REPORT BY THE

Comptroller General

OF THE UNITED STATES

OPM Should Promote Medical Necessity Programs For Federal Employees' Health Insurance

This is GAO's third report calling for the Office of Personnel Management to pay more attention to the medical necessity provisions of its Federal Employees Health Benefits program contracts. OPM has been slow to encourage health insurance plans to use medical necessity programs which are designed to help hold down medical costs and to encourage good medical practice.

Promoted by many health insurers and approved by numerous medical specialty societies, the programs have been available since 1977. Until recently, however, OPM provided virtually no guidance to participating health insurance plans about medical necessity programs. Plans' awareness and use of them varied greatly. OPM should monitor the programs, evaluate their benefits, and require health insurance plans to use their beneficial aspects.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-199466

The Honorable Gladys Noon Spellman
Chair, Subcommittee on Compensation
and Employee Benefits
Committee on Post Office and
Civil Service
House of Representatives

Dear Madam Chair:

This report is in response to your request that we determine how the Office of Personnel Management assures that plans participating in the Federal Employees Health Benefits program do not pay for outmoded surgery. Because reducing incidence of and payment for outmoded surgical procedures was included as part of various medical necessity programs, we expanded our review to include other aspects of the programs as well. These additional aspects include reducing diagnostic testing of doubtful value and routine hospital admission testing.

Our review showed that the Office needs to keep abreast of medical necessity program developments both in and outside the Federal Government. We are making recommendations to the Office's Director which should help assure that program and plan managers make effective use of available information on medical necessity programs.

In commenting on our draft report, the Office did not indicate whether it agreed or disagreed with our individual recommendations that encourage the Office to increase its involvement in making better use of medical necessity programs. While the Office indicated agreement with the general concept of medical necessity as related to its Federal Employees Health Benefits program contracts with individual plans, it did not evidence a commitment to increase its role as a promoter of such efforts. Comments provided by representatives of several program plans and carriers showed a willingness to work with the Office to improve program administration. We believe this willingness presents the Office with the opportunity to provide leadership and guidance in making better use of medical necessity programs.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days from its issue date. At that time we will send copies to interested persons and make copies available to others on request.

Sincerely yours,

Comptroller General
of the United States

REPORT BY THE
COMPTROLLER GENERAL
OF THE UNITED STATES

OPM SHOULD PROMOTE MEDICAL NECESSITY PROGRAMS FOR FEDERAL EMPLOYEES' HEALTH INSURANCE

D I G E S T

Medical necessity programs were developed to help contain health care costs and promote good health care. They can reduce the incidence of, and payment for, health care procedures not found to be medically necessary or consistent with generally acceptable medical practice.

The programs were publicized in 1977, but the Office of Personnel Management (OPM) has been slow to recognize them. It should systematically monitor and evaluate them and promote their beneficial aspects.

Federal Employees Health Benefits program plans have not been required to use medical necessity programs. As a result, plans' use of medical necessity programs has varied greatly. Data from plans using the programs show that benefits have been achieved and should increase. In October 1979, OPM began encouraging employee organization plans of the Federal Employees Health Benefits program to use such programs. (See ch. 2.)

AVAILABLE MEDICAL NECESSITY PROGRAMS

The Blue Cross and Blue Shield Associations have developed one medical necessity program. Similar programs have been developed by the Health Insurance Association of America and the Department of Health and Human Services' 1/ Medicare program. (See pp. 1 to 6.)

1/Before May 4, 1980, activities discussed in this report as the responsibility of the Department of Health and Human Services were the responsibility of the Department of Health, Education, and Welfare. A separate Department of Education began operations on May 4, 1980.

The Associations have recommended that Blue Cross and Blue Shield plans not (1) routinely provide benefits for 68 health care procedures and require special medical justification for payment and (2) pay for diagnostic tests for medical and surgical hospital admissions unless a physician ordered the tests. The Associations expect to address other issues as the program continues. (See pp. 2 to 4.)

OPM INVOLVEMENT LIMITED

In October 1979, GAO discussed these programs with OPM officials. They said that they had been aware of the Blue Cross and Blue Shield Associations' medical necessity program, but had not monitored or evaluated it for possible use in the Federal Employees Health Benefits program. The officials were not aware of the Health Insurance Association of America's program. (See pp. 9 to 11.)

PLANS' USE OF PROGRAMS VARIED

Health benefits plans' awareness and use of the medical necessity programs varied greatly--from no policy on using the programs to detailed claim processing instructions based on the programs. The Service Benefit Plan has endorsed the Associations' medical necessity program fully; however, administration varied somewhat among four Blue Shield plans GAO visited. The Indemnity Benefit Plan expects to use selected parts of available programs. Seven out of nine employee organization plans that GAO reviewed did not use medical necessity programs in their claim processing systems. (See pp. 11 to 17.)

PROGRAMS ARE ACHIEVING BENEFITS

Data from the Service Benefit Plan and two Blue Shield plans show that the Associations' medical necessity program has been beneficial, and the program's direction indicates savings should increase. The Associations estimated that the initial list of health care procedures could

affect claims valued at about $27 million. A more recent program effort addressed the need for routine hospital admission tests that cost an estimated $2.5 to $3.0 billion annually. Officials said that savings are also being achieved because of education and publicity. The programs GAO reviewed did not maintain sufficient data to measure savings.

A Service Benefit Plan study of the frequency of procedures listed in the medical necessity program indicates that from 1975-78 the number of claims paid for (1) surgical procedures listed as not generally useful declined 26 percent, (2) listed diagnostic procedures declined 84 percent, and (3) listed X-ray procedures rose 14 percent. Data from the District of Columbia Blue Shield plan showed that, between 1976 and 1979, the dollar amount and number of claims paid for the listed procedures declined 90 and 91 percent, respectively. Data from the Pennsylvania Blue Shield plan showed that, from April 1977 to October 1979, about 93 percent of claims for procedures listed as not medically necessary or beneficial were denied. (See pp. 17 to 19.)

RECENT OPM ACTIONS TO ENCOURAGE USE OF MEDICAL NECESSITY PROGRAMS

In late October 1979, the OPM program manager for employee organization plans asked plans to comply with their contractual obligations to review claims to determine that they represented medically necessary services. In December 1979, the official sent to the plans for their use in claim processing the Blue Cross and Blue Shield Associations' list of procedures deemed not generally useful. He also met with certain plans' and underwriters' representatives to discuss ways to use medical necessity programs. GAO was advised that these representatives had agreed to include the listed surgical procedures in their claim processing systems. (See pp. 19 and 20.)

CONCLUSIONS

Improved care and cost reduction benefits of medical necessity programs can be realized more fully if OPM keeps abreast of program developments and makes sure they are adopted promptly. Medical necessity programs are relatively new; benefits realized so far have been limited. However, these programs enjoy widespread physician acceptance, and benefits appear likely to increase as the programs are expanded and more widely used. (See pp. 20 and 21.)

RECOMMENDATIONS

To make sure that medical necessity programs receive appropriate attention and consideration, the Director, OPM, should:

--Systematically monitor developments in these programs, in both the private and public sectors.

--Evaluate these programs to determine how Federal Employees Health Benefits program plans might use them to foster better health care and lower health insurance costs.

--Require the Federal Employees Health Benefits program plans to use aspects of these programs that are proven beneficial. (See p. 21.)

OPM'S AND OTHER ORGANIZATION'S COMMENTS AND GAO'S EVALUATION

Although representatives of several health benefit plans and carriers indicated that full implementation of medical necessity programs would not be easy, they expressed general agreement with the programs and a willingness to cooperate with OPM in implementing them. OPM's comments on the draft report generally stressed the difficulties associated with using medical necessity programs. While OPM supported the

general medical necessity concept, it did not express a commitment to fully consider GAO's recommendations.

GAO believes that the plans' and carriers' willingness to cooperate presents OPM with the opportunity to provide leadership and guidance in making better use of medical necessity programs. (See pp. 21 to 25.)

Contents

ABBREVIATIONS

APWU	American Postal Workers Union
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office
HHS	Department of Health and Human Services
HIAA	Health Insurance Association of America
NALC	National Association of Letter Carriers
OPM	Office of Personnel Management

CHAPTER 1

INTRODUCTION:

MEDICAL NECESSITY PROGRAMS AND HEALTH INSURANCE

FOR FEDERAL EMPLOYEES

This report discusses the Office of Personnel Management's (OPM's) oversight of various Federal Employees Health Benefits (FEHB) program plans' compliance with the "medical necessity" and "generally accepted professional medical standards" clauses of their contracts. It focuses on OPM and FEHB program plan managers' use of publicly available information on medical necessity programs to assure that benefits are not provided for health care procedures not recognized as generally acceptable or medically necessary. Our review was requested by the Chairwoman, Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service.

MEDICAL NECESSITY PROGRAMS

Medical necessity programs have been developed to help contain health care costs and promote good health care. They can reduce the incidence of diagnostic, radiological, or surgical procedures that professional medical organizations (see app. I) have found to be inconsistent with good medical care standards. The Blue Cross and Blue Shield Associations (Associations), the Health Insurance Association of America (HIAA), and the Department of Health and Human Services' (HHS') 1/ Medicare program each advocate or use medical necessity programs to reduce the number of procedures that contribute to cost without contributing to the quality of care.

1/Before May 4, 1980, activities discussed in this report as the responsibility of the Department of Health and Human Services were the responsibility of the Department of Health, Education, and Welfare. A separate Department of Education began operations on May 4, 1980.

The Associations' medical necessity program

The Associations' program 1/ (formally called the Medical Necessity Project) was initially developed for local Blue Shield plans. Since its announcement in April 1977, the program has grown into a multifaceted effort designed to contain health care costs and maintain quality of care. The Associations have recommended that member Blue Cross and Blue Shield plans not routinely pay for 68 health care procedures (see app. II) unless physicians provide special medical justification. A second facet of the program urged plans not to pay for diagnostic tests for medical and surgical hospital admissions unless a physician specifically ordered the tests. The Associations plan to extend the program to address other aspects of medical necessity.

In 1977, the Associations, after collaborating with the American College of Radiology, the American College of Surgeons, the American College of Physicians, and other participating professional organizations, announced a program that included listing 42 health care procedures that contributed to cost without contributing to the quality of care. These procedures were described as: (1) new procedures of unproven value, (2) established procedures of dubious current usefulness, (3) procedures that tended to be redundant when performed in combination with other procedures, and (4) procedures unlikely to yield additional information through repetition.

The Associations stressed two points to member plans:

1. Plans should not always deny payment for the procedures. In some circumstances, nearly any procedure might be medically justified. Therefore, it was

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1/Before January 1978, the Associations were separate organizations: the Blue Cross Association and the Blue Shield Association. The National Association of Blue Shield Plans, which became the Blue Shield Association in May 1977, initially developed the program. The Blue Cross Association approved the program in November 1977. Therefore, for simplicity, we refer to the program as the Associations' program.

recommended that, after appropriate notice and education of physicians, payment for these procedures be provided only upon submission of reports satisfactorily establishing medical necessity.

2. The purpose was not to have plans deny claims and leave the financial obligation to the subscriber. Rather, the purpose was to disseminate authoritative clinical opinion to the profession in an effort to reduce unwarranted utilization so that claims for these services would also be reduced or eliminated.

Since announcing the program, the Associations have expanded the list of procedures. In February 1979, 26 diagnostic procedures were identified by the American College of Physicians and added to the list. The Associations recommended that plans also require satisfactory justification for these procedures before making payments.

Based on the advice of the American College of Physicians, the Associations also recommended in February 1979 that plans pay for diagnostic tests for medical (nonsurgical) hospital admissions only when the tests had been specifically ordered by a physician for that patient. Routine diagnostic tests, commonly known as "admission batteries," include blood counts, urine analyses, biochemical blood screens, chest X-rays, and electrocardiograms. In April 1979, based on the advice of the American College of Surgeons, the Associations' position on hospital diagnostic admission testing was extended to include testing for surgical admissions as well.

