156152

United States General Accounting Office

GAO

Testimony

Before the Human Resources and Intergovernmental Relations Subcommittee, Committee on Government Reform and Oversight, House of Representatives

For Release on Delivery
Expected at 9:00 a.m.
Thursday, February 8, 1996

MEDICARE

Millions Can Be Saved by Screening Claims for Overused Services

Statement of Sarah F. Jaggar, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-96-86

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss how Medicare can avoid paying millions of dollars in claims for unnecessary services. The Congressional Budget Office estimates that Medicare costs of $162 billion in 1994 will spiral to $336 billion by the year 2002 unless costs are controlled. We believe that preventing payments for unnecessary services is an important way to help control costs, prevent the waste of program dollars, and help restore public confidence in the integrity of the Medicare program.

In the past year we have come before the Congress many times, describing how increasing the government's investment in program safeguards can help control Medicare costs. Some of the approaches could require substantial investments, but today we will focus on a program safeguard that is relatively inexpensive and easy to use with existing claims processing systems and that can be quickly implemented. This very basic safeguard, called an autoadjudicated (or fully automated) prepayment screen, can help control payments for some of the services most frequently billed to Medicare. More specifically, we will discuss why Medicare payments for unnecessary services are a problem, how autoadjudicated screens can save millions--even hundreds of millions--of dollars being wasted on unnecessary services, and what the Health Care Financing Administration (HCFA) can do to help prevent these payments.

Our comments today are based on our report, Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996), which we are releasing today. Our work focused on Medicare spending for six groups of medical procedures that are susceptible to widespread overuse and should, therefore, be of concern nationwide to the contractors that pay the claims billed to Medicare. Four of these procedures--echocardiograms, eye examinations, chest X rays, and duplex scans of extracranial arteries--are noninvasive diagnostic tests. The other two procedures are colonoscopy, which can be either diagnostic or therapeutic, and YAG (yttrium aluminum garnet) laser surgery, sometimes used to correct cloudy vision following cataract surgery. As shown in table 1, these six procedures accounted for almost $3 billion in Medicare payments in 1994.

Table 1: Medicare Services and Payments for Six Medical Procedures (1994)

Procedure (procedure codes)	Medicare services (in thousands)	Medicare payments (in millions)
Echocardiography (93307, 93320, 93325, 93350)	8,976	$851
Eye exams (92002, 92004, 92012, 92014)	14,400	686
Chest X rays (71010, 71020)	34,597	507
Colonoscopy (45378, 45380, 45385)	1,416	478
YAG laser surgery (66821)	895	325
Duplex scan of extracranial arteries (93880)	1,513	143
Total	**61,797**	**$2,990**

We selected those procedures because evidence from various studies shows that they are commonly used even when not warranted by medical symptoms. To determine the Medicare savings possible by greater use of autoadjudicated screens, we reviewed the Medicare claims paid by seven of the largest claims processing contractors. We estimated the claims they paid for services in 1993 that would have been denied if the contractors had used autoadjudicated screens.

In brief, we found that many Medicare claims processing contractors routinely pay claims without using their computers to evaluate the patient diagnosis included on the claim to determine if the claim makes sense. For example, in one instance we found that Medicare paid a claim for an echocardiogram--an ultrasound image of the heart--when the diagnosis on the claim was conjunctivitis (an inflammation of the eyelid). If the seven claims processing contractors in our study had used autoadjudicated screens for all six groups of procedures we looked at, they would have ultimately denied payment for as much as $150 million in claims. HCFA can and should work with its contractors to make greater use of prepayment screens to deny payments for unnecessary services and reduce the widespread overuse of certain medical procedures.

