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MEDICARE

Using Education and Claims Scrutiny to Minimize Physician Billing Errors

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Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the challenges physicians and the Medicare program face in ensuring that claims for physician services are billed and paid appropriately. The General Accounting Office, an agency within the legislative branch that monitors the effectiveness and efficiency of federal programs for the Congress, has conducted oversight of the Medicare program for many years. With annual fee-for-service payments now totaling about $192 billion, the Centers for Medicare and Medicaid Services (CMS), the agency responsible for administering Medicare, has an important responsibility to safeguard payments for health services delivered to elderly and disabled individuals by hundreds of thousands of providers. In its most recent audit, covering fiscal year 2001, the Department of Health and Human Services' (HHS) Office of Inspector General found that $12.1 billion, or about 6.3 percent of fee-for-service payments, was improperly paid to Medicare providers.[1]

However, physicians and other providers have raised concerns that Medicare's efforts to provide information on billing rules fall far short of the need for clear explanations of the program's increasingly complex coverage policies and billing requirements. Physicians have also raised questions about whether the program's enforcement of payment rules has imposed too great an administrative burden on those billing Medicare. In light of these issues, legislation before this committee seeks to address some of these concerns while maintaining effective payment safeguards.

We have recently completed two studies that examine aspects of the interactions between physicians and carriers—the contractors responsible for processing physicians' Medicare claims.[2] The first study, issued in February 2002, reviewed the information that carriers provide physicians about billing rules. The study we are releasing today addresses how carriers conduct medical reviews of claims to ensure compliance with those rules. Medical reviews involve a detailed examination of a sample of claims by clinically trained staff and require that physicians submit

[1]Department of Health and Human Services/Office of Inspector General, *Improper Fiscal Year 2001 Medicare Fee-For-Service Payments*, A-17-00-02000 (Washington, D.C.: Feb. 15, 2002).

[2]In February 2002, we issued *Medicare: Communications With Physicians Can Be Improved,* GAO-02-249 (Washington, D.C.: Feb. 27, 2002). In conjunction with this hearing, we are releasing our report *Medicare: Recent CMS Reforms Address Carrier Scrutiny of Physicians' Claims for Payment*, GAO-02-693 (Washington, D.C.: May 28, 2002).

medical records to substantiate their claims. My remarks today will focus on (1) carriers' provision of information to physicians regarding Medicare's billing requirements and program changes, (2) carriers' scrutiny of physicians' claims selected for medical review because they are more likely to have billing errors, and (3) implications of Medicare's recent changes to claims review policies for physicians. (The details of how we conducted our studies are included in the two reports.)

In summary, our February report showed that physicians often do not receive complete, accurate, clear, or timely guidance on Medicare billing and payment policies. At the carriers we studied, we found significant shortcomings in printed material, Web sites, and telephone help-lines that carriers used to provide information and respond to physicians' questions. We concluded that CMS needed to initiate a more centralized and coordinated approach, and provide technical assistance to carriers, to substantially improve Medicare carriers' provider communications.

In the report we are releasing today, we examined the operations of three carriers that serve six states and process claims for about one-quarter of Medicare participating physicians. The vast majority of physician practices—at least 90 percent in fiscal year 2001—had no claims selected for medical review by their carrier. For the relatively few practices with any claims reviewed, the carriers typically requested patients' medical records for no more than two claims during the year. In an independent assessment we sponsored, carriers were found to be highly accurate in their decisions to deny, reduce, or pay claims in full. The overall level of accuracy was consistent across the three carriers at about 96 percent. However, improvements could be made in selecting claims for review that are more likely to be inappropriate, thereby making better use of program resources and reducing documentation requests to providers who have not made billing errors.

In fiscal year 2001, CMS revised its policy on conducting medical reviews under an initiative called Progressive Corrective Action (PCA).[3] The policy directs carriers to differentiate among levels of billing problems and tailor corrective actions accordingly. It also instructs carriers to focus educational outreach on physicians who have experienced billing problems. Under PCA, carriers are to limit extrapolation—a process by

[3]HHS, Health Care Financing Administration, *Medical Review Progressive Corrective Action*, Program Memorandum Transmittal AB-00-72 (Baltimore, MD: Aug. 7, 2000).

which overpayment amounts are projected from a sample of claims reviewed—to those cases that involve major billing problems. In fiscal year 2001, the three carriers in our study virtually eliminated the use of extrapolation. As a result of this and other medical review modifications, the highest overpayment amounts assessed a physician practice by a carrier dropped substantially. The carriers in our study increased feedback to individual physicians concerning the results of medical reviews and how to bill appropriately in specific situations.