According to the Associations' president, "The point of this recommendation is to encourage medical professionals to think about costs of procedures routinely performed." As with earlier parts of the program, the Associations urged plans to familiarize physicians, hospitals, and other providers with the medical necessity requirements regarding admission tests. After a time, claims were to be paid only if a physician gave satisfactory justification for a particular procedure.

Although there are no firm estimates of savings attributable to the Associations' medical necessity program, program officials (as discussed on p. 18) believe the program has been beneficial and has helped reduce claims for the listed procedures. Moreover, the Associations expect the program to be further expanded. For example, the Associations plan to examine the possible duplication between tests done in a

physician's office and those done in a hospital. In addition, according to the Associations' senior vice president for professional and provider affairs, 76 more procedures are being considered for addition to the existing list of 68. The Associations' representative said that in the future the program would address medical necessity issues that were broader than examination of specific procedures. He said this more systemic approach would produce greater savings.

HIAA's Medical Procedure Appropriateness Program

HIAA, a trade organization for over 300 private health insurance companies, has a medical necessity program called the Medical Procedure Appropriateness Program. HIAA's member insurance companies provide nearly 85 percent of the group and individual private health insurance issued in the United States.

HIAA's program, announced in December 1977, is conducted under the guidance of the Council of Medical Specialty Societies (Council), which is composed of 22 specialty societies. (See app. I.) The Council is the focal point for questions raised by insurers requiring evaluation of possibly outdated or unnecessary procedures and the review of new technologies. Because of the impracticality of having several hundred insurers contacting the Council directly, HIAA coordinates insurance companies' requests for evaluation of medical procedures. The Council, in turn, refers these questions to the appropriate specialty societies and transmits their recommendations to HIAA. HIAA then disseminates the responses to the inquiring carrier and other HIAA members.

HIAA's position is that the use of information provided through the Council is a matter for each company to decide. HIAA offers the results of reviews by the Council's component societies as guides to HIAA members in making individual decisions to administer benefit payments properly and promote good medical care. The professional opinions on the appropriateness of certain procedures are, according to HIAA, provided for insurance companies to use as a basis for informed inquiry and requests for further documentation before paying a claim.

As of December 1979, HIAA had disseminated a list of over 50 procedures that the Council had said should not be reimbursed routinely by third-party payers. (See app. II.) At

HIAA's request, the Council is coordinating evaluation of additional procedures. Besides its own list, HIAA has also distributed to its member companies for their guidance the Associations' recommendation that plans not pay for hospital admission tests unless they were specifically ordered by a physician. At HIAA's request, the Council is seeking a broader review and additional support by the medical community on this recommendation.

The Medicare medical necessity program

HHS' Medicare program 1/ also uses parts of the Associations' program. The director of the Medicare Bureau said that the Associations' program was

> "* * * based on principles which * * * are similar to the requirements that have been in effect under the Medicare program since its inception. Medicare contractors have

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1/The Social Security Amendments of 1965 (42 U.S.C. 1395) established the Medicare program to protect eligible persons, principally those over age 65, against the cost of health care. In 1972 Medicare was extended to those under age 65 who are disabled. Medicare provides two forms of protection: (1) Medicare part A, hospital insurance benefits, covers inpatient hospital services and posthospital care in extended-care facilities or the patients' homes. Payment is financed by regular social security taxes collected from employees, employers, and the self-employed. (2) Medicare part B, supplementary medical insurance benefits, is a voluntary program that reimburses part of a physician's services and a number of other medical and health benefits. Benefits under this part are financed by premiums paid by enrollees and funds appropriated from general U.S. Treasury revenue.

The responsibility for administering the Medicare program rests with the Secretary of HHS. Within the Department, the responsibility has been delegated to the Medicare Bureau of the Health Care Financing Administration. The Bureau contracts with public or private agencies to process Medicare claims and make payments on behalf of the Government.

> agreed to apply the safeguards against unnecessary utilization of services called for under sections 1816(b)(1)(B) and 1842 (a)(2)(B) of the Medicare law and to assure, as provided in section 1862(a)(1), that payment is not made for items and services which are not 'reasonable and necessary for the diagnosis or treatment of illness or injury * * *.'"

At the request of Medicare officials, Public Health Service medical consultants evaluated the Associations' initial list of health care procedures. The consultants concluded that, in general, these procedures either were of dubious effectiveness or were outmoded and had been replaced by better means of diagnosis or treatment. The Public Health Service recommended that some of these procedures not be paid for by Medicare, that others be paid for only if the physician performing the procedure satisfactorily justified the medical need for it, and that others be paid for only if the physician justified the medical need for it when performed for a specific condition.

In May 1978 Medicare officials issued an intermediary letter to contractors for Medicare parts A and B. The letter instructed the contractors not to pay routinely for certain health care procedures. (See app. II.) Medicare's program is more rigorous than the Associations' in that four of the listed procedures are never to be reimbursed.

Beginning in September 1979, Medicare policy required that diagnostic tests performed as part of the hospital admitting procedure be (1) specifically ordered by a physician and (2) found medically necessary. The Administrator of the Health Care Financing Administration explained the rationale for the policy, saying it was

> "* * * consistent with current medical and health care opinion on the use of routine admission diagnostic tests. For example, automatic coverage of routine admission chest X-rays for all patients on the presumption they are needed for the detection of respiratory disease is no longer appropriate, particularly in view of the concern about exposing patients to unnecessary radiation."

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The FEHB program, established by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901), provides health insurance coverage for enrollees (Government employees and annuitants) and their dependents. The Government and enrollees share the program's cost. Total program obligations were estimated at about $3.2 billion in fiscal year 1979 and about $3.6 billion in fiscal year 1980. On June 30, 1979, the program covered about 3.5 million enrollees and 6.5 million dependents. OPM contracts for coverage through the following types of health benefit plans:

--Service Benefit Plan: This Government-wide plan is available to all eligible Federal employees regardless of their agency, occupation, or location. The plan, administered by the Associations through local Blue Cross and Blue Shield plans, generally provides benefits through direct payments to doctors and hospitals. In calendar year 1979, this plan covered about 1.9 million enrollees and about 3.5 million dependents and paid benefits estimated at $1.7 billion.

--Indemnity Benefit Plan: This Government-wide plan provides benefits by cash reimbursement to enrollees or directly to doctors and hospitals. The plan, administered by Aetna Life Insurance Company, is open to all eligible employees regardless of their agency, occupation, or location. In calendar year 1979, this plan covered about 482,000 enrollees and about 779,000 dependents and paid benefits estimated at $354.8 million.

--Employee Organization Plans: The health benefit plans sponsored by employee organizations provide claim benefits by cash reimbursements to enrollees or directly to doctors or hospitals. To join any of these plans, an employee must generally also become a member of the sponsoring organization. In 1979, seven of the plans were open to most or all Federal employees and annuitants; the other five restricted membership to employees in a specific agency, occupation, or location. In calendar year 1979, these plans covered about 807,000 enrollees and about 1.7 million dependents and paid benefits estimated at $776.3 million.

--Comprehensive Prepayment Plans: For 1980 there are 86 comprehensive plans, each available only to Federal employees living in a certain geographic area. As contrasted with other plans, which pay claims, these plans provide comprehensive medical services by physicians and technicians practicing in common medical centers or benefits in the form of direct payments to physicians with whom the plans have agreements. The plans also provide hospital benefits. In calendar year 1979, the program's 74 plans covered about 335,000 enrollees and about 532,000 dependents and received premium payments of about $305.5 million.

Administration of FEHB program plans

OPM contracts annually with FEHB program plans to provide health insurance to the plans' members through the FEHB program. Each plan contracts separately with OPM, and each has its own benefit structure and premium rates. Although benefits differ from plan to plan, all the contracts require that the plans not provide benefits for services and supplies which are not provided in accordance with generally accepted professional medical standards in the United States or which are not medically necessary.

OPM, through its Compensation Group (which includes the Division of Government-wide Plans and the Employee Organization Plans Division), is responsible for overseeing the Government's contracts with the FEHB program plans. An important aspect of this responsibility is the annual contract negotiation with each plan. During the negotiations, OPM and the plans agree to specific terms and conditions each party is obligated to meet in the next contract year. Descriptions of both covered and specifically excluded health services are incorporated in the contracts and later included in the plans' health benefit brochures. The brochures are binding statements of benefits and exclusions that plans are obligated to follow as parties to the FEHB program contracts.

OPM begins the yearly negotiations by calling on the participating plans to submit their benefit and rate proposals for the next contract year. Since 1976, the call for proposed benefits and rates has expressed the need to hold down premium costs. OPM, for example, has directed the plans to pursue "vigorous cost containment efforts." OPM has suggested to the plans that cost containment should include claim review, informational activities with providers of health care, and education of enrollees.

CHAPTER 2

VARIED USE OF MEDICAL NECESSITY PROGRAMS

Although the Associations' and HIAA's medical necessity programs have been available since 1977, until very recently OPM has not promoted or evaluated their use. As a result, FEHB program plans' use of medical necessity programs has varied greatly. Plans' positions have ranged from no policy on using the programs to detailed claim processing instructions based on the programs.

Officials of plans using medical necessity programs believe that the programs have been cost beneficial and that they offer the potential for increased savings. According to some Blue Cross and Blue Shield representatives, savings so far have resulted mainly from submission of fewer claims for the listed procedures. Associations' and other program officials could not provide an overall estimate of their programs' savings. Representatives of FEHB program plans that had not incorporated the medical necessity programs into their claim processing systems were generally unaware of the programs.

OPM SLOW TO RECOGNIZE MEDICAL NECESSITY PROGRAMS

OPM has not been aggressive in requiring FEHB program plans to comply with the medical necessity and generally acceptable medical practices clauses of their contracts. In two prior reports, we recommended stronger OPM management measures to get plans to process claims to assure the services were medically necessary. 1/ OPM has said that a primary reason for its inactivity in this area has been that "doctors themselves cannot agree" on medical necessity. The Associations' and HIAA's programs, however, were developed in consultation with, and formally adopted by, national physician organizations. Despite this, OPM's use of medical necessity programs to encourage health care cost control has been limited. Although aware of the Associations' program from

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1/"More Civil Service Commission Supervision Needed to Control Health Insurance Costs for Federal Employees" (HRD-76-174, Jan. 14, 1977) and "Stronger Management Needed to Improve Employee Organization Health Plans' Payment Practices" (HRD-79-87, Sept. 7, 1979).

its inception, OPM did not encourage plans to apply it to the FEHB program. Additionally, OPM was not aware of HIAA's program.

OPM has not evaluated or monitored medical necessity programs

Although Service Benefit Plan officials told OPM of the Associations' program in June 1977, OPM managers have not evaluated it for potential use throughout the FEHB program. In addition, OPM officials did not keep abreast of certain developments in the commercial insurance industry. Since all but three employee organization plans are underwritten by private insurance companies, it is important that OPM be informed about cost containment initiatives in the industry. In December 1977, HIAA began disseminating to its members information that could be used to aid medical necessity determinations. OPM officials were unaware of HIAA's program until we discussed it with them in late October 1979.

OPM provided limited guidance on medical necessity programs to FEHB program plans

OPM provided limited guidance to FEHB program plans on medical necessity programs until October 1979, when employee organization plans were provided more extensive guidance. Not all representatives of the plans sponsored by employee organizations had been aware of the nature or scope of the programs. Aetna officials, who administer the Indemnity Benefit Plan, said that in 1977 OPM had sent them a copy of the Associations' announcement of its program. Blue Cross and Blue Shield plans were informed of the program by the Associations.

The chief of OPM's Division of Government-wide Plans said that his division had not been involved in promoting or evaluating medical necessity programs. According to him, there were three reasons for this: (1) the Indemnity Benefit Plan does not have agreements with physicians as do Blue Shield plans and therefore could not administer a program in the same manner as the Service Benefit Plan; 1/ (2) the

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1/Many Blue Shield plans have agreements or contracts with doctors (called "participating physicians"). The agreements stipulate how physicians must submit claims and generally set forth the responsibilities of the plans and the physicians.