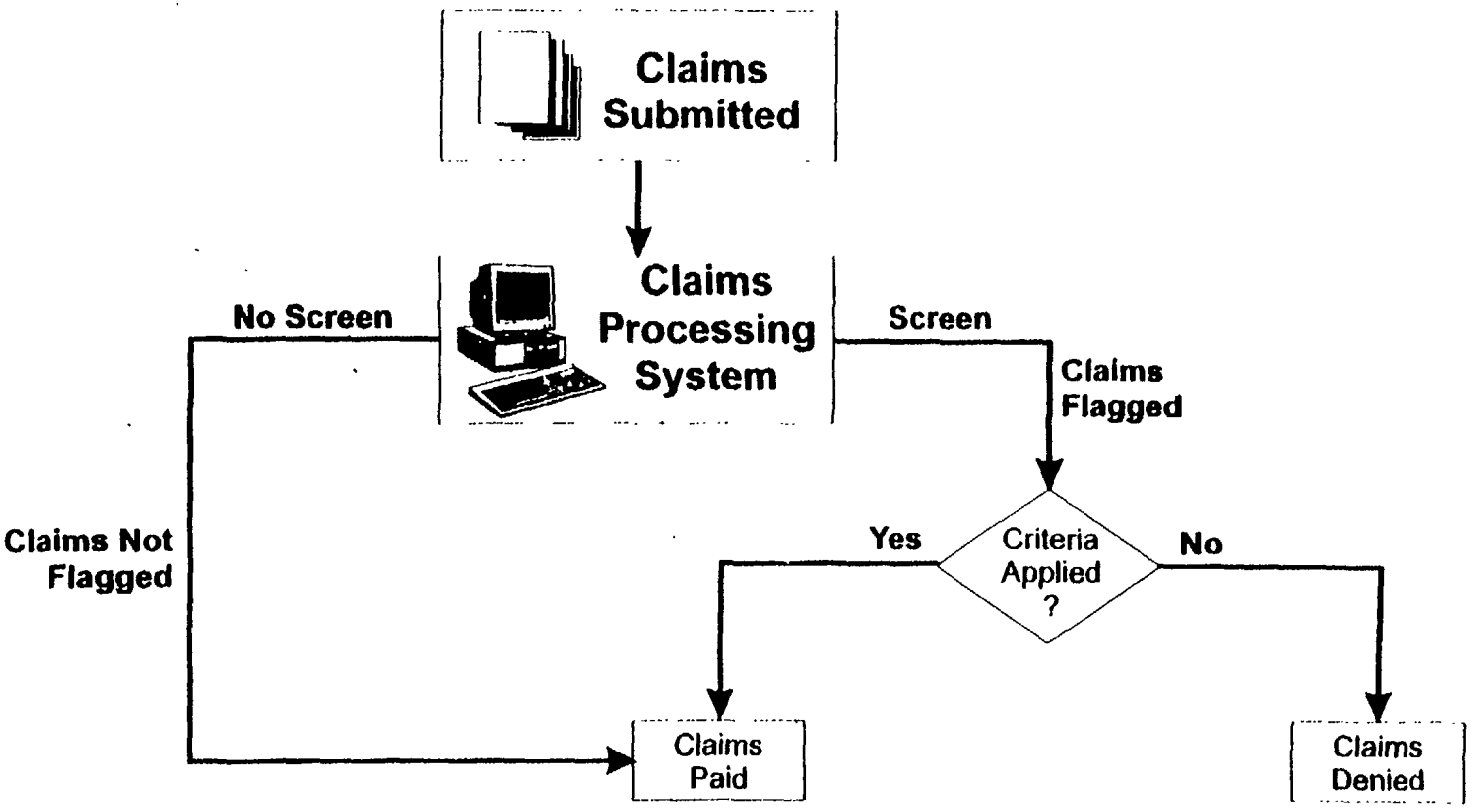
BACKGROUND

HCFA contracts with 29 firms to process Medicare part B claims.[1] As chart 1 shows, these contractors pay claims without question unless a computer screens the claims to determine if they are reasonable. Claims are screened in one of two ways: screening for manual review and autoadjudicated screening. Manual review by claims examiners is time-consuming and expensive, and funding for claims review has declined in relation to claims processed. HCFA required contractors to review only about 4.6 percent of all claims before payment in 1995--down from 15 percent in 1991. However, autoadjudicated screening automatically and immediately approves or denies a claim instead of