Background

Within HHS, CMS provides operational direction and policy guidance for the nationwide administration of the Medicare program. It contracts with carriers—23 in fiscal year 2002—to process and pay part B claims from Medicare physicians and certain other providers.[4] To help providers bill properly, carriers are required to issue bulletins periodically that publicize new national and local Medicare coverage rules, inform providers of billing changes, and address frequently asked questions. In addition, they must use Web sites and maintain toll-free lines to disseminate new information and respond to physician inquiries.

Carriers are also responsible for ensuring that claims are paid properly. Few claims receive more than a computerized review designed to detect missing information, services that do not correspond to a beneficiary's diagnosis, or other obvious errors. However, in some cases, carriers review claims manually to determine, for example, whether the services physicians bill for are covered by Medicare, are reasonable and necessary, and have been billed with the proper codes. In the most thorough type of claims review, called medical review, clinically trained personnel determine a claim's conformance with payment rules by examining medical records submitted by the physician. Medical reviews can occur before a claim has undergone final processing (prepayment) or after the claim has been paid (postpayment).

[4]Part B covers charges from licensed practitioners, as well as clinical laboratory and diagnostic services, surgical supplies and durable medical equipment, and ambulance services. Part A covers hospital inpatient and certain other services.

Substantial Improvement Needed in Carriers' Routine Communications

In our February report, we noted that carrier communications with physicians regarding Medicare rules and program changes are often incomplete, confusing, untimely, or even incorrect. We found that Medicare bulletins were often unclear and difficult to use. The bulletins from 10 carriers we reviewed were typically over 50 pages in length, contained long articles written in dense language, and were printed in small type. Many of the bulletins were also poorly organized, making it difficult for a physician to identify relevant or new information. For example, several bulletins lacked tables of contents and the information provided was not delineated by specialty or by states where it applied. Moreover, information concerning program changes was not always communicated in a timely fashion, so that physicians sometimes had little or no advance notice prior to a program change taking effect.

Carriers' other principal means of communicating information with physicians—Web sites and information call centers—also proved to be problematic. Our review of 10 Web sites found that only 2 complied with CMS content requirements and most did not contain features that would allow physicians to readily obtain the information they need. Sites often lacked logical organization, search functions, and timely information. To assess the accuracy of call-center-provided information, we placed approximately 60 calls to three carriers' provider inquiry lines. The customer service representatives rarely provided appropriate answers to our questions. The three test questions, selected from the "frequently asked questions" on various carriers' sites, concerned the appropriate way to bill Medicare under different circumstances. The results, which were verified by CMS, showed that only 15 percent of the answers were complete and accurate.

CMS has few standards to guide carriers' communications with physicians. While the standards require that carriers issue bulletins at least quarterly, they require little in terms of content or readability. This is also the case for Web sites, as CMS has done little, through standards, to promote clarity or timeliness of the information presented. Similarly, with regard to call centers, the agency has not established a clear performance requirement for accurate and complete telephone responses.

CMS is planning several steps to improve and monitor carrier communications with physicians. These include developing training for customer service representatives and maintaining a CMS Web site that contains, among other things, reference materials on billing changes. In our February report, we recommended that CMS adopt a standardized approach to information dissemination that includes the publication of

one national bulletin for physicians (supplemented with information from local carriers), performance standards for carriers' call centers, and requirements for carriers' Web sites to link to CMS's national information sources.

Medical Reviews Affect Few Physicians and Result in Accurate Payment Decisions

In addition to poor communication from the carriers, physicians have expressed concern about whether carriers apply excessive scrutiny to claims billed appropriately. In our study released today, we focused on the medical review of claims submitted by physicians to three carriers: National Heritage Insurance Company (NHIC) in California, Wisconsin Physicians Service Insurance Corporation (WPS), and HealthNow NY.[5] Data from these carriers show that more than 90 percent of the physician practices—including individual physicians, groups, and clinics—did not have any of their claims selected for medical review in fiscal year 2001. Table 1 shows that about 10 percent of the practices that filed claims with WPS had a prepayment medical review, while this proportion was even lower at HealthNow NY and NHIC California. In addition, only about one-tenth of 1 percent of the practices for any of the carriers had claims selected for postpayment medical review.

