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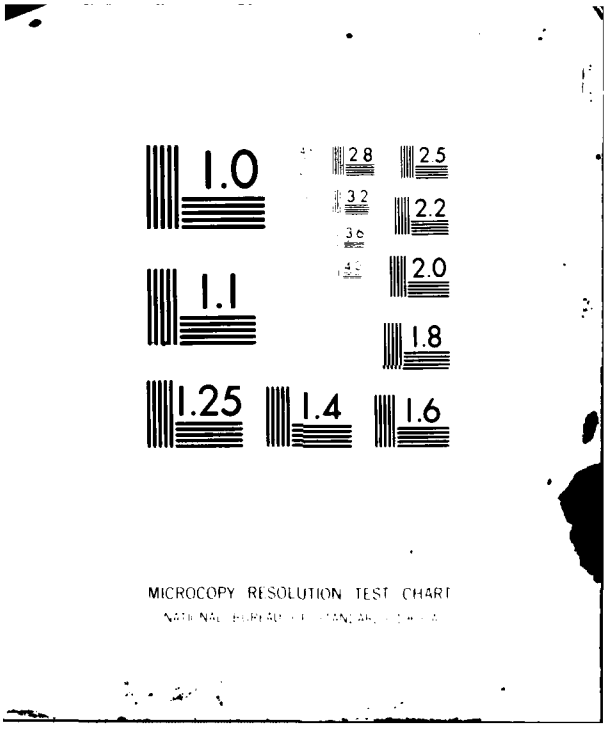
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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES DIVISION

B-200144

SEPTEMBER 3, 1981

The Honorable Lawton Chiles
United States Senate

Dear Senator Chiles:

Subject: More Action Needed to Reduce Beneficiary Underpayments (HRD-81-126)

This report was prepared at the request of your office and represents the results of our follow-on work to an earlier report, also prepared at your request. That report, to the Secretary of Health and Human Services (HHS), dated October 22, 1980, and entitled "Reasonable Charge Reductions Under Part B of Medicare," addressed four areas where beneficiaries were subject to inequitable out-of-pocket costs for services covered by Medicare. We made several recommendations to the Secretary of HHS aimed at improving the equity and accuracy of reimbursements to beneficiaries on unassigned claims. When doctors do not accept assignment (unassigned claim), beneficiaries are liable for the difference between what the doctors charge and what Medicare allows as the reasonable charge. During 1979, the beneficiaries' liability for the differences between the submitted and allowed charges on unassigned claims was about $1.1 billion.

This report contains another recommendation to the Secretary of HHS which we believe will provide further safeguards for preventing underpayments to beneficiaries for services covered by Medicare. Claims that are subject to relatively large reasonable charge reductions often involve underpayments which go undetected because of poor claims review. The Health Care Financing Administration (HCFA)--as part of its Contractor Performance Evaluation program and related Carrier Quality Assurance program 1/--should

1/The quality assurance program is designed to measure the accuracy and overall quality of claims processing under Part B of Medicare. To achieve this objective, a sampling of actual claims that have been processed are reviewed by both carrier and HCFA quality assurance reviewers.

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specifically address how well its contractors (carriers) review and resolve the discrepancies on these types of claims.

As requested by your office, this report also provides an assessment of HHS actions taken on recommendations made in our October 1980 report. In summary, HHS had taken little action on our recommendations as of June 29, 1981.

This report is based on work performed at HCFA headquarters in Baltimore and fieldwork within the HHS Dallas region. The fieldwork was done primarily at Arkansas Blue Shield Inc., a Medicare Part B carrier in Little Rock. At this carrier, we focused on assessing the procedures for reviewing unassigned claims where significant portions were disallowed for payment because the submitted charge exceeded the carrier's determination of the reasonable charge. Our purpose was to determine how the safeguards established by the carrier to identify potential underpayments associated with large reasonable charge reductions were being applied. Arkansas Blue Shield, Inc., was selected for several reasons including that, according to HCFA regional officials, the carrier is one of the better performers in the region.