flagging the claim for manual review. This sort of screen usually compares the diagnosis included on the claim with the acceptable diagnostic conditions specified by corresponding Medicare medical policy. As shown in chart 2, for example, an autoadjudicated screen for echocardiograms would approve such a claim for a patient with heart disease, but would deny this claim for a patient whose diagnosis was, for instance, depression. Because this type of screen is entirely automated, contractors can review all the claims for a specific procedure, and at far less cost than manually reviewing claims.

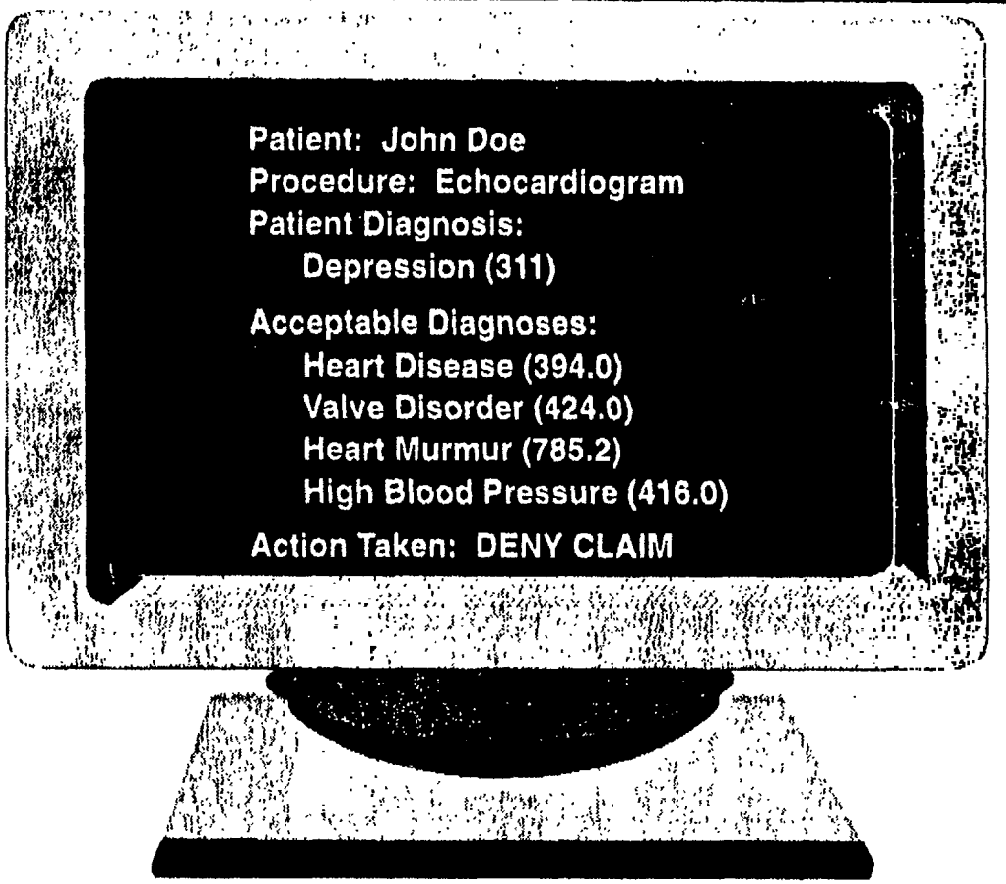
[1]Four additional contractors process Medicare part B claims for durable medical equipment.

