropriateness). In our continuing work, we will explore this issue further.

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[1]We are aware of the revised CPEP scoring system that will be implemented on October 1, 1992. We do not believe that the revised scoring system affects our findings.

HCFA officials informed us that they have not conducted any evaluations beyond the QA Program and the CPEP on the accuracy of carriers' denial of claims. Further, we found that HCFA has not developed a systematic analysis of appeals that have been reversed. Such an analysis could identify specific areas where errors are occurring consistently and would help to increase accuracy in claims processing.

<u>SUMMARY</u>

HCFA has two methods to monitor the quality of carriers' processing of claims: the QA Program and CPEP. While the QA Program measures the reliability of claims processing, it does not measure the validity of the criteria used to evaluate the accuracy of claims processing. Further, the payment/deductible error rate is not a direct measure of underpayment because the rate is a combination of three types of errors--underpayment, overpayment, and misapplied deductible payments.

The criteria used to calculate CPEP scores include a measure of the amount of payment errors. However, they could be more complete by adding a measure of the number of processing errors, including the inaccurate determination of medical necessity and appropriateness.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or members of the Committee may have.