Associations' program was public and therefore the information was available to any insurance company that wanted it; and (3) if all Blue Cross and Blue Shield plans implemented the program, other plans would have little need to use it, since doctors would not practice different types of medicine depending on the type of insurance a patient had.

Regarding OPM's rationale for providing only limited guidance, Aetna officials told us that the lack of agreements with physicians has not hampered their use of medical necessity programs. OPM, therefore, has the opportunity to determine how plans without physician agreements use the programs and how other such plans might use them. As to the second reason, although the programs are public, OPM has a management responsibility to assure that FEHB program plans avail themselves of medical necessity and cost-containment programs consistent with program contracts. Third, not all Blue Cross and Blue Shield plans have fully implemented the program, and among those that have, administration has varied.

The chief of OPM's Employee Organization Plans Division also said that he had not provided any information on the medical necessity programs to the plans for which he had responsibility. He believed that the plans' underwriters would have advised them of the programs. Discussions with representatives of four of the five plans underwritten by Mutual of Omaha in 1979 indicated that they had received HIAA medical necessity information. 1/ Although Prudential is a member of HIAA, medical necessity program information was not being used in the claim processing systems of the plans Prudential underwrote in 1979. In addition, the two largest employee organization plans--those sponsored by the American Postal Workers Union (APWU) and the National Association of Letter Carriers (NALC)--were not familiar with the Associations' or HIAA's medical necessity program. These two plans are self-underwritten and, therefore, would not have received information from a commercial underwriter.

FEHB PROGRAM PLANS' USE OF MEDICAL NECESSITY PROGRAMS VARIED

FEHB program plans' awareness and use of the medical necessity programs varied greatly, ranging from no policy at all to detailed claim processing instructions. For example:

1/Our review did not include the fifth plan--Canal Zone Benefit Plan--underwritten by Mutual of Omaha.

--The Service Benefit Plan's policy was to use the Associations' program fully, although administration varied somewhat among Blue Shield plans.

--The Indemnity Benefit Plan's policy was to use some, but not all, of the Associations' and HIAA's program criteria.

--Of the nine employee organization plans whose representatives or underwriters we contacted, seven (including the two largest) had not incorporated the medical necessity programs into their claim processing systems.

Following is a summary of the FEHB program plans reviewed and their position on using medical necessity programs:

FEHB program plan	Policy to use HIAA's or Associations' program
Service Benefit	Yes
Indemnity Benefit	Partly
American Federation of Government Employees	Yes
Alliance	No
American Postal Workers Union	No
Foreign Service	Yes
Government Employees Benefit Association	No
National Association of Letter Carriers	No
Postmasters	No
Rural Carrier	No
Special Agents Mutual Benefit Association	No

Service Benefit Plan supports the Associations' program

The Service Benefit Plan fully supports the Associations' program. Plan officials told us that the program had reduced use of certain procedures, thereby helping to contain health care costs without reducing the quality of care. An April 1979 Associations' survey indicated that 93 percent of the Blue Cross and Blue Shield plans had implemented the program or were planning to implement it.

The four Blue Shield plans we visited were using the program; however, program administration varied somewhat. For example, the Pennsylvania Blue Shield plan's program is subject to the participating physician agreements. If the plan denied a claim as not medically necessary, the participating physician who provided the care could not legally collect from the patient. The other three Blue Shield plans we visited did not have such a provision. In dealing with these three plans, providers could collect from the patient if the plans denied the claims. However, officials from these plans could not recall this ever happening.

Indemnity Benefit Plan will use parts of the medical necessity programs

The Aetna Life Insurance Company, underwriter and administrator for the Indemnity Benefit Plan, has not fully adopted information developed in HIAA's and the Associations' medical necessity programs. However, Aetna officials said they planned to incorporate aspects of the programs into their claim processing system. The officials were aware of both programs and said their decision not to use all the criteria had been based on research.

The Aetna claim processing system did not include any screens to detect the surgical procedures listed in the two programs. Officials at Aetna told us that, upon learning of the list of outmoded surgical procedures, they had examined their claim experience to determine how many of the procedures they had paid for. They found that the incidence of payment was extremely low throughout their business; in the FEHB program specifically, they found only two claims for all the procedures, and these claims were for a procedure later deemed acceptable. Based on this information and an estimated cost of $25,000 to implement screening for the procedures, Aetna decided not to use the surgical aspect of the program.

Although Aetna has not yet formally adopted diagnostic aspects of any medical necessity program, officials told us that their claim processing system would not permit routine payment for most of the diagnostic procedures on the lists. For Aetna to pay an FEHB program claim routinely for a diagnostic procedure, the procedure must appear on a list of procedures appropriate for the specified diagnosis or the physician must justify the procedure. Of the 26 procedures on the Associations' February 1979 list, for example, none was on Aetna's list of acceptable procedures. However, Aetna's claim manual would permit payment for a few of the diagnostic procedures that the Associations had listed earlier. Aetna representatives told us that they expected to delete several of these procedures from their lists of acceptable tests in spring 1980.

Additionally, Aetna officials explained that in some ways they had been ahead of the medical necessity programs. For example, Aetna had advised its claim processors in 1978 not to accept routinely claims for intermittent positive pressure breathing. This procedure was added to HIAA's list in February 1979. Aetna officials said that their program of checking claims to assure the tests given were medically related to the diagnosis had resulted in claim savings of "millions of dollars." They contended that not having contracts with hospitals and physicians, such as Blue Cross and Blue Shield plans may have, had not prevented them from aggressively enforcing the requirement that services and procedures be medically necessary or in accordance with accepted medical standards. However, they acknowledged that they had not implemented a policy to prohibit reimbursement for routine hospital admission tests. While recognizing that this aspect of the programs offers the potential for great savings, Aetna representatives said they had not determined a way to administer it. They said they were continuing to study the matter.

Besides planning to use aspects of the programs in claim processing, Aetna requests information through HIAA on the value of procedures thought to be questionable. An HIAA representative told us that most requests for review and evaluation of procedures came from Aetna.

Few employee organization plans use medical necessity programs

Of the nine FEHB program employee organization health plans we reviewed, seven, including the two largest, had no

policy or specific instructions for using medical necessity programs. Some plans' officials were not aware of the Associations' or HIAA's medical necessity program. Although a claim processing agency for two plans had incorporated HIAA's list of questionable procedures into its claim processing manual, no other plan had established review procedures to identify specifically the health care procedures included in either the Associations' or HIAA's medical necessity program. Representatives of two other plans, upon learning of the programs, said that they thought such programs would not be worthwhile from an administrative and cost-benefit view.

NALC and APWU officials acknowledged that their plans had no claim review procedures to identify specifically the health care procedures listed in the Associations' or HIAA's program. The plans' officials stated that, if the procedures were being performed, they were paying for them. They indicated that, because they did not have contracts with physicians and hospitals, as Blue Cross and Blue Shield plans often have, they could not effectively enforce a medical necessity program.

According to NALC officials, they could easily establish a way to check for the questionable surgical procedures in their computerized claim processing system. However, as of August 1979, they had not seen a list of the Associations' or HIAA's procedures. They also commented that, if such a program were adopted, administrative costs would increase because of the required medical reviews. In January 1980, an NALC representative told us that his plan was working to stop payment for routine hospital admission tests. He did not expect much resistance from hospitals because of the publicity this aspect of medical necessity programs had already received. In commenting on our draft report, however, the NALC plan director noted that his plan had received complaints and that the program was not being generally accepted by hospitals, doctors, and patients.

On the other hand, the APWU plan director stated that the plan should pay all claims for services ordered by a physician. In commenting on our draft report, the plan director reiterated that, "Absolutely no payment is made for medical services not prescribed by a physician." A principal aspect of medical necessity programs is, however, to evaluate the services and procedures ordered by a physician because some ordered services may not be necessary.

Two FEHB program employee organization plans underwritten by Mutual of Omaha in 1979 had established claim review procedures that identified health care procedures in HIAA's list. These plans, sponsored by the American Federation of Government Employees and by the Foreign Service Benefit Association, have their claims processed by the Joseph E. Jones Agency. A Jones Agency official told us that the HIAA list provided by Mutual of Omaha was included in the two plans' claim review manuals. The representative explained that, if a claim for any of the procedures on the list is received, it is automatically denied. If the denial is appealed, then a medical review is made.

Although these two plans were using HIAA's list, two other FEHB program plans that Mutual of Omaha underwrites were not. A Rural Carrier Benefit Plan official told us in mid-November 1979 that he had recently received HIAA's list from Mutual of Omaha. He said that he had not had a chance to review the procedures and consequently had not established any specific claim review procedures. He doubted that instituting such a review process would be cost beneficial.

The Mutual of Omaha regional office that processes claims for the Alliance Health Benefit Plan had also received the HIAA list. However, an Alliance official commented that, since claims were seldom seen for any of the procedures, the list had not been incorporated into Alliance's claim review manual. According to the official, if a claim for one of the procedures on the HIAA list were submitted, it would probably not be among the plan's list of allowable charges for various procedures. Therefore, a detailed review of the claim would be made.

The three FEHB program employee organization plans that the Prudential Insurance Company underwrote in 1979 had no specific procedures for identifying the questionable health care procedures. Although Prudential processes claims for one of these plans (Government Employees Benefit Association Plan) and routinely provides advice as well as claim manuals to two other plans that process their own claims (Postmasters Benefit Plan and Special Agents Mutual Benefit Association Plan), no information on medical necessity programs was being used.

The Government Employees Benefit Association Plan, whose claims are processed by Prudential, did not have claim review procedures for the questionable health care procedures. Prudential officials said that, although they review claims

for medical necessity, they had no procedure built into their claim processing system that specifically would detect procedures on either HIAA's or the Associations' list.

The Postmasters Plan official was not familiar with the Associations' program before our review, and Prudential had not provided any specific information on the program. Consequently, the plan's claim processing manual contained no specific instructions to review the procedures. The administrator commented that, if the procedures were among the plan's lists of procedure costs, claims for the procedures would be paid unless the charges were not reasonable.

The Special Agents Mutual Benefit Association Plan manager was also not aware of the Associations' program until October 1979. Although OPM advised employee organization plans in October 1979 to implement the medical necessity programs, the plan manager did not intend to do so until OPM issued specific guidance concerning program implementation and enforcement. He said the program would be (1) difficult to administer, (2) an additional encumbrance on the claim processing system, and (3) unwarranted because the plan had processed few claims for the listed procedures.

Prudential officials commented that implementing HIAA's or the Associations' program would not be justified. They said that Prudential does not specifically check for the listed surgical procedures because they occur so rarely. Additionally, a Prudential official said that his company does not specifically screen for the listed diagnostic procedures because (1) hospitals do not usually itemize laboratory and other diagnostic procedures and (2) the charges for these procedures are relatively low, making the benefit of monitoring the procedures questionable.

SOME BENEFITS HAVE BEEN ACHIEVED, AND SAVINGS ARE EXPECTED TO INCREASE

When the Associations announced their medical necessity program in 1977, they estimated that about $27 million in claim payments could be considered for rejection. The estimate was based on Service Benefit Plan data on the incidence of the listed procedures and was projected to all Blue Shield business. The Associations did not estimate the amounts of claim payments that could be affected by the 26 procedures later added to the list. The Associations have also estimated (based on 1977 data) that the six most frequently performed hospital admission tests cost $2.5 to $3.0 billion annually.

The Associations have estimated their program could affect millions of dollars in health care costs, but they have not attempted to measure the program's overall effect to date. According to an Associations' senior vice-president, it would be costly to assess the program's full effect in terms of claim rejections. More importantly, officials told us that considerable savings were probably attributable to claims never being submitted because of the program's publicity and physician education efforts.

Although the Associations have not evaluated the program's effect, Service Benefit Plan, Associations', and Blue Shield plans' officials believe the program has been cost beneficial and expect savings to increase. They believe the program has contributed to (1) containing health care costs, (2) reducing the incidence rate of procedures of questionable value, (3) increasing physician awareness of questionable procedures and health care costs, and (4) assuring quality health care.

