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MEDICARE PART B

Factors That Contribute to Variation in Denial Rates for Medical Necessity Across Six Carriers

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Mr. Chairman and Members of the Subcommittee:

It is a pleasure to be here to share with you the results of our ongoing work on the Medicare Part B claims processing system. My statement is based upon our report entitled Medicare Part B: Regional Variation in Denial Rates for Medical Necessity, which is being issued today. Our report has two objectives--to determine the extent of carrier variability in denial rates for lack of medical necessity and (2) to identify and examine factors that may contribute to such intercarrier variation. To develop this information, we analyzed a 5-percent sample of 1992 and 1993 Medicare Part B data on claims processed by six Medicare carriers for 74 services that were either expensive or heavily utilized. The carriers included in this study were California Blue Shield (jurisdiction: Northern California), Transamerica Occidental Life Insurance (jurisdiction: Southern California), Connecticut General Life Insurance Company (jurisdiction: North Carolina), Blue Shield of South Carolina, Illinois Blue Cross and Blue Shield, and Wisconsin Physicians' Service.

Our analysis showed that the magnitude of carrier denial rates for Medicare Part B claims was generally low and persistent for 2 consecutive years, although rates for some services shifted. Medical necessity denial rates for 74 services across six carriers varied substantially. The primary reason was that certain carriers used computerized screening criteria for specific services while others did not. Thus, carriers' selecting the services to be screened and their determining the stringency of the screen criteria probably account for a significant proportion of the variability in denial rates. Further, a small proportion of the providers accounted for 50 percent of the denied claims. To a lesser degree, the varying interpretation of certain national coverage standards across carriers, differences in the way carriers treated claims with missing information, and reporting inconsistencies also helped explain the variation in carrier denial rates. We make specific recommendations to the Health Care Financing Administration to address these issues.

Before turning to our specific findings, let me briefly discuss the program and the process by which carriers determine medical necessity.

The Medicare program, authorized under title XVIII of the Social Security Act, is a nationwide entitlement program to provide health care benefits to persons 65 years old or older, certain disabled beneficiaries, and most persons with end-stage renal disease. Since its inception, the program has grown considerably: The number of people with coverage increased from 19 million in 1967 to over 35 million in 1993. Currently, about 96 percent of those eligible for Medicare are enrolled. HCFA administers the Medicare program and establishes the regulations

and policies under which it operates.

In accordance with section 1842 (42 U.S.C. 1395u) of the Social Security Act, HCFA contracts with 32 private insurance carriers to process and issue benefit payments on claims submitted under Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1993, carriers processed about 576 million Part B claims submitted by about 780,000 physicians and 136,000 suppliers.

Section 1842 of the Social Security Act provides that carriers pay only for services that are covered and that they reject a claim if they determine that the services were not medically necessary. In fiscal year 1993, carriers denied 112 million Part B claims in whole or in part (19 percent of all claims processed) for a total of $17 billion (which represented 18 percent of all billed charges, a figure unchanged from the previous year). Services deemed not medically necessary constituted about 9 percent of the dollar amount denied by carriers.

Although most claim denials are the result of routine administrative checks made during claims processing (for example, denials for duplicate claim submissions or ineligible claimants), a portion of denials are the result of coverage determinations. Coverage under Medicare is determined by three criteria: Medicare law, national coverage standards developed by HCFA, and local coverage standards developed by individual carriers.

According to section 1832 (42 U.S.C. 1395k) of the Social Security Act, Medicare Part B covers a wide range of health services, such as physician services, outpatient hospital services, the purchase of durable medical equipment, prosthetic devices, and laboratory tests. At the same time, the act limits podiatric, chiropractic, and dental services and specifically excludes some categories of service, such as routine physical checkups and cosmetic surgery.

Although carriers make most coverage decisions, HCFA has set national coverage standards for some specific services. Where HCFA has issued a national coverage decision, carriers are expected to enforce it. Although national coverage standards are for the most part straightforward, some standards may require clarification or interpretation. In such instances, carriers are advised to consult with a HCFA regional office, which may in turn ask the HCFA central office for guidance.