THE CONTRACTOR PERFORMANCE EVALUATION PROGRAM (CPEP) NEEDS TO ADDRESS HIGH CHARGE REDUCTIONS

CPEP provides for an annual evaluation of a carrier's operations. Performance is evaluated in terms of specific performance criteria and statistical measures. The performance criteria cover six functional areas--(1) claims processing, (2) utilization review, (3) program payments, (4) beneficiary services, (5) fiscal management, and (6) general administration. The statistical measures are cost, timeliness, and quality of claims processing. A major component of CPEP is the Carrier Quality Assurance program, which assesses quality of claims processing on a statistical basis. Under the program, carriers systematically review a sample of paid claims on a weekly basis and classify errors in seven categories (e.g., reasonable charge determinations, adequacy of documentation, and coding errors). Further, to validate the carrier's quality assurance efforts, HCFA regional offices review a 10-percent subsample of the claims sampled by the carrier. Underpayments and overpayments identified in the sample are to be corrected.

HCFA claims processing standards require that Part B carriers process reasonable charge reductions automatically when billed charges are in excess of reasonable charges within established safeguards. The safeguards are to identify for manual review and

resolution those claims and related medical procedures where submitted charges are reduced significantly for payment purposes. CPEP does not address how well carriers review these types of claims but because they often involve underpayment situations, we believe it should.

As discussed in our October 1980 report, the Medicare carrier in the Washington, D.C., area (D.C. Blue Shield) had implemented this "high charge reduction safeguard" by requiring that claims be manually reviewed when the submitted charge was reduced by 33 percent or more. Further, after a charge is identified for manual review, data entry personnel were required to check the information entered into the computer against the information on the claim. If the data were entered correctly but the submitted charge was greater than $75, the clerk was to submit the claim for manual review by his or her unit leader. If the submitted charge was less than $75, the clerk was to process the claim routinely. 1/

Our October 1980 report concluded that the manual review associated with D.C. Blue Shield's high charge reduction safeguard was not effective in identifying underpayments. We randomly sampled 50 unassigned claims where the submitted charge exceeded the physician's customary or usual charge by 150 percent or more. For example, if a doctor normally charged $100 for a given medical procedure, we looked at cases where the doctor had charged $250 or more for that procedure. We found that, in 21 or 42 percent of the sampled claims, the beneficiaries were underpaid a total of about $540.

In another instance, a medical procedure for one physician exceeded the D.C. Blue Shield high charge safeguard on 68 occasions in 1979. In all 68 cases underpayments to either the physician or the beneficiaries were involved, but the carrier's safeguard did not detect any of them. We had identified this situation during our examination of claims subject to quality assurance reviews. At least one of the claims involved was included in the carrier's quality assurance sample and HCFA's subsample, but the underpayment was not detected by either the carrier or the HCFA quality assurance reviews.

At Arkansas Blue Shield, claims are to be reviewed manually when submitted charges are reduced by 50 percent or more for payment purposes. At this carrier most claims failing the high charge reduction safeguard are cleared by data entry clerks and are not referred to medical staff or supervisory personnel for review.

1/All claims for podiatry, durable medical equipment or surgical procedures that exceed the high charge safeguard are automatically subject to manual review by the unit leader.

To see how well the carrier was reviewing these types of claims, we obtained a computer print-out of unassigned claims paid in July 1980 where the reasonable charge reductions met or exceeded the 50 percent criteria. About 5,700 services or line items or about 3 percent of the line items processed that month were listed. About 85 percent of these services, however, involved reductions of $50 or less and thus were eliminated from our selection process. We selected for indepth review 15 claims with both high percentage and high dollar (usually $100 or more) reductions which we believed had a high potential for being underpayments. Ten of the 15 claims involved underpayments to beneficiaries totaling about $1,200, 1/ which we believe should have been identified and resolved through the carrier's high charge safeguard.

For example, on one claim we identified errors netting $484 in underpayments to the beneficiary. The errors included a $1,000 charge for a kidney removal incorrectly coded by the doctor as a kidney biopsy, for which Medicare allowed $182. On another unassigned claim a charge of $270 was submitted for a lesion biopsy and the carrier allowed $23. Because of the large difference between the submitted charge and the allowed charge, we contacted the physician and verified that the procedure actually performed was a breast biopsy, which is a more complicated and expensive procedure. Although this claim clearly exceeded the carrier's high charge safeguard for manual review, the error was not identified and the beneficiary was underpaid $104.

Although HCFA's Quality Assurance Manual for use by carrier and HCFA personnel provides for checking the sampled claims against the carrier's claims processing rules and standards, it does not specifically provide for determining adherence to a carrier's standards for identifying high reasonable charge reductions for resolution through special handling or manual review. In fact, at Arkansas Blue Shield, quality assurance personnel told us that they (1) would not have detected errors we identified because the procedure code and narrative description on the claim forms were in agreement and (2) did not question or investigate the reasonableness of submitted charges in relation to the indicated procedure codes and allowed amounts.