[5]NHIC's California component is a large insurer with separate facilities that serve the northern and southern areas of the state. WPS, also a large insurer, has separate facilities in four states (Wisconsin, Illinois, Michigan, and Minnesota). In comparison, HealthNow NY is a small insurer that serves providers in upstate New York.

Table 1: Physician Practices Whose Claims Received Medical Review, Fiscal Year 2001

Medical review	NHIC California[a]		WPS[b]		HealthNow NY	
	Number	Percent of total[c]	Number	Percent of total[d]	Number	Percent of total[d]
Prepayment	5,590	7.4	13,732	10.1	1,270	4.3
Postpayment	113	0.1	80	0.1	33	0.1

Note: Physician practices were identified by the Medicare Provider Identification Number (PIN).

[a]The number of practices shown include data from northern California for November 2000 to September 2001 and from southern California for December 2000 to September 2001.

[b]WPS prepayment data include reviews in Illinois, Michigan, and Minnesota only; data were not available for Wisconsin. Postpayment data include Illinois, Michigan, Minnesota, and Wisconsin.

[c]Because a list of active PINs was not available from NHIC California, we estimated the total number of solo and group practices in California based on data from the most recent American Medical Association census of group medical practices, adjusted for increases in the total number of nonfederal medical doctors as of December 31, 2000, and the number of osteopaths in the state.

[d]Percentages are based on lists of active PINs obtained from the carrier.

Source: GAO analysis of carrier data, and physician practice data from the American Medical Association and American Osteopathic Association.

Further, for most of the physician practices that had any claims subject to medical review in fiscal year 2001, the carriers examined relatively few claims. For example, at each carrier, over 80 percent of the practices whose claims received a prepayment review had 10 or fewer claims examined and about half had only 1 or 2 claims reviewed. The typical number of claims per practice that received a postpayment review was 30 to 50.

For those claims that carriers selected for medical review, we found that carriers' decisions were highly accurate regarding whether to pay, deny, or reduce payment. To assess the appropriateness of clinical judgments made by carriers' medical review staff, we sponsored an independent review—by a firm that monitors claims payment error rates for the Medicare program—of the three carriers' payment decisions. This review included samples of physician claims from each carrier that were selected randomly from all claims undergoing either prepayment or postpayment medical review in March 2001. The independent reviews validated the carriers' decisions for almost all claims. As shown in table 2, the carriers and reviewers agreed that the original decisions were correct in 280 of 293 cases examined, or about 96 percent of the time. Carrier decisions tended to be least accurate when they partially reduced payment amounts. In 5 of 59 claims where carriers denied payment in part, our reviewers

determined that the claim should have been denied in full, reduced by a smaller amount, or paid in full.

Table 2: Accuracy of Carrier Medical Review Decisions on Physician Claims (percent)

	Accurate decision rate (percent)	Inaccurate decision rate	
Carrier decision		**Overpayment (percent)**	**Underpayment (percent)**
All decisions on sampled claims[a] (n=293)	95.6	2.7	1.7
Deny in full (n=64)	98.4	0.0	1.6
Deny in part (n=59)	91.5	1.7	6.8
Pay in full (n=170)	95.9	4.1	0.0

[a] Claims randomly selected from all carrier prepayment and postpayment reviews during March 2001. Although 100 claims were selected from each of the three carriers, five claims from WPS and two from HealthNow NY were excluded either because the billing entity did not meet our definition of physician or because documentation from the carrier associated with the claim was unavailable or not interpretable.

Source: GAO analysis of independent review results.

To avoid payment errors, carriers should target for medical reviews those claims most likely to be billed inappropriately. After identifying and validating a suspected billing problem, they develop computerized edits—instructions programmed into the claims processing system that identify a set of claims meeting specified characteristics.[6] Although carriers' reviews produced highly accurate payment decisions, their selection of potentially erroneous claims left opportunities for improvement. We examined fiscal year 2001 data on carrier edits used for medical reviews conducted before a payment decision is made. Specifically, we looked at denial rates—the percentage of claims selected for review for particular reasons that were denied, in full or in part—and the average value of the amount denied. We found that denial rates for the edits that accounted for the largest number of claims reviewed by the carriers varied considerably. CMS does not provide information to carriers programwide on criteria for selecting claims to review that have proven to be effective, nor does it encourage carriers to share information on their most productive criteria. These actions could lead to more effective claims reviews with potential

[6]Some edits focus on billing codes for certain clinical procedures; others focus on the frequency with which services are delivered. Carriers develop edits based on their analysis of billing data or other factors that suggest a pattern of erroneous billing, followed up by medical reviews of small samples of claims selected by the edit to test the validity of identified problems.

reduction in inappropriate Medicare payments, better investment of administrative resources, and less burden on providers.