In the absence of national coverage standards, HCFA has, consistent with Medicare law, given carriers the discretion to develop and apply their own medical policies based on local standards of medical practice. Carriers often "must decide

whether the service in question appears to be reasonable and necessary and therefore covered by Medicare." HCFA has given carriers broad latitude in this area--that is, it has given them primary responsibility for defining the criteria that are used to assess the medical necessity of services. Such local medical policies allow carriers to target specific services that may need greater scrutiny. For example, local medical policies may be developed in response to excessive utilization of a service or inappropriate billing patterns.

Concerning medical necessity, you asked us to assess whether carriers differ significantly in denial rates for lack of medical necessity for Medicare Part B claims and to identify factors that contribute to intercarrier variations. In response to your request, we analyzed 1992 and 1993 Medicare Part B data on claims processed by six Medicare carriers for 74 services that were either expensive or heavily utilized. We computed denial rates for services that were determined by carriers to be not medically necessary using a definition of denial rate as the number of services denied for medical necessity divided by the number of services allowed multiplied by 1,000. In our report, we present the results of our analysis of these denial rates and examine five factors that may contribute to the observed rate differentials among the six carriers.

Now let me turn to the results of our study.

FINDINGS

To determine whether there were significant differences with regard to medical necessity denial rates among six carriers across 74 expensive or heavily utilized services, we examined the (1) magnitude, (2) variability across carriers, and (3) changes of denial rates for 1992-93.

First, within this group of 74 services, denial rates were generally low--a finding that was consistent across all six carriers. Most services had denial rates less than 10 per 1,000 services allowed.

Second, the denial rates showed notable variability across the carriers. For example, the denial rates for a chest x-ray varied between 0.1 and 90.2 per 1,000 allowed. In the latter case, almost one chest x-ray was denied for every 10 allowed.

Third, variation persisted across years, although rates changed for some specific services. Services that had high denial rates in 1992 also tended to have high rates in 1993. Conversely, services with low denial rates in 1992 also were generally low in 1993.

WHY THIS VARIATION IS IMPORTANT

Carrier differences in the treatment of claims denied for reason of medical necessity is an important issue, one that has implications for appropriate management of Medicare expenditures as well as consistency of treatment of providers and Medicare beneficiaries.

FACTORS THAT CONTRIBUTED TO INTERCARRIER VARIATION IN DENIAL RATES

We identified five factors that may help explain the variation in denial rates across carriers: (1) differences in how carriers implemented the prepayment screens, (2) the varying interpretation of certain national coverage standards across carriers, (3) differences in the way carriers treated claims with missing information, (4) reporting inconsistencies, and (5) aberrant billing practices of a minority of providers.

Carriers Differed in How They Implemented the Prepayment Screens

To gauge the effect of medical necessity screens on carrier denial rates, we asked the carrier with the highest denial rate for medical necessity for 5 selected services to identify the specific reason for denial for a small sample of 15 to 20 claims. In this way, we were able to identify the key screens that most directly caused the claims to be denied.

First, with respect to computerized prepayment screens, we found that the types of services screened for medical necessity varied across carriers. For example, only one of the six carriers (Southern California) screened echocardiography and myocardial perfusion imaging services. Carrier denial rates were also associated with the presence or absence of a screen. Although the presence or absence of a screen was not sufficient to account for all variation in denial rates across carriers, it is important to note that the highest denial rates were invariably associated with screens. Similarly, while three carriers screened multichannel blood test services, the types of screens they used varied. For example, the North Carolina carrier used a utilization screen, the Wisconsin carrier used a diagnostic screen, and the Illinois carrier used both.