Incidence of the program's health care procedures in the Service Benefit Plan generally has declined. A plan study of the frequency of procedures 1/ performed during 1975-78 indicated that the number of claims paid for the listed surgical procedures declined 26 percent, claims paid for diagnostic procedures (Blue Shield only) declined 84 percent, while claims for the listed X-ray procedures rose 14 percent.

Statistics maintained by the Pennsylvania Blue Shield plan also show cost savings and lower incidence rates for medical necessity procedures. From the beginning of its program in April 1977 to October 1979, Pennsylvania Blue Shield processed 2,066 claims for listed medical necessity procedures, of which 1,916 (92.7 percent) were denied. 2/

1/These data do not cover the 26 diagnostic procedures added to the program in February 1979.

2/The Pennsylvania Blue Shield plan had its own medical necessity program in effect before the announcement of the Associations' program. As of October 1979, Pennsylvania Blue Shield, which makes a separate evaluation of procedures listed in the Associations' program, had classified 36 procedures as of "questionable current usefulness." Other procedures were under review. (Statistics do not include Medicare program business.)

By September 30, 1979, claims totaling almost $63,000 for listed procedures had been denied. The Service Benefit Plan accounted for 5.4 percent of the plan's 1979 claim volume.

The Medical Service of the District of Columbia data for medical necessity procedures in the FEHB program between 1976 and 1979 show a 90- and 91-percent decline in the dollar amount and number of claims paid for the listed medical necessity procedures, respectively. The following table illustrates these declines.

Calendar year	Number of claims paid	Amount paid
1976	5,371	$560,000
1977	613	103,000
1978	577	94,000
1979 (note a)	480	56,000

a/Projected to a full year using 8 months' information.

Associations' officials believe the program's direction indicates that savings will increase. One official explained that, rather than continuing to address medical necessity questions on a procedure-by-procedure basis, the program managers are seeking solutions to larger problems. For example, the Associations' position on routine hospital admission tests and their examination of the issue of test duplication between a doctor's office and a hospital represent more comprehensive approaches. In contrast to the $27 million in claim payments that could be affected by the initial phase of the program, the Associations estimated that the routine hospital admission tests could affect $2.5 to $3.0 billion annually. The Associations' president said that, if 10 percent of these tests could be eliminated, $300 million could be saved annually.

RECENT OPM ACTION TO ENCOURAGE USE OF MEDICAL NECESSITY PROGRAMS

Since we began our review, OPM's Employee Organization Plans Division chief has acted to encourage FEHB program employee organization plans to use medical necessity programs. In October 1979, after we had discussed OPM's lack of guidance to the plans, the chief wrote to the plans, asking them to check claims for medical necessity. (See app. III.) He said,

"* * * we are not aware of any plan routinely screening claims for medically unnecessary services and supplies such as obsolete surgical procedures and unneeded diagnostic testing. Since this is a contractual obligation we ask that procedures to review for medical necessity be implemented immediately."

Plan officials we spoke to were generally critical of OPM's vagueness in stating the medical necessity requirements for claim processing. One plan official said he would do nothing until OPM specifically directed all plans to implement the procedures and specified which procedures were obsolete or unnecessary. In December 1979, the Employee Organization Plans Division chief sent each employee organization plan a list of the procedures included in the Associations' program to aid claim processors.

Besides asking the plans to implement the medical necessity programs and telling them which procedures were on the Associations' list, the chief invited representatives of the APWU and NALC plans and the Mutual of Omaha and Prudential Insurance Companies to meet in December 1979 to discuss the matter. He believed the meeting had resulted in moving toward implementation of measures to assure medical necessity. For example, according to the OPM representative, the plans' and underwriters' representatives agreed to do more to educate physicians and enrollees about medical necessity requirements. Additionally, the representatives agreed to begin checking claims for the Associations' listed surgical procedures and to investigate ways to screen claims efficiently for the Associations' listed diagnostic procedures. Finally, the plans' and underwriters' representatives agreed to investigate ways to inform hospitals that admission tests should include only procedures specifically ordered by a physician.

CONCLUSIONS

OPM has the opportunity to assure that all plans participating in the FEHB program reap the benefits of medical necessity programs. These programs are relatively new, and the benefits realized thus far have been limited. However, the programs generally have widespread physician acceptance, and the numbers of claims for the listed procedures have declined. In addition, several Federal and non-Federal health insurance organizations have adopted the programs.

The programs should help make physicians more aware of the financial consequences of their practices. Greater benefits should be realized as the programs are expanded and become more widely used. These programs would help all the FEHB program plans fulfill their contractual obligations. They can provide one facet of a plan's overall approach to assuring that it pays only for medically necessary health care provided in accordance with accepted professional standards.

The programs can help promote good health care, while helping to hold down costs. Since the programs have already produced some benefits and benefits are expected to increase, we believe OPM should make sure program managers and health plan administrators keep abreast of the programs. Additionally, by giving all FEHB program plans specific, consistent guidance on medical necessity programs, OPM managers can help assure that all plans (1) are treated equitably and (2) receive specific guidance to be used in their claim payment systems.

RECOMMENDATIONS

We recommend that the Director, OPM:

--Systematically monitor developments in medical necessity programs in both the private and public sectors.

--Evaluate these programs to determine how FEHB program plans might use them to foster better health care and lower health insurance costs.

--Require FEHB program plans to use aspects of these programs that are proven beneficial.

OPM'S AND OTHER ORGANIZATIONS' COMMENTS AND OUR EVALUATION

We received comments on our draft report from OPM and 11 of the other organizations included in our review. (See apps. IV to XV). Although representatives of some of the organizations noted problems associated with implementing medical necessity programs, the organizations generally favored them and agreed with our conclusions concerning the beneficial aspects of these programs.

OPM comments

OPM said that careful oversight and guidance on claim payments can prevent unnecessary cost increases and that it continuously seeks to make improvements in these areas to control costs without unfairly penalizing FEHB enrollees. OPM did not, however, indicate whether it agreed or disagreed with our individual recommendations that encourage OPM to increase its involvement in making better use of medical necessity programs. While OPM indicated agreement with the general concept of medical necessity as related to its FEHB program contracts with individual plans, it did not evidence a commitment to increase its role as a promoter of the programs. Such a role would include increased monitoring of other organizations' efforts, identifying beneficial aspects of the programs, and incorporating those aspects into the FEHB program.

OPM commented that medical necessity contract provisions were not as efficient as other cost containment efforts being used by FEHB program plans. Plans are contractually bound to pay only for medically necessary services, and we believe that medical necessity programs can provide OPM and FEHB program plans with another tool to help (1) prevent the providing of medically unnecessary services and (2) control costs. The Associations', HIAA's, and Medicare's use of these programs indicates that they are useful in containing costs while maintaining quality of care.

OPM also stated that there are practical limits to conducting an exhaustive examination of every claim submitted and that doing so is not consistent with industry practice. OPM said that such claim examinations would impose intolerable delays, create substantial backlogs of payments, and cause unwarranted increases in administrative costs. We believe that OPM has overstated the difficulties associated with claims processing and that the use of medical necessity program procedures would not necessarily cause the types of problems OPM mentioned. First, medical necessity programs do not require an exhaustive examination of every claim submitted. The claims to be examined are those claims that appear questionable based on medical necessity program provisions. Second, using automated claim processing techniques (as many FEHB program plans are using or planning to use) permits rapid preliminary examination of every claim. Our review disclosed no situations where plans that were using medical necessity programs had experienced the problems OPM noted. For example, Prudential commented that a normal part

of its daily claims processing routine is an automatic computerized selection of claims which receive high level intensive review. Part of this intensive review is the verification of the medical necessity of the procedures for which claims were submitted.

Although OPM commented that denial of claim payments places members at a financial disadvantage, we do not believe that FEHB program plans should pay for claims for services that are not medically necessary. OPM and FEHB program plans could develop an educational program for enrollees about medical necessity programs. Educated enrollees should have a role in containing health insurance costs. Strictly speaking, the enrollee is not being penalized when a claim for noncovered services is denied. Paying claims for medically unnecessary services without seeking to implement a means to screen out such claims--whether by physician education, claim denials, or both--penalizes both enrollees and taxpayers because both share the cost of FEHB program premiums.

OPM stated that it has been reluctant to issue definitive guidelines on medical necessity for a variety of reasons. OPM said that the question of medical necessity is one on which doctors themselves find it hard to agree. Further, OPM said, "A rigid set of guidelines would restrict benefit payment and penalize enrollees if necessary, yet out of the ordinary, services were provided." We are not recommending that OPM issue guidelines until it evaluates medical necessity programs and identifies aspects of the programs that are proven beneficial. As we stated in our report, "Stronger Management Needed to Improve Employee Organization Health Plans' Payment Practices" (HRD-79-87, Sept. 7, 1979), we believe that physicians generally can agree on the necessity of most services. In the case of medical necessity programs, numerous professional medical organizations have already agreed that the procedures listed in appendix II are highly questionable.

OPM believes that the major incentive for careful claims administration continues to be competition among FEHB program plans. We agree that competition can be a strong incentive for contract adherence and claim cost control. However, as our two earlier reports pointed out (see note 1, p. 9), not all the plans we reviewed were reviewing claims thoroughly to assure payment for only medically necessary services. Further, competition among the plans depends significantly on the potential enrollees' being able to compare knowledgeably costs and benefits various plans offer. OPM has not provided

information in a form to allow such a comparison among plans. 1/

Other organizations' comments

Most of the organizations which commented on our draft report expressed agreement with the report. These included Pennsylvania Blue Shield, Medical Service of D.C., Mutual of Omaha, the Associations, HIAA, the NALC plan, the Service Benefit Plan, and the Prudential Insurance Company. For example, the Medical Service of D.C. said that the plan was "in concurrence with the findings pertaining to the Federal Employee Health Benefits (FEHB) Program in our Plan, as well as the conclusions and recommendations * * *." The Mutual of Omaha representative stated, "We are in agreement that there are benefits to be derived in having some type of medical necessity program." HIAA commented that it believed that governmental agencies responsible for health benefit programs would find medical necessity programs useful.

FEHB program carriers and plans generally stated their willingness to address the problems associated with using medical necessity programs and their desire to cooperate with OPM on this matter. For example, the NALC plan director suggested that OPM should supply information on questionable tests and procedures. The APWU plan director assured complete cooperation in implementing a medical necessity program "should OPM find it appropriate." Prudential supported the concept of medical necessity but also noted more discussion was needed before implementing programs. Prudential also noted several steps it would take to improve claim processing in line with medical necessity programs.

Aetna believed that our recommendations should be directed to efforts to reduce the extent of health care services provided rather than to reduce health insurance costs. Aetna expressed concern that, if the focus is on health insurance costs, the enrolled beneficiaries will pay for these reductions. Aetna also stated that, if the focus is the services themselves, a reduction in health insurance costs will be automatic. We believe that education of physicians, other health care providers, and subscribers can reduce the incidence of questionable procedures and services--thus promoting better and less costly care and also lowering

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1/"Federal Employees Need Better Information for Selecting a Health Plan" (MWD-76-83, Jan. 26, 1976).

health insurance costs. However, education alone will not stop all providers from performing medical services of questionable medical necessity. We believe, therefore, that provider and enrollee education should be coupled with strict enforcement of medical necessity contract provisions. This should result in reduction of health insurance costs, improvements in quality of health care, and a reduction in the frequency of questionable services.

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In commenting on our draft report, OPM, NALC, Prudential, and Aetna noted some difficulties associated with administering medical necessity programs. We agree that implementation may be difficult. However, because of the programs' potential benefits and the plans' willingness to use medical necessity programs, OPM has an excellent opportunity to provide leadership and guidance in promoting the programs' beneficial aspects.