Chart 1

GAO Impact of Prepayment Screens



GAO Autoadjudicated Screen



Autoadjudicated screens are most effective for denying claims that do not meet very basic medical necessity criteria. Claims denied by these screens can be resubmitted by providers or appealed. Also, claims that pass these basic criteria may be further screened against more complex medical criteria to identify claims that warrant manual review. To screen claims for medical reasonableness, HCFA or the claims processing contractor need only develop specific screening criteria, a process referred to as setting medical policy. For example, some contractors have medical policies that specify the patient diagnoses that warrant an echocardiogram. Most medical policies are developed by contractors, then finalized after consultation with local physician advisory groups and publication of draft policies for comment.

WHY PAYMENTS FOR UNNECESSARY SERVICES ARE A PROBLEM

Controlling the alarming growth in Medicare spending has proven difficult, in part because the fee-for-service payment system that Medicare uses provides little financial incentive for physicians or patients to resist unnecessary diagnostic tests and routine services.[2] In addition, patients often lack the information and expertise needed to question the medical necessity of services ordered by physicians. Preventing such payments therefore calls for program safeguards that check the medical necessity of the services billed.

Some Procedures Are Vulnerable to Widespread Overuse

Evidence from studies by the Inspector General of the Department of Health and Human Services (HHS) and analyses by some claims processing contractors strongly suggest that certain high-volume procedures billed to Medicare are especially vulnerable to overuse. These procedures are frequently performed on patients who show few or none of the symptoms requiring such treatment. The six groups of procedures in our study are typical of such widely overused procedures. But despite the evidence that these procedures are widely overused, many claims processing contractors do not use the computerized screens that could prevent payment for these procedures when they are used unnecessarily.

---

[2]The Medicare fee-for-service payment system, which currently covers more than 90 percent of all Medicare enrollees, pays physicians a fee for each service they perform. In contrast, capitated managed care plans receive an annual fee for each Medicare enrollee, regardless of the number of services they perform.

Contractors Focus Primarily on Local Problems

HCFA requires contractors to use a process called focused medical review to help decide what claims to review. This process focuses on local overuse of medical procedures and is largely ineffective in controlling overuse that is national in scope. Contractors analyze the claims they have paid and identify procedures where local frequency of use differs from the national average.[3] Contractors then decide whether to develop a medical policy covering payment for that procedure and, if a policy is created, whether to enforce the policy with a computerized prepayment screen or to educate physicians to get them to conform to the policy.

Based on our survey of 17 Medicare claims processing contractors, we found that fewer than half were using computerized screens to check claims for each of the six groups of procedures in our study. The lack of this basic control had very expensive consequences. For example, even though echocardiography is the most costly diagnostic test in terms of total Medicare payments, only seven of the contractors we surveyed used screens to review echocardiography claims. Some contractors had developed screens for echocardiography because local use exceeded the national average, but others allowed unconstrained use of the procedure. At the same time, national use of echocardiograms increased from 101 per 1,000 Medicare beneficiaries in 1992 to 113 per 1,000 in 1994. This increased by 12 percent the national benchmark against which contractors compare their local utilization rates.

USE OF AUTOADJUDICATED SCREENS COULD SAVE MILLIONS

We tested claims that seven contractors paid for six groups of procedures to identify any payments that would have been denied had contractors used autoadjudicated screens.[4] In each case, we found that contractors used no medical criterion to screen claims for one or more of the six groups of procedures. Had they used autoadjudicated screens for these procedures, the seven contractors would have denied between $38 million and $200 million in claims. (Our estimate of the range of payments that would have been denied reflects the different diagnostic criteria used by those contractors who did have autoadjudicated screens for these procedures.) As shown in chart 3, most of the denied claims would have been for five of the six groups of procedures. For the sixth--eye examinations, not shown on the chart--less than $1 million in claims would have been denied.