We also found that even when carriers screened the same service, they used different criteria for suspending claims. For example, the first 12 visits to a chiropractor for spinal manipulation to correct a subluxation must meet certain basic HCFA coverage criteria, such as that an x-ray demonstrating the spinal problem must be available, signs and symptoms must be stated, and the precise level of subluxation must be reported. The carriers we contacted had all incorporated these criteria into their medical policies for chiropractic spinal manipulation.

HCFA requires that carriers assess the necessity of visits in excess of 12 per year, but carriers diverged in how they assessed such treatments. One carrier stated that, after 12 visits, additional documentation on medical necessity would be required. Another carrier based the number of additional visits allowed on the injured area of the spine. When that number of additional visits was reached, this carrier required additional documentation from the provider. Still another carrier stated that, while it reviewed visits beyond 12, it usually did not require additional documentation until the 30-visit mark.

Carriers Differed in How They Interpreted Certain National Coverage Standards

Second, we learned from carriers that they sometimes differed in their interpretations of national coverage standards. Because some standards leave key elements of the policy undefined, carriers interpreted and applied the same standards in different ways.

In 1993, Transamerica Occidental Life, in coordination with HCFA, conducted an internal study of claims that it had processed for 17 different services for which Transamerica showed variation denial rates in 1992 with respect to the other carriers. This study uncovered some problem areas that relate to the implementation of national coverage standards. For example, Transamerica found differences across carriers in how they assessed chest x-ray and mammography claims. This suggests that, at least with respect to chest x-rays and mammographies, carriers had difficulty distinguishing whether these procedures were performed for screening or diagnostic purposes. This difficulty may also extend to other types of test procedures.

Thus, issuing a national coverage standard for a service is not sufficient to ensure consistency of application. While it is probably not feasible for HCFA to develop coverage standards that anticipate every conceivable circumstance under which a claim might be filed, chest x-ray and mammography are coverage issues that appear to be in need of further clarification by HCFA.

Carriers Differed in How They Treated Incomplete Claims

A third factor relates to the manner in which carriers treated claims with billing errors or missing information. For example, if a carrier's medical policy required that the provider indicate the diagnosis when submitting a claim for a particular type of service and the claim lacked this information, the carrier had several options. The carrier could (1) return the claim to the provider, (2) "develop" the claim (that is, delay adjudication and try to obtain the required information by contacting the provider), or (3) deny the claim.

If the first option was exercised and the claim was returned, it was as if the claim had never been submitted. If the second option was exercised and the carrier received the requisite information, then the claim was adjudicated. If the third option was selected and the carrier denied the claim, the provider had either to resubmit the claim or go through the appeal process to obtain payment for this service. The resubmitted claims might well be paid, but the carrier's records would still show that the claim had been denied.

Although carriers had several ways of processing incomplete claims, the option they selected for any given claim depended on such factors as the cost incurred to develop the claim, the capability of their computer systems, and special instructions from HCFA. For example, a carrier may have chosen to develop incomplete claims involving surgical procedures while denying incomplete claims involving chiropractic treatments, or the carrier may have rejected claims missing beneficiary health insurance numbers while developing claims with missing provider identification numbers.

Because the preceding examples highlight only a handful of the numerous possible combinations that may have been used to process claims with incomplete information, it is difficult to characterize any one carrier's approach, much less systematically compare carrier differences in this respect. However, it is reasonable to infer that carriers that emphasized claim denial over claim development (or rejection) for incomplete claims may have had higher denial rates for medical necessity than carriers that did not.

HCFA has examined this issue in an internal working document and has asked its Office of the General Counsel for advice that would bring consistency to the way that claims lacking basic information are processed. In brief, HCFA's recommendation calls for eliminating the denial option for incomplete claims. Claims that lack the requisite information would be returned or deleted, and the provider or supplier would be notified.

We believe that standardizing the process of handling incomplete claims would improve the accuracy of carrier workload statistics by making them more comparable across carriers.