CHAPTER 3

SCOPE OF REVIEW

From September 1979 to January 1980, we reviewed how OPM has overseen or encouraged FEHB program plans' use of medical necessity programs. We interviewed OPM officials and reviewed documents related to involvement of OPM's divisions of Government-wide and employee organization plans. We did not review activities of the Comprehensive Plans Division since medical necessity programs were designed for insurance plans that pay claims.

To obtain information and documentation on the development, purpose, and future direction of medical necessity programs, we met with representatives of the Associations, HIAA, Medicare, and medical specialty societies that participated in the programs' development. To see how FEHB program plans were using medical necessity programs, we met with representatives of the 2 Government-wide and 9 of the 12 employee organization plans that participated in the FEHB program in 1979 and 4 local Blue Shield plans participating in the Service Benefit Plan. This provided an indication of how plans used medical necessity programs.

Data were not available to measure the programs' overall effects on health insurance costs, but we obtained statistics on the incidence of the various listed procedures. Because they maintained information on experience with the program, we focused our review on the Service Benefit Plan, the Medical Service of the District of Columbia, and the Pennsylvania Blue Shield plan. HIAA and Medicare did not maintain statistics on their medical necessity programs.

During our review, we contacted the following organizations:

FEHB Program Plans and Related Organizations

American Postal Workers Union Hospital Plan	Silver Spring, Md.
Indemnity Benefit Plan	Hartford, Conn.
Joseph E. Jones Agency (the claim processing agency for two FEHB program employee organization plans)	Washington, D.C.
Mutual of Omaha Insurance Company (underwriter of five FEHB program employee organization plans)	Washington, D.C., and Rockville, Md.
National Association of Letter Carriers Health Benefit Plan	Reston, Va.
Postmasters Benefit Plan	Alexandria, Va.
Prudential Insurance Company (underwriter for three FEHB program employee organization plans)	Willow Grove, Pa.
Rural Carrier Benefit Plan	Washington, D.C.
Service Benefit Plan	Washington, D.C.
Blue Shield of Maryland	Baltimore, Md.
Blue Shield of Virginia	Richmond, Va.
Medical Service of the District of Columbia	Washington, D.C.
Pennsylvania Blue Shield	Camp Hill, Pa.
Special Agents Mutual Benefit Association Health Benefit Plan	Washington, D.C.

Medical Necessity Program Originators

Blue Cross and Blue Shield Associations	Chicago, Ill.
Health Insurance Association of America	Chicago, Ill.

Federal Executive Agencies

Department of Health and Human Services; Health Care Financing Administration	Baltimore, Md.
Office for the Civilian Health and Medical Program of the Uniformed Services	Aurora, Colo.
Office of Personnel Management	Washington, D.C.

Medical Specialty Societies

American College of Physicians	Philadelphia, Pa.
American College of Surgeons	Chicago, Ill.
American College of Radiology	Chicago, Ill.
American Medical Association	Chicago, Ill.

Congressional Agencies

Congressional Budget Office	Washington, D.C.
Congressional Research Service	Washington, D.C.
Office of Technology Assessment	Washington, D.C.

APPENDIX I

PROFESSIONAL MEDICAL ORGANIZATIONS PARTICIPATING IN MEDICAL NECESSITY PROGRAMS

Organizations That Have Participated in the Associations' Program

American Academy of Family Practice
American Association of Medical Colleges
American College of Physicians
American College of Radiology
American College of Surgeons
American Hospital Association
College of American Pathologists
Council of Medical Specialty Societies

Organizations Participating in HIAA's Program

American Academy of Allergy
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology and Otolaryngology
American Academy of Orthopedic Surgeons
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American College of Radiology
American College of Surgeons
American Psychiatric Association
American Society of Anesthesiologists
American Society of Colon and Rectal Surgeons
American Society of Plastic and Reconstructive Surgeons
American Urological Association
College of American Pathologists
Society of Nuclear Medicine
Society of Thoracic Surgeons

APPENDIX II

PROCEDURES LISTED IN THREE MEDICAL NECESSITY PROGRAMS

Associations' Medical Necessity Program (as of December 31, 1979)

Procedures to be Payable Only Upon Satisfactory Justification

Amylase, blood isozymes, electrophoretic

Angiocardiography, multiplane, supervision and interpretation in conjunction with cineradiography 1/

Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography 1/

Angiocardiography, using CO2 method, supervision and interpretation only

Angiography--coronary, unilateral selective injection supervision and interpretation only, single view unless emergency

Angiography--extremity, unilateral, supervision and interpretation only, single view unless emergency

Autogenous vaccine

Ballistocardiogram

Basal metabolic rate

Bronchoscopy--with injection of contrast medium for bronchography

Bronchoscopy--with injection of radioactive substance

Calcium, feces, 24-hour quantitative

Calcium saturation clotting time

Capillary fragility test (Rumpel-Leede) (independent procedure)

Cephalin flocculation

Chromium, blood

Chymotrypsin, duodenal contents

1/Considered as two procedures.

Circulation time, one test

Circumcision, female

Colloidal gold

Congo red, blood

Gastric analysis, pepsin

Gastric analysis, tubeless

Guanase, blood

Hormones, adrenocorticotropin quantitative animal tests

Hormones, adrenocorticotropin quantitative bioassay

Hypogastric or presacral neurectomy (independent procedure)

Hysterotomy, nonobstetrical, vaginal

Icterus index

Kidney decapsulation, bilateral

Kidney decapsulation, unilateral

Ligation of internal mammary arteries, bilateral

Ligation of internal mammary arteries, unilateral

Ligation of thyroid arteries (independent procedure)

Nephropexy: fixation or suspension of kidney (independent procedure), unilateral

Omentopexy for establishing collateral circulation in portal obstruction

Perirenal insufflation

Phonocardiogram with interpretation and report, and with indirect carotid artery tracing or similar study 1/

Protein bound iodine

1/Considered as two procedures.

Radical hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area 1/

Skin test, actinomycosis

Skin test, brucellosis

Skin test, cat scratch fever

Skin test, leptospirosis

Skin test, lymphopathia venereum

Skin test, psittacosis

Skin test, trichinosis

Starch, feces, screening

Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both

Thymol turbidity, blood

Uterine suspension

Uterine suspension, with presacral sympathectomy

Zinc sulphate turbidity, blood

Procedures Requiring Justification When Performed for the Specific Condition Indicated

	As treatment for
Excision of carotid body tumor without excision of carotid artery; with excision of carotid artery 2/	asthma
Fascia lata by incision and area exposure, with removal of sheet	lower back pain
Fascia lata by stripper	lower back pain
Ligation of femoral vein, bilateral	post-phlebitic syndrome

1/Later deleted from list.

2/Considered as two procedures.

APPENDIX II

	As treatment for
Ligation of femoral vein, unilateral	post-phlebitic syndrome
Splanchnicectomy, bilateral	hypertension
Splanchnicectomy, unilateral	hypertension
Sympathectomy, lumbar, bilateral	hypertension
Sympathectomy, lumbar, unilateral	hypertension
Sympathectomy, thoracolumbar, bilateral	hypertension
Sympathectomy, thoracolumbar, unilateral	hypertension

HIAA's Medical Procedure Appropriateness Program (as of December 31, 1979)

Procedures That Should Not Be Reimbursed Routinely

Abderhalden reaction

Abdominal proctopexy (Moscowitz)

Amylase, blood isozymes, electrophoretic

Autogenous vaccine

Bendien's test

Bolen test

Calcium clotting time

Calcium, feces, 24-hour quantitative

Calcium saturation clotting time

Capillary fragility test (Rumpel-Leede) (independent procedure)

Cecopexy

Cephalin flocculation, thymol turbidity

Cerebellar stimulator pacemakers for cerebral palsy

Chelation therapy

Chromium, blood

Chymotrypsin, duodenal contents

Circulation time, one test

Clitoridectomy

Colloidal gold

Congo red, blood

Fishberg concentration test

Gastric analysis pepsin

Gastric analysis, tubeless (Diagnex Blue)

Guanase, blood

Hair analysis for multiple trace elements

APPENDIX II

HCG injection for treatment of obesity

Hormones, adrenocorticotropin, quantitative animal tests

Hormones, adrenocorticotropin quantitative bioassay

Hyperalimentation

Hyperbaric oxygen therapy for senility, stroke, heart attack

Hyperbaric oxygen therapy for skin grafts

Intermittent positive pressure breathing

Intragastric hyperthemia

Megavitamin therapy for learning disabilities

Mosenthal test

Motais operation (Ptosis)

Mucoprotein blood (seromucoid)

Orthomolecular medication for learning disabilities

Phrenicotomy

Phrenicotripsy

Prolotherapy

Refractive keratoplasty

Rehfus test

Skin test, actinomycosis

Skin test, brucellosis

Skin test, cat scratch fever

Skin test, leptospirosis

Skin test, lymphopathia venereum (Frei test)

Skin test, psittacosis

Skin test, trichinosis

Staphylorrhaphy

Starch, feces, screening

Taste and smell clinic services

Thymol turbidity, blood

Tonsillectomy by X-ray treatment

Uvulectomy

Zinc sulphate turbidity, blood

Skin, nasal, lingual, eye, cytotoxic food test, neutralization test, intracutaneous tritation, sublingual allergy desenitization, leucocytotoxic testing

APPENDIX II

HHS' Medicare Program (as of December 31, 1979)

Procedures Covered Only Upon Satisfactory Justification of Medical Necessity

Angiocardiography plain films or single views (single plane or multiplane)

Angiocardiography using CO2 method

Angiography--extremity, unilateral, single view (unless emergency)

Basal metabolic rate

Circumcision, female

Coronary angiography, unilateral selective injection, single view (unless emergency)

Hypogastric or presacral neurectomy (independent procedure)

Hysterotomy, nonobstretical, vaginal

Kidney decapsulation

Nephropexy (independent procedure)

Omentopexy for establishing collateral circulation in portal obstruction

Perirenal insufflation

Phonocardiogram

Radical hemorrhoidectomy, Whitehead type

Supracervical hysterectomy

Uterine suspension with or without presacral sympathectomy

APPENDIX II

Procedures Covered Only Upon Satisfactory Justification of Medical Necessity for a Specific Condition

Fascia lata by incision and area exposure, as treatment for lower back pain

Fascia lata by stripper, as treatment for lower back pain

Ligation of femoral vein, as treatment for post-phlebitic syndrome

Sympathectomy, thoracolumbar or lumbar, as treatment for hypertension

Procedures Excluded From Coverage

Ballistocardiogram

Icterus index

Ligation of internal mammary arteries

Protein bound iodine

APPENDIX III

United States of America
Office of Personnel Management Washington, D.C. 20415

In Reply Refer To

Your Reference

Dear

This is to inform you the General Accounting Office will be conducting audits on procedures to determine medical necessity and effectiveness of money management.

In recent years we have asked each employee organization sponsoring health benefit plans under the Federal Employees Health Benefits Program to pursue vigorous cost containment efforts. Also, we have instructed each plan to implement benefit modifications to encourage use of second surgical opinions, outpatient surgical facilities, surgi-centers, and free standing facilities. We have stressed use of available concurrent review for hospital inpatient stays and Professional Standards Review Organizations. And have advised plans to initiate programs of continuing education for claims processors.

Most plans routinely audit hospital charges before payment, but we are not aware of any plan routinely screening claims for medically unnecessary services and supplies such as obsolete surgical procedures and unneeded diagnostic testing. Since this is a contractual obligation we ask that procedures to review for medical necessity be implemented immediately.

We believe employee organizations employ sound money management techniques, but urge each plan to continue to seek prudent yet more efficient techniques.

May we have your comments please.

Sincerely,

George M. MacWhorter

George M. MacWhorter, Chief
Employee Organization Plans Division
Insurance Programs

GAO note: This letter was sent to all employee organization plans in October 1979.