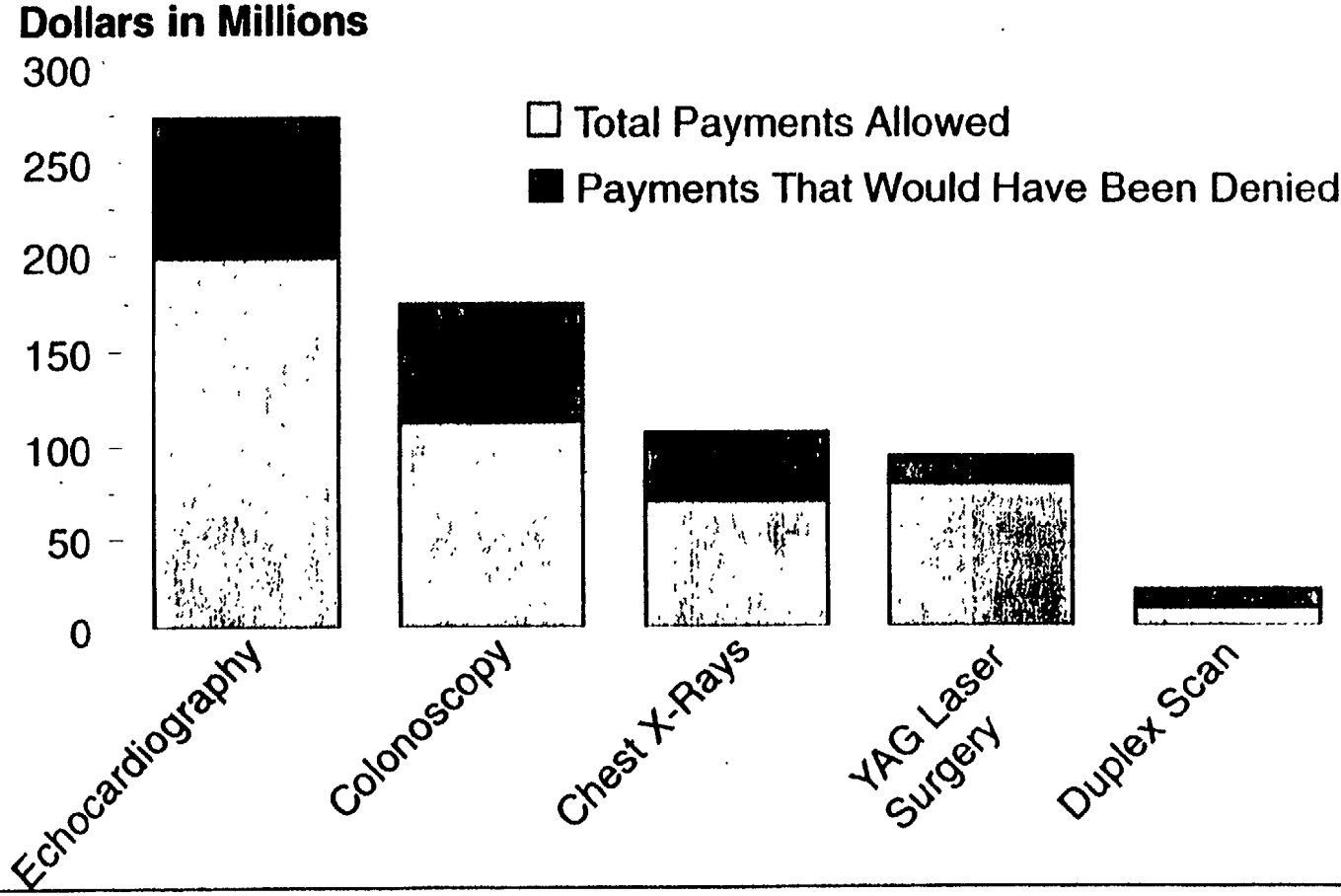
---

[3]Some contractors receive permission from HCFA to identify aberrant procedures using alternative methods, such as trend analysis.

[4]The claims we tested were for services provided in 1993.