Carriers Differed in How They Reported the Reason for a Claim Denial to HCFA's Central Database

A fourth factor is that because carriers used different computer systems to process claims, their internal action codes--which indicate the reason for denying a service--were not identical. To facilitate carrier comparisons, HCFA has required that each carrier translate its own set of internal action codes into 10 broad categories when transmitting data to HCFA's central

database. However, because HCFA has given carriers little guidance in performing this task, carriers have been uncertain as to how denials should be classified for reporting purposes. This, in turn, has affected the reliability of estimated denial rates.

Transamerica, in its internal study of denial rates, identified two service categories that carriers have tended to use interchangeably: "noncovered" and "medically unnecessary" care. The study found that "medically unnecessary" was used to classify denials for 3 service codes (of 17 studied) that should have been classified as "noncovered" care.

Our analysis corroborates Transamerica's findings. We found that while reporting misclassifications of this type does not affect the actual outcome of claims, it can affect the reliability of estimated denial rates for certain services. Still, we found significant intercarrier variability in denial rates whether we looked at noncovered care, medical necessity, or both categories combined. Reporting inconsistencies of this type affect HCFA's ability to accurately monitor program operation activities. This is an area where additional guidance from HCFA could improve the quality of the data it collects.

A Few Providers Account for a Significant Proportion of the Variation in Carrier Denial Rates

To test the fifth factor, the hypothesis that the billing practices of a few aberrant providers account for a significant proportion of the variation in carrier denial rates, we examined 4 services that exhibited wide variation in carrier denial rates for medical necessity. We defined providers with aberrant billing practices in two ways: (1) those with the highest denial rates or (2) those with the largest number of denials. We then calculated a carrier's denial rate for a service excluding the contribution of the top 5 percent of providers (in terms of both rate and total) to determine whether variations in denial rates were still observable. We found that the top 5 percent of providers contributed substantially to carrier denial rates for each of the 4 services. However, excluding these providers did not eliminate the variation across carriers.

Furthermore, in analyzing the 16 services with denial rates above 90 per 1,000 services allowed, we found that a small minority of providers, between 2 and 11 percent, accounted for 50 percent of services denied for lack of medical necessity (and thus were responsible for the bulk of denials).

CONCLUSIONS

While we cannot explain differing patterns of denials--for example, they may result from unnecessary services being

disproportionately offered by a few providers, differences in patient characteristics, variations in billing practices, different local standards of medical practice, or other factors--further examination of the reasons for differences is warranted.

We are not in a position to address the question of whether high or low denial rates for individual services were appropriate. Low denial rates are desirable from the standpoint that they imply less annoyance and inconvenience for providers and beneficiaries. However, low denial rates are desirable only insofar as providers do not bill for medically unnecessary services.

What is clear from our work is that further analysis of denial rates can provide useful insight into how effectively Medicare carriers are managing program dollars and serving beneficiaries and providers. Since the carriers have funding constraints that limit the number of claims they can examine on a prepayment basis, it is important that they use the most effective and appropriate screens.

We believe that HCFA could improve its oversight capabilities by actively monitoring data on carrier denial rates and improving the reliability of the data that it collects. Data on denial rates are useful for identifying inconsistencies across carriers in the way that claims are assessed for medical necessity. This information, in turn, could be used to identify services that certain carriers have found to have billing problems. In addition, for services that are more uniformly screened by carriers, variation in denial rates could indicate that carriers are using different screen criteria, which raises issues of appropriateness and effectiveness. Finally, data on denial rates could be used to construct a profile of the subpopulation of providers that have a disproportionately large number of denials, which might suggest a solution to this problem.

We recommend that, to improve its oversight of the Medicare Part B program, HCFA

-- issue instructions to carriers on how to classify the reason for denial when reporting this information;

-- analyze intercarrier screen usage (including the stringency of screen criteria), identify effective screens, and disseminate this information to all carriers; and

-- direct carriers to profile the subpopulation of providers responsible for a disproportionate share of medical necessity denials in order to devise a strategy for addressing this problem.

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

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