APPENDIX IV

United States of America
Office of Personnel Management Washington, D.C. 20415

MAY 12 1980

Mr. H. L. Krieger, Director
Federal Compensation and
Personnel Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Krieger:

Thank you for the opportunity to review your draft audit report, "Medical Necessity Programs--Another Opportunity for the Office of Personnel Management to Improve Federal Employees' Health Insurance." The report recommends that the Office of Personnel Management (OPM) monitor, evaluate, and require Federal Employees' Health Benefits (FEHB) plans to use medical necessity programs.

We agree that careful oversight and guidance on claim payments can prevent unnecessary cost increases and OPM continuously seeks to make improvements in these areas to effect cost control without unfairly penalizing FEHB enrollees.

Medical necessity programs have been strictly administered by the FEHB Government-wide plans for the past 10 years and claims for reimbursement for unnecessary medical procedures have been denied. The incidence of such claims and denial of payment is not widespread, however. This is not surprising since the real objective of a medical necessity program is to educate medical providers and consumers about unnecessary and outmoded medical procedures which should not be performed in the first place. The Service Benefit Plan, through the Blue Cross-Blue Shield agreements with participating physicians, has been able to place real pressure on medical providers to avoid performing unnecessary and outmoded medical procedures.

The comprehensive plans, by design and nature of operation, encourage moderation in the use of services. Physicians in group and individual practice prepayment plans unlike those in fee-for-service plans, have a built-in incentive to control costs. Therefore, the plans have not developed medical necessity programs as such. Plan brochures, which are part of the contract, do, nevertheless, state that any

GAO note: Any page references in this and the following appendixes have been changed to correspond to page numbers in this report.

service which is not, in the judgement of the plan doctor, medically necessary for the prevention, diagnosis, or treatment of an illness or condition will not be provided.

OPM has been monitoring FEHB employee organization plans' efforts toward controlling payments for medically unnecessary services and supplies. As a result, the organizations are increasing efforts to educate enrollees about unnecessary services and supplies. In addition, continued educational programs for claims processors are being implemented. Further, most organizations are utilizing sophisticated screening procedures to detect medically unnecessary services and supplies.

Medical necessity provisions, however are not, in our opinion considered to be as efficient as other cost containment efforts conducted by the FEHB plans such as the use of free-standing surgi centers, dialysis centers which provide quality care at less cost than in-hospital patient care; in and out same day surgery where appropriate; the use of second surgical opinions where elective surgery is involved; the use of Professional Standards Review Organizations (PSROs) and peer review committees; home nursing services; pre-admission testing, hospital utilization and review committees, the monitoring of hospital stays, and patient and employee education designed to eliminate unnecessary utilization of benefits. Many of the procedures listed as medically unnecessary are generally acknowledged by physicians as being outmoded and have largely been replaced by newer procedures. Page 6 of GAO's draft report cites the Public Health Service's evaluation of these procedures. The PHS medical consultants concluded that many of the practices had been replaced by better means of diagnosis or treatment.

In addition, there are practical limits to conducting an exhaustive examination of every claim submitted. Such a procedure, which is not consistent with any industry practice, would impose intolerable delays, create substantial backlogs of payments, and would cause unwarranted increases in administrative costs. Most claims represent a reimbursement for medical expenses incurred by individuals on the advice of their physicians. Many of these expenses have already been paid by the members of the plan. Denial of payment places members at a financial disadvantage. Typical insurance industry practice with respect to indemnity plans places heavy reliance on physician diagnosis and treatment recommendations in claims adjudication, particularly with regard to the necessity of hospital admissions. Indemnity plans do not have the advantage of contractual agreements with providers to guarantee recognition of the plans' benefits.

APPENDIX IV

If plans deny claims in the absence of very compelling reasons, health care providers, particularly hospitals, may then refuse to accept assignment of the plans' benefits as payment for services. This could force subscribers to pay sizeable out-of-pocket medical expenses and impose a substantial hardship. The National Association of Letter Carriers, in fact, reports that most hospital admission procedures denied by its plan in the absence of a physician's prescription are billed to enrollees. Furthermore, both Blue Cross-Blue Shield and Aetna Life Insurance Company have incurred lawsuits because of claims denials based on medical necessity.

OPM has been reluctant to issue definitive guidelines for plans on medical necessity for a variety of reasons. The question of medical necessity is one on which doctors themselves find it hard to agree. There were disagreements between plan medical advisers and the views expressed in GAO's report HRD 79-87, "Stronger Management Needed to Improve Employee Organization Health Plans' Payment Practices," dated September 7, 1979. A rigid set of guidelines would restrict benefit payment and penalize enrollees if necessary, yet out of the ordinary, services were provided.

The major incentive for careful claims administration, in our opinion, continues to be the competition among FEHB plans. These plans offer a variety of benefits at various price levels. The payment of benefits is the major factor in determining FEHB premiums, and price is one of the key determinants in the choice of a health plan. Unnecessary costs drive up premiums for a plan and reduce its competitive position. Thus, the FEHB Program has a built-in incentive for careful claims administration to maintain attractive premium rates. Nevertheless, we continue to urge FEHB plans to pursue vigorous cost containment efforts and require each plan to submit an annual description of these efforts.

I appreciate the opportunity to review the proposed report. I trust that these comments will be made part of any final report you may issue.

Sincerely yours,

Gary R. Nelson
Associate Director
for Compensation

APPENDIX V

Blue Cross
Association
Blue Shield
Association

840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

April 30, 1980

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

Thank you for sending me a draft copy of your report titled, "Medical Necessity Programs - Another Opportunity for the Office of Personnel Management to Improve Federal Employees' Health Insurance," for my review and comment. This is an excellent study and accurately represents the Blue Cross and Blue Shield Associations' Medical Necessity Project.

My comments on the draft are as follows:

Page iii, Para. 1 - Should read, "A more recent program effort addressed the need for routine hospital admission tests which cost an estimated $2.5 - $3.0 billion annually.

Page 2, Para. 1 - Should read, "Since its announcement in April 1977 ...."

Page 2, Para. 2 - Should read, "In 1977, the Associations, after collaborating with The American College of Radiology, The American College of Surgeons, The American College of Physicians ...." The American College of Surgeons provided valuable initial support and should be mentioned by name.

Page 6, Para. 3 - Please include the following sentence. "The Blue Cross and Blue Shield Associations filed an objection to the procedures on their list being used without provision for review. The objection was not accommodated."

Commemorating fifty years
Working for a healthier America

APPENDIX V

Page 17,
last sentence - Please add, " .... tests cost $2.5 - $3.0 billion annually, much of it fully justified."

Thank you for the opportunity to review the document and offer my comments. And again, let me compliment you and your staff on a fine study.

Sincerely,

Lawrence C. Morris, Jr.
Senior Vice President
Professional and Provider Affairs

LCM/jc

APPENDIX VI

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO NEW YORK WASHINGTON

CONSUMER and PROFESSIONAL RELATIONS DIVISION
Thomas O'Hare, *Associate Director*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 322-0800

May 9, 1980

Mr. Gregory J. Ahart, Director
Human Resources Division
U. S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

The purpose of this letter is to confirm, in writing, my conversation of May 8 with Michael Speer of your staff, regarding the proposed report on medical necessity programs. As you recall, you were kind enough to distribute to our office a draft copy of the proposed report.

After reviewing the document, HIAA requests a modification of the first full sentence on Page 5. In order to more properly represent the factual situation, that sentence should be changed to read as follows:

> "Besides its own list, HIAA has also distributed to its member companies for their guidance the Associations' recommendation that its member plans not pay for routine hospital admission tests unless they were specifically ordered by a patient's physician."

I believe that this slight change in wording more adequately reflects HIAA's intention that the specific use of information relative to medical appropriateness is a matter for individual company determination.

Because of the positive reaction of our member companies to the Medical Procedure Appropriateness Program, I am confident that governmental agencies responsible for health benefit programs will also find similar programs to be useful.

Thank you very much for this opportunity to present comments on a well done report.

Sincerely,

Thomas O'Hare

Thomas O'Hare
Associate Director - CPR

TO:mh

cc: Michael Speer
John Hanna

APPENDIX VII

Federal Employee Program
1800 M Street, N.W.
Washington, D.C. 20036
202/785-7950

May 9, 1980

Mr. Gregory J. Ahart, Director
U. S. General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

We appreciate the opportunity to review and to comment on the draft of your proposed report, "Medical Necessity Program - Another Opportunity for the Office of Personnel Management to Improve Federal Employees' Health Insurance."

It is our understanding that you have received comments from Medical Service of D.C., Pennsylvania Blue Shield, and the Chicago office of the Associations under separate cover. The comments below encompass the reviews of Blue Shield of Maryland and Blue Shield of Virginia, who have elected to coordinate their responses with this office.

In general, we find the draft report to be concise and accurate, and we concur with its conclusions and recommendations. In a few instances, however, clarifying comments are appropriate.

In referring to Blue Shield of Virginia on page 13, the draft report indicated that "the Plan would begin routine initial denials of all claims for the listed procedures and would review only those denials that were appealed." It should be noted that the Plan has given further consideration to its procedural policy for the administration of the Medical Necessity Program, and has concluded that an educational program for providers will be a more effective means of informing the medical community and the public of the Program. After this educational effort is accomplished, the Plan will process claims for the referenced procedures only in those instances where justifying documentation is provided with the claim.

Also on page 13, the draft report indicates that a spokesman from Blue Shield of Maryland stated that the policy of the Plan is to deny routinely and initially all claims for listed laboratory procedures and that reviews of these claims are made only upon the appeal of the denial. In point of fact, this is not the case. No claims for any of the services listed in the Medical Necessity Program are denied automatically unless the service is inherently considered non-coverable or the claim, and any data associated with it, fails to provide justification for the service reported.

GAO note: Our final report does not include the material referred to in the last two paragraphs on this page.

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The draft report indicated, in several instances, that while the Blue Cross and Blue Shield Federal Employee Program supports the Medical Necessity Program, administration may vary among the Plans. It should be noted that variations in the type of administration are not necessarily indicative of varying levels of effectiveness. As stated in the draft report, the purpose of the Medical Necessity Program is "to disseminate authoritative clinical opinion to the profession in an effort to reduce unwarranted utilization so that claims for these services would also be reduced or eliminated." This purpose may be effectively accomplished through various administrative means. Because of differing processing systems and differing arrangements with providers among the Plans, the effective administration of the Medical Necessity Program at the local Plan level requires that local circumstances are taken into consideration. Administrative procedures which are quite effective in one local Plan may not be as effective in another Plan environment.

We are pleased to have been of service to the General Accounting Office in this endeavor, and we applaud your efforts to encourage the further expansion of the Medical Necessity Program throughout the Federal Employees' Health Benefits Program. If we can be of further assistance, please contact us.

Very truly yours,

James N. Gillman
Vice President

JNG/css

APPENDIX VIII

Blue Shield

Medical Service of D.C.

550 12th Street, S.W.
Washington, D.C. 20024
202/484-4500

April 22, 1980

Mr. Gregory J. Ahart, Director
U.S. General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

We appreciate the opportunity to review and comment on the draft of your proposed report "Medical Necessity Programs - Another Opportunity for the Office of Personnel Management to Improve Federal Employees' Health Insurance".

We have reviewed the report and are in concurrence with the findings pertaining to the Federal Employee Health Benefits (FEHB) Program in our Plan, as well as the conclusions and recommendations contained therein.

We are pleased to have been of service to you in the preparation of this comprehensive report and if additional information is needed or future assistance required, please contact me.

Very truly yours,

R. L. Surdam
Manager
Blue Shield FEP Claims Department

Pennsylvania Blue Shield

CAMP HILL PENNSYLVANIA 17011

SERVING ALL PENNSYLVANIA

PHONE: (717) 763-3151

May 9, 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

As requested, we are providing the following comments relative to our review of your proposed draft report, "Medical Necessity Programs - Another Opportunity For the Office of Personnel Management to Improve Federal Employees' Health Insurance."

We concur with the references made by the U. S. General Accounting Office relative to Pennsylvania Blue Shield's medical necessity program. The report concludes that although program administration varies from Plan to Plan, the adoption of such a program tends to reduce costs and also reduces the incidence of claim submissions for those procedures deemed to be inconsistent with good medical care standards. Our experience supports these conclusions.