We believe that this is a weakness in HCFA's Carrier Quality Assurance program for measuring how well carriers are adhering to their claims processing standards. HCFA should specifically require HCFA and carrier quality assurance reviewers to assess the

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1/After we identified the errors, the carrier reimbursed the beneficiaries the amount of the underpayments.

quality of the manual review for claims that exceed the high charge reduction safeguard. Our experience is that an indepth review, including contacting the physician's office, is often needed to detect underpayments involving wide discrepancies between submitted and allowed charges. Further, because of the importance of this safeguard in preventing underpayments, and because the underpayments are often attributed to coding or other errors by the doctors, not the carriers, the quality assurance program should have a separate category of errors due to inadequate review of and resolution of claims failing the high charge reduction safeguard.

Recommendation to the Secretary of HHS

Our work at both D.C. Blue Shield and Arkansas Blue Shield showed that the existing "high charge reduction safeguards" have not been effective in preventing underpayments to beneficiaries. Therefore, to provide greater assurance that safeguards for identifying potential underpayments are effective; we recommend that the Secretary direct the Administrator of HCFA to modify CPEP for Part B carriers to place additional emphasis on detecting and preventing underpayments. Specifically, the Quality Assurance program should address as a separate category of error the quality of the review of claims that exceed the carriers' high charge reduction safeguards.

ACTIONS TAKEN ON PRIOR REPORT

HHS, in commenting on our October 1980 report, said:

"We believe that there are some aspects of the existing physician reimbursement and assignment systems which need to be examined in depth. The Health Care Financing Administration (HCFA) is planning to engage in an organized process of consultation with beneficiary groups and the medical community to discuss these matters. HCFA plans to have the Institute of Medicine convene a group of physicians, third party payors, and other interested persons to discuss physician reimbursement issues in order to have a firm understanding of what concerns they may have. In addition, HCFA's Office of Beneficiary Services will meet with representatives of senior citizens and other beneficiary groups to discuss physician reimbursement issues.

"The issues studied by GAO are relatively small compared with the larger issues of physician reimbursement and participation."

According to HCFA officials, the Institute of Medicine effort has been deferred because of higher priority work and budget constraints.

Concerning the relative significance of the issues raised in our report, we would agree that the physician reimbursement and assignment issues are much broader. Yet these issues have existed for many years and do not appear to offer any quick and/or easy solutions. Conversely, we believe that the issues raised in our October 1980 report, while admittedly narrower, are specific problems that could offer some relief to beneficiaries if action were taken to address them.

Physicians' markup on laboratory procedures

Physicians frequently have their laboratory work done by laboratories independent of their offices. In turn, the physicians' charges to the Medicare program often include significant markups over their costs or the fee charged by the laboratory. For example, an independent laboratory might charge a physician $5 to do a blood count, and in turn the physician will charge the Medicare program $10. While actions have been taken to preclude unreasonable reimbursements from program funds, Medicare beneficiaries remain vulnerable to excessive physician markups on unassigned claims because beneficiaries are liable to physicians for the difference between submitted charges and allowable charges under Medicare.

We recommended that HHS develop a legislative proposal to address this problem and that consideration be given to including provisions which would (1) make it a misdemeanor for physicians to markup laboratory charges (similar to section 4 of Public Law 95-142 pertaining to assignment violations to the detriment of beneficiaries) and/or (2) require laboratories to bill Medicare directly. The latter would eliminate physician participation in the reimbursement process and the accompanying markups.

HHS responded as follows:

"Our work plans for this fiscal year provide for studying the reimbursement issue related to the laboratory benefit and for the development of appropriate recommendations. It should be noted that Section 918 of P.L. 96-499, the 'Omnibus Reconciliation Act of 1980,' requires that if

the doctor indicates on the claim the lab that performed the test, the reimbursement amounts would be the lower of the lab's reasonable charge or the actual charge by the lab to the physician. In either case, the doctor could receive a nominal handling charge. If the physician did not indicate which lab performed the test, reimbursement would be at the lowest rate for which the doctor could have obtained the lab test in the area."

While the study specified in the work plan might have been beneficial, HCFA officials advised that it has been postponed due to higher priority work and staffing shortages. The second part of the response dealing with the Omnibus Reconciliation Act of 1980 simply restates the information in our report pertaining to an earlier legislative proposal and does not address the recommendation.

Fee and one-half reimbursement practices

The phrase "fee and