Under PCA, Physicians Had Lower Repayment Amounts Assessed and More Individualized Education

Carriers in our study conducted postpayment reviews for about 0.1 percent of physician practices. However, individuals involved in such reviews have raised concerns regarding carrier procedures. We found that, since implementation of CMS's revised medical review policy—PCA—in fiscal year 2001, the carriers in our study have adopted a more strategic approach to medical reviews, particularly postpayment reviews. As PCA has been applied to these reviews, carrier requests for documentation from physicians and assessments of amounts to be returned to the program have declined, while efforts to educate physicians individually about appropriate billing have increased.

The following components of the PCA initiative are designed to ensure the effective use of carriers' medical review resources and improve physicians' ability to achieve compliance with program billing rules:

- Differentiating billing errors by levels of concern. Carriers are instructed to conduct a "probe" medical review—examining a small sample of a practice's claims—to determine whether a suspected billing problem exits. After taking this interim step, carrier staff classify the billing problems identified in the sample as belonging to one of three levels of concern: minor, moderate, or major. For example, minor concerns can include cases where the percentage of dollars billed in error is small and the billing physician does not have a history of filing problem claims. In contrast, major concerns can include cases where the percentage billed in error is high, or moderate if the physician has not responded to carrier education efforts to correct previous billing problems.

- Tailoring corrective actions to the seriousness of the billing errors identified. Across all levels of concern, PCA directs carriers to contact physicians individually to discuss their particular billing problems and to recover payments for erroneous claims. For minor concerns, education may be the principal action the carrier takes. For moderate concerns, carriers may also medically review a portion of the physician's claims prior to payment for a set period of time. For major concerns, carriers may go one step further by reviewing another larger postpayment claims sample in order to estimate and recover potential additional overpayments.

- Educating physicians about appropriate billing practices. Carriers must inform physicians and their staffs about billing rules to prevent the

recurrence of payment errors. Carriers are instructed to notify physicians of billing problems through one-on-one contacts using phone calls, letters, and meetings. Whereas in the past, carriers' medical review staff simply pointed physicians toward the applicable Medicare rules, under PCA, carrier staff are directed to assist physicians in applying these rules to their specific billing situation. As part of their strategies to increase physician education, the three carriers in our study reported greater use of phone calls and letters to provide individual physicians feedback on their billing errors.

Although we cannot identify as yet how PCA affects the rate of physician billing errors, one effect is measurable. The highest amount a physician practice in our study was required to repay the Medicare program decreased substantially. In fiscal year 2000—the year before PCA implementation—the largest overpayment amounts assessed ranged from about $95,000 to $372,000 across the three carriers. These amounts declined in fiscal year 2001, when PCA was implemented, with overpayment assessments ranging from $6,000 to $79,000. A major factor contributing to this decline is that, under PCA, the carriers in our study virtually eliminated their use of extrapolation—a way of estimating the amount Medicare overpaid a physician by projecting an error rate found in a sample of the physician's claims. According to an October 2001 CMS survey, most other carriers similarly limited their use of extrapolation. Of the 18 carriers that responded to the CMS survey, only three—serving Ohio, West Virginia, Massachusetts, and Florida—had more than nine cases involving extrapolation in fiscal year 2001.

Concluding Observations

Carriers, CMS, and physicians all have a role in efforts to minimize erroneous claims. Carriers must do a better job than in the past of providing physicians with clear and complete information on appropriate billing practices. In this regard, CMS, through its PCA initiative, has made billing education a key component of its payment safeguard activities. Over time, it should become evident whether the strategic and educational approach under PCA will effectively reduce Medicare's payment errors. In addition, we have recommended that CMS assume a direct role in communicating programwide information to all physicians and other providers rather than relying on the individual carriers. In previous work, we also recommended that CMS take steps to ensure that medical review "best practices" of individual carriers are shared and, when appropriate, implemented by other carriers. In our view, it is essential CMS take the necessary steps to strike a reasonable balance between safeguarding a

fiscally troubled program while not placing an inappropriate burden on physicians.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or other Committee Members may have.

Contact and Acknowledgements

For further information regarding this testimony, please contact Leslie G. Aronovitz at (312) 220-7600. Rosamond Katz, Hannah Fein, Jenny Grover, Joel Hamilton, and Eric Peterson made contributions to this statement.