Your report (page 18) describes the fact that savings attributable to claims never being submitted because of the program's publicity and physician education efforts are considerable. On page 18 you cite Pennsylvania Blue Shield's actual cost savings, and also reference lower incidence rates for medical necessity procedures. We believe the latter situation is more significant than the former as to program savings.

Thank you for the opportunity to review your report. If you have any questions or need additional information, please contact me at your convenience (717-763-3300).

Sincerely,

Charles W. Wise
Manager, Internal Audit

CWW/smw

cc: W. C. Dunn
R. B. Edmiston, M.D.
W. E. Keller
K. A. Rabena
W. A. Smith
E. R. Thoms
K. E. Larsen (FEP National Office)

APPENDIX X

Aetna
LIFE & CASUALTY

151 Farmington Avenue
Hartford, Connecticut 06156

Laurence B. Huston, Jr
Assistant Vice President
Group Division

May 7, 1980

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I am responding to your letter of April 10, 1980, addressed to Malcolm McIntyre, Director, of our Company, in which you requested written comments relative to the draft of your proposed report on Medical Necessity Programs which was attached thereto.

Those of my associates who met with representatives of the General Accounting Office have advised me that the comments contained in the draft report which are attributable to Aetna personnel do, in fact, reflect the comments and observations which they made during their meeting with your associates.

It is my understanding that you are also interested in our reaction to the specific recommendations contained in your report which appear on page 21 of that report. We will carefully consider whether we feel it is appropriate that we comment on your recommendations, and if we choose to so comment we will do so in a letter which will be dated not later than May 16, 1980.

Thank you very much for giving us an opportunity to comment.

Sincerely,

Laurence B. Huston, Jr.
Assistant Vice President
Group Division

cb

APPENDIX X

Aetna LIFE & CASUALTY

151 Farmington Avenue
Hartford, Connecticut 06156

Laurence B. Huston, Jr.
Assistant Vice President
Group Division

May 16, 1980

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

In my letter of May 7, 1980, I indicated that if we deemed it appropriate to comment on the recommendations contained in your proposed report on Medical Necessity Programs that we would do so by today's date. We have concluded that comments are in order.

The following observations bear directly on the specific comments which we will make relative to your recommendations.

1. If a third party payor denies benefits with respect to outmoded medical or surgical procedures, or procedures of questionable effectiveness, there is a very real question, whether or not litigation becomes involved, as to whether the effect of such denials represents other than cost shifting from the benefit program to the enrolled beneficiary.

2. The performance of routine diagnostic tests for medical and surgical hospital admissions is rooted in medical tradition, hospital rules and regulations, and in some instances, even in state law. Setting aside the question as to whether all of these services are medically necessary in all instances, once again, the only thing we can be certain of relative to third party denial of benefits is that the burden of these denials will generally fall on enrolled beneficiaries.

3. Given the above circumstances, we believe that our ultimate objective as a society should be a reduction in the number and kinds of these services which are performed rather than an increase in the number and kinds of such services with respect to which benefits are denied.

Based on the foregoing background, we feel very strongly that your recommendations on monitoring, evaluation and action relative to Medical Necessity Programs should be directed to efforts to reduce the extent of health care services provided rather than to reduce health insurance costs. If the focus is health insurance costs,

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we are concerned that enrolled beneficiaries will pay for these reductions. If the focus is the services themselves, a reduction in health insurance costs will be automatic and the value, in terms of costs to enrolled beneficiaries, very real indeed.

Reflection of the foregoing concept in your recommendations would obviously result in significant changes in the specifics of your recommendations. For example, you would presumably recommend that the Office of Personnel Management participate actively with at least the major plans in working with the providers of medical care, and with others, to achieve changes in provider behavior relative to the provision of identified medical services of questionable medical necessity. With respect to your second recommendation, you would not indicate that one of your primary objectives would be to lower health insurance costs. Similarly, you would not ask the Office of Personnel Management to require plans to use aspects of Medical Necessity Programs that are proven beneficial, i.e., there should be greater specificity as to whom they may be beneficial for.

If for any reason you cannot accept our observations relative to the potential for cost shifting to enrolled beneficiaries, i.e., you are committed to going forward with your recommendations without the caveat which I have suggested, then we would raise the following questions about your recommendations as they now stand.

1. How would you propose that OPM monitor developments in Medical Necessity Programs? Do you intend that they ask for help from the plans themselves? If so, we think that this could be specified.

2. What are the criteria to be used in evaluating these programs?

3. With respect to your third recommendation, it would seem, as suggested above, that we must decide to whom these programs are of benefit. Similarly, we would need to develop standards for measuring beneficial effects, and also, we would need to determine who would bear the costs of such measurement. In the absence of specific answers to these questions, it would seem premature to impose requirements on all of the Federal Employees Health Benefits Program's plans.

We hope that you will view the foregoing comments in the spirit in which they are intended, namely, support of your concern relative

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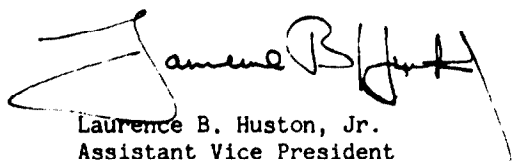
to the provision of services which are not medically necessary while, at the same time, questioning the specifics of your conclusions because we would not wish to see stringent requirements placed on plans at the expense of enrolled beneficiaries.

Thank you very much for giving us an opportunity to comment on your proposed report.

Sincerely,



Laurence B. Huston, Jr.
Assistant Vice President
Group Division

cb

APPENDIX XI

Mutual of Omaha Insurance Company ■ Home Office: Dodge at 33rd Street, Omaha, Nebraska 68131 ■ V. J. Skutt, Chairman of the Board ■ I. D. Minton, President

Address all correspondence to

WASHINGTON, DC REGIONAL GROUP OFFICE
Suite 703
1919 Pennsylvania Ave. NW
Washington, DC 20006
Phone 785-1919

NORMAN C. CONWAY
Regional Manager

May 12, 1980

Mr. Gregory J. Ahart
Director, U. S. General
Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

Thank you for your letter of April 10, 1980. We have reviewed the draft copy of the proposed report, "Medical Necessity Programs--Another Opportunity for the Office of Personnel Management to Improve Federal Employees' Health Insurance."

We are in agreement that there are benefits to be derived in having some type of medical necessity program. While those benefits may be difficult, if not impossible, to measure, we do feel that it is important to have guidelines available to monitor the various aspects of medical necessity.

We do have such guidelines presently available and are continually looking to expand the areas covered by guidelines as well as improve those currently in place. Our computerized claim system when fully operational will provide us with significant monitoring capabilities which we intend to make full use of in our cost containment efforts and medical necessity review.

In addition to guidelines, we have a hospital audit program in effect which entails verifying that services and supplies charged were actually received and were ordered by the doctor. We also continue to participate in a hospital utilization review program conducted by the National Capital Medical Fouhdation.

Sincerely,

Lawrence D. Keck

Lawrence D. Keck
Regional Claim Manager

LDK:slr

The Prudential Insurance Company of America
Central Atlantic Home Office
P.O. Box 388, Fort Washington, PA 19034

William J. Riester
Account Executive

May 7, 1980

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

I have enclosed Prudential's official comments to your proposed report to the House Subcommittee regarding Medical Necessity Programs. I would like to take this opportunity to highlight and augment some of our comments.

The main point of our reply is that we are in concert with the concept of Medical Necessity. We continue to feel, however, that much further discussion is necessary before the concept can be endorsed as truly cost effective. We note, for example, that the Blue Cross and Blue Shield Associations estimate significant savings attributable to their programs, without, however, producing statistics or data to support this position. Once again we wish to point out, as we did at our November 1, 1979 meeting, that over a recent fifteen month period Prudential experienced just eight claims in the Washington, DC area for procedures identified by the Associations as outmoded.

We also wish to point out that Purdential now underwrites six FEHB program employee organization plans effective in 1980. Under the Government Employees Benefits Association Plan we have initiated a system to analyze hospital confinement usage under our Automatic Claim Analysis System (ACAS). Under this system we will identify hospital claims by hospital, then compare the length of stays with both Prudential and national statistics to determine whether there is abuse in this area.

Again I wish to, on behalf of Prudential, express our gratitude for being afforded the opportunity to review the proposal reply. We support the concept of Medical Necessity but feel much more discussion is appropriate before actual programs are implemented. We look forward to the opportunity for these discussions if the GAO wishes to proceed with specific changes.

Sincerely,

William J. Riester

WJR:djh

Enclosure

APPENDIX XII

The Prudential Insurance Company of America
Central Atlantic Home Office
P O Box 388, Fort Washington, PA 19034

William J. Riester
Account Executive

May 6, 1980

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

We appreciate the opportunity to review your draft report on "Medical necessity programs."

At the outset, we would like to convey to you that our company has been, and will continue to be, actively supportive of any programs that are directed toward the elimination of unnecessary medical services and the reduction of health care costs. This is one of our major responsibilities as an insurer and administrator of health care benefit programs. During our meeting on November 1, 1979 with GAO representatives, Dave Bixler and Mike Speer, we outlined in some detail the kind of efforts we have expended in the general area of cost control and the proper administration of health policy language. As was intended, a significant portion of those discussions focused on the need for payment of only medically necessary services. Since the subject of the present draft report is "medical necessity programs", we would like to briefly recap some of the points we feel are pertinent.

First of all, we do not consider "medical necessity programs", and particularly those that have received a good deal of publicity in the last several years, to be new devices. In the very early design of our health insurance policies, we included language which stated we would pay only for "medically necessary" services. And over the years, we have enforced that provision even though our stance has frequently placed us in an unpopular position with various providers of health care services. Perhaps one of the more dramatic current situations we could offer as an example involves the well-publicized laetrile treatment for cancer. Because of our position that this medically unsubstantiated treatment is not necessary for the care and treatment of patients, we have consistently refused to pay for charges submitted for this form of treatment. We are maintaining that position in the face of pending major litigation in the courts.

Again, directly related to the subject of medical necessity, an important part of our claims administration for many years has been the national distribution for use by our claims examining staffs of a periodically up-dated list of medical supplies and services which are either questionable or completely ineligible. This list is developed through consultation with our medical department and has proved to be a valuable tool in screening out medically unnecessary charges. Additionally, a normal part of our daily claims processing routine is an automatic computerized selection of claims which receive a high level intensive review.

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A part of this intensive review, which we refer to as Quality Review, is verification of the medical necessity of the expenses submitted.

Turning now to the specific "medical necessity programs" referred to in the draft report, we would like to outline for you the courses of action we feel will represent our responsiveness to the recommendations of your office. For convenience, we would like to address the "programs" in three parts: (1) diagnostic procedures (2) surgical procedures and (3) routine hospital admission batteries. Before doing so, however, we would like to address one item that has a bearing on any type of "medical necessity program" and that is the contractual language which permits the enforcement of payment for only medically necessary services. As we mentioned earlier Prudential has for many years included "medically necessary" language in health contracts. We recently revised and expanded our original wording to make the provision more definitive and effective as a claim cost control device. It is our recommendation that this expanded language be incorporated in the three federal employee plans we are associated with (GEBA, SAMBA, and Postmasters) and reflected in the employee brochures. The expanded language appears below:

". . . charges for any service or supply which is not reasonably necessary for the medical care of the patient's sickness or injury. To be considered reasonably necessary, the service or supply must be ordered by a Physician and must be commonly and customarily recognized throughout the Physician's profession as appropriate in the treatment of the patient's diagnosed sickness or injury. The service or supply must not be educational or experimental in nature, nor provided primarily for the purpose of medical or other research. In addition, in the case of Hospital confinement, on an in-patient or out-patient basis, the length of confinement and Hospital services and supplies will be considered reasonably necessary only to the extent they are determined by Prudential to be (a) related to the treatment of the condition involved and (b) not allocable to scholastic education or vocational training of the patient".

Diagnostic Procedures

The draft report refers to a number of diagnostic procedures that have been identified by private carriers in concert with the HIAA, the Association of Blue Cross-Blue Shield Plans, and D.H.E.W. which should not be routinely accepted for payment. (Four procedures have been listed as excluded from payment by D.H.E.W.).

There are two primary problems associated with implementing screening for these diagnostic procedures which all claims administering organizations must deal with. First, the providers of these services (primarily hospitals) generally do not routinely identify specific procedures when billing for their services. Secondly, many organizations such as ourselves, have developed on-line computerized claim payment systems to reduce claims administration costs. Ideally, screening programs should be designed within these computerized systems to alert processors when identified questionable diagnostic procedures are presented for payment. At the present time, such a sophisticated screening program for these procedures is not in place.

APPENDIX XII

We do agree there are other positive steps that can be initiated, and these are described below:

1. We will prepare and distribute to all claims personnel responsible for processing claims a list of all diagnostic procedures which must be questioned and justified before payment is made when the procedure is specifically identified on a bill or claim form. This will be a consolidated list and will be continually updated to reflect any changes or additions. Coincident with the initial distribution of this list, we will conduct instructional sessions on the purpose and use of this list for the claims personnel involved.

2. On a pilot basis, we would be willing to conduct sample audits of selected non-itemized hospital claims. The primary purpose would be to identify institutions and/or physicians utilizing questionable diagnostic tests. The scope and methodology of this pilot sampling audit technique requires some further discussion and analysis as to feasibility, objectives and costs with all concerned parties.

While not listed as a specific step, we will continue to analyze the feasibility of developing on-line computerized screening techniques. At this point in time, aside from programming feasibility, the major question appears to be cost justification, i.e., would there be sufficient savings to offset start-up and on-going administration costs.

Surgical Procedures

As in the case of diagnostic procedures, certain surgical procedures have been identified as having questionable value. In fact, the medical profession generally has recognized their questionable value by performing very few of them in recent years. We ran an analysis of our nearly one million on-line surgical charges profile late last year and found that the questionable surgical procedures comprised just under one-tenth of one percent of all procedures. The point of this, of course, is that we feel the listed questionable surgical procedures represent a minute, and ever-decreasing problem.

Nevertheless, we are prepared to take some steps to assure ourselves that any such procedures presented are questioned.

1. On the GEBA case, whose claims are processed directly by our own staff, we will take advantage of one of the capabilities of our on-line computer claim payment system. The system will be pre-set to automatically identify for a detailed high level review any of the questionable surgical procedures.

2. For the SAMBA and Postmasters claims processing personnel, we will provide a listing of the questionable surgical procedures. Any claims presented involving these questionable surgical procedures together with any additional supporting information that may be necessary, e.g., operative reports and/or hospital records will be forwarded to us for review with our Medical Department.

APPENDIX XII

Routine Hospital Admission Batteries

Considerable attention has been focused recently on the necessity for routine diagnostic tests for medical and surgical hospital admissions. At issue specifically is whether all such routine tests are always necessary for the proper evaluation and treatment of each individual patient and should such tests be administered only at the direction of the attending physician. As part of our on-going efforts to effect cost controls, we have been examining this subject closely. Some of the questions that concern us are (1) what impact does routine testing have on our standard pre-admission testing program which encourages pre-admission testing on an out-patient basis to eliminate unnecessary in-patient confinement charges? (2) to what extent will attending physicians substantiate or not substantiate the necessity of admission tests when questioned? (3) how do we protect the patient from potential out-of-pocket expense in a situation where he or she, practically speaking, has no voice? (4) what are the potential dollar savings versus additional claim administration expense? and (5) related to cost-savings, what are the possibilities of hospitals merely cost shifting to offset loss of revenue?

In view of the foregoing questions and other potential ramifications of implementing a "medical necessity program" related to routine hospital admission batteries, we feel further discussion among the appropriate parties is warranted. Assuming some course of action in this area is deemed desirable after such discussions, the following steps occur to us.

1. A prerequisite would be employee education on the subject of medical necessity in general and the hospital "routine admission testing program" in particular. The purpose would be two-fold - to make them aware of what the program is about and to alert them to the possibility of out-of-pocket expense. Vehicles such as payroll stuffers, articles in house organs and leaflets could be employed.

2. As part of the hospital admission - certification process, the hospitals could be informed of our position via an attachment to or a pre-printed statement on the hospital admission-certification form.

3. The hospital billing sampling audit program referred to under Diagnostic Procedures could be a mechanism for also identifying hospitals where routine admission testing may present a problem.

4. Through data obtained from 3. above and/or obtained as a by-product of claims processing, a record could be maintained of hospitals employing routine battery testing. Such a record could be used to send out a "position" letter on such testing to the hospital as an initial educational advisory. In the event of repetitive billings for such items without supporting substantiation, no payment would be made.

APPENDIX XII

Before ending our comments on the various "medical necessity programs", we would like to mention a computerized program we call ACAS (Automatic Claim Analysis System). This device provides our clients with a very comprehensive breakdown of the kinds of claims paid under their programs, identifying claims by diagnosis, by physician name, by name of hospital, by patient age/sex, by employment class or claim branch, by nature of surgery, etc., which further identifies "questionable" claims comparing them with expected norms and durations. This program has been very helpful to clients who have large numbers of employees concentrated in circumscribed geographical areas, especially if they and their dependents tend to utilize a reasonable number of the same physicians and hospitals. In terms of identifying hospitals, doctors, and claimants who tend to overutilize facilities and plan benefits on a retrospective basis, this system is outstanding.

In conclusion, we again wish to thank you for permitting us to review the draft report on this important subject. We look forward to cooperating with all parties concerned and will be pleased to provide any additional information with respect to formulating approaches.

Sincerely,

William J. Kiester

WJR:djh

APPENDIX XIII

Hospital Plan

AMERICAN POSTAL WORKERS UNION, AFL-CIO
P. O. Box 967, Silver Spring, Maryland 20910

JOHN R. DUBAY
DIRECTOR

BEN EVANS
EXECUTIVE ASSISTANT

FRANCIS J. KOWALCZUK
ADMINISTRATIVE ASSISTANT

April 23, 1980

Gregory J. Ahart
Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I wish to acknowledge receipt of your letter of April 10 with the enclosed draft report pertaining to "Medical Necessity Programs."

I wish to clarify any misunderstandings and note two exceptions we take to the enclosed report. First, it is the position of the Hospital Plan Department of the American Postal Workers Union, AFL-CIO, to provide its members with payments for medical care in accordance with the provisions of its contract with the Office of Personnel Management. The contract has never been knowingly violated and its provisions are strictly adhered to.

The draft report emphasizes the need to implement a medical necessity program to ensure benefits are paid only for medically necessary services. It is the primary condition of our contract, as stated on page 5 of our 1980 brochure (BRI 41-206), that no payment be made unless the services are "medically necessary" as ordered by a physician in "accordance with professional medical standards generally accepted in the United States." The physician who orders any type of medical or diagnostic services must state the diagnosis or symptom in relation to the treatment provided so that the Hospital Plan knows that the services were medically necessary. Hospital Plan members are educated and/or advised of this requirement on many occasions each year through the use of the Plan's educational materials, magazine articles, meetings, conventions, etc. Absolutely no payment is made for medical services not prescribed by a physician.

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Second, the GAO report infers that without the use of a medical necessity program, the FEHB in general, and the Hospital Plan in particular, cannot be cost effective. As has been stated in the past, we strongly believe there is a necessity for cost control and cost containment with regard to medical services. For this reason we have medical consultants who are used to investigate and review services by medical providers to make certain that payments for medical care are proper when the decision cannot be made by our staff. In addition, our inter-office brochure is designed to require our claims processors and technicians to process claims in accordance with the provisions of our contract with OPM. Beyond relying on our medical consultants and the procedures in our inter-office brochure, the Hospital Plan is simply unable independently to review the medical and diagnostic decisions of physicians.

Consistent with the Hospital Plan's longstanding willingness to implement ideas to improve FEHB, we want to assure you of our complete cooperation in implementing a medical necessity program should OPM find it appropriate. Members of your staff should feel free to call or visit us whenever they wish to do so. The Hospital Plan is committed to working with the government to provide its members with high quality and low cost medical care.

With best regards,

Sincerely,

JOHN R. DUBAY
Director

JRD/gs
enclosure

APPENDIX XIV

National Association of Letter Carriers

Health Benefit Plan

11111 Sunset Hills Road, Reston, Virginia 22093 (703) 471-1550

Robert J. Buntz Anthony B. Morell

May 1, 1980

Mr. Gregory J. Ahart, Director
Human Resources Division
U.S. General Accounting Office
Washington, D. C. 20548

Re: Medical Necessity Programs

Dear Mr. Ahart:

Thanks for submitting the draft of the proposed report to us for review. We feel the statements made regarding NALC were justified and accurately reported, and do not wish to comment.

We will, however, comment on a few of the general statements made in the report.

1. We disagree with the position that routine admitting tests should be paid if specifically ordered by the patient's physician. State laws and hospital policy, in many instances, require specified tests. Our contract excludes services or supplies not medically necessary. The fact that a doctor has ordered a test does not, of itself, make the test medically necessary.

2. We do not feel that the Programs are being generally accepted, as stated, by hospitals, doctors, or patients. We have accumulated quite a large file of the complaints received and will make this available if you would like to review it.

There are two general problems the Plan faces in the administration of the Program. The hospital bills we receive are not always fully itemized. They are departmental summaries only. In order to properly consider the bill, we must know the individual service and charge. This requires a letter on our part, a delay in payment, handling the file twice, and sometimes a service charge for reproduction of the itemized bill. The other problem is similar in that for each rejection we receive a reply

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or complaint which requires a review of the file. Both problems add to the administrative costs of the Plan.

The Office of Personnel Management has been of great assistance to us in establishing our Claim Loss Control Program. The future of the Program would be enhanced if OPM could supply the various plans with H.I.A.A. updates on questionable tests and procedures and also provide copies of Medicare's guidelines on the subject.

We would appreciate the opportunity to meet and discuss the Program in the near future.

Sincerely yours,

Robert J. Buntz
Director

RJB:mw

APPENDIX XV

SPECIAL AGENTS MUTUAL BENEFIT ASSOCIATION, INC. SAMBA SUITE 750 • 1325 G STREET, N.W. • WASH., D.C. 20005

(202) 737-3666

April 16, 1980

Mr. Gregory J. Ahart
Director
Human Resources Division
U. S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

Reference is made to your letter of April 10, 1980, enclosing a draft of proposed report on "Medical Necessity Programs." On page 17 of the proposed report you quote me and refer to my position as "The Special Agents Plan manager." Our Association is the "Special Agents Mutual Benefit Association" (SAMBA) and not The Special Agents Plan. Additionally, in quoting me you indicate that "Although OPM's Employee Organization Plans Division chief advised plans in October 1979 to implement the medical necessity programs, the Special Agents Plan manager said he would not do so." My recollection of my comments are as follows and if I am to be quoted, it should be as follows: "Although OPM's Employee Organization Plans Division chief advised plans in October 1979 to implement the medical necessity programs, the SAMBA Plan manager said he would not do so until specific guidelines were issued to each association plan concerning implementation of the program and how it would be enforced. It is imperative that there be uniformity and consistency in the administration of such a program if it is to be effective and obtain the desired results." I also stated that SAMBA is well aware of cost containment and, as a matter of fact, we were embarking on a new program called "Mandatory Second Opinion Surgery" during the contract year 1980, which we considered to be a more viable program and one that would produce significant actual savings.

Inasmuch as I am leaving the city and will not be back until April 28th, I am directing this communication to you so that there is ample time to correct the record. I tried to reach Mr. Speer this morning and he was at a conference. I will try to reach him this afternoon to convey the contents of this letter.

Thank you for the draft and for the opportunity to review it prior to its publication.

Sincerely yours,

Thomas J. Feeney, Jr.
Manager

TJF:hs

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