GAO

Medicare Payments That Would Have Been Denied by Seven Contractors



It is important to note that autoadjudicated denial of claims does not preclude ultimate payment of the claim if the service is appropriate. When claims are denied by an autoadjudicated screen, the billing physician can later resubmit the claim with additional or corrected information or else appeal the denial. Based on a limited analysis of claims denied by autoadjudicated screens, about 25 percent of the claims denied were ultimately paid. Assuming that our 25-percent rate is typical and that, as we have said, between $38 million and $200 million would have been denied by autoadjudication of claims in our review, then between $29 million and $150 million in savings would have been realized for the six groups of procedures we tested. However, all the claims in our review were paid by the seven contractors.

While these estimates involve only six groups of procedures and cannot be statistically generalized beyond the seven contractors included in our analysis, we should also remember that all 29 contractors--and not just the seven--focus their efforts on local rather than national overutilization problems. The 22 contractors not included in our tests may also lack medical necessity screens for some of these procedures and have likely paid millions of dollars in claims for services that should have been denied. Moreover, because autoadjudicated screens do not suspend claims for manual review, their use would not increase the workload of claims examiners.

WHAT HCFA CAN DO TO PREVENT PAYMENTS FOR UNNECESSARY SERVICES

By using its national claims database to examine national trends and develop a strategy for controlling payments for widely overused services, HCFA can save hundreds of millions of dollars. And while HCFA has made some limited progress in this area, by establishing contractor workgroups to develop model medical policies for local use, HCFA had approved only one model medical policy at the time of our review. Feedback from HCFA and the contractors' medical director steering committee on a draft of our report indicates support for more model medical policies.

HCFA also has a responsibility to monitor and evaluate its contractors' prepayment screens and other safeguarding efforts. Yet HCFA does not know which contractors have diagnostic screens for which medical procedures; what medical necessity criteria are used in the screens; or how effective the screens are in denying claims for unnecessary services. Without this information, HCFA cannot identify best practices and promote such approaches as autoadjudicated screens that can be cost-effective alternatives and complements to manual review.

HCFA officials told us that they are considering greater use of autoadjudicated screens in a new national claims processing system. However, full implementation of that system is scheduled for late in 1999. Meanwhile, HCFA continues to allow contractors to pay millions of dollars for services that may be unnecessary.

CONCLUSIONS AND RECOMMENDATIONS

Our report, which is being released today, identifies several strategies that HCFA should implement now to help prevent Medicare spending for unnecessary services. We believe that the following strategies can help the agency target and address Medicare's most significant payment problems.

First, HCFA should systematically analyze its national Medicare claims database to identify medical procedures that are widely overused. This would allow it to focus on screens that would identify unnecessary claims for these procedures. Second, HCFA should work with its contractors to evaluate existing medical policies and prepayment screens for widely overused procedures and disseminate model policies and screens to all of its contractors. Third, the agency should hold contractors accountable for implementing local policies and prepayment screens or for taking other corrective action to control payments for widely overused procedures.

- - - -

Mr. Chairman this concludes my prepared statement. I will be happy to answer any questions you or other members of the committee might have.

For more information on this testimony, please call Edwin Stropko, Associate Director, at (202) 512-7108, or William Reis, Assistant Director, at (617) 565-7488. Other major contributors include Teruni Rosengren, Stephen Licari, Michelle St. Pierre, and Vanessa Taylor.

RELATED GAO PRODUCTS

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996)

Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995)

Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995)

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995)

Medicare: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995)

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nurses Homes (GAO/HEHS-95-23, Mar. 30, 1995)

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995)

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75), Feb. 6, 1995)

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995)

Medicare Part B: Regional Variation and Denial Rates for Medical Necessity (GAO/PEMD-95-10, Dec. 19, 1994)

Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny (GAO/HEHS-95-2, Oct. 20, 1994)

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994)

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994)

(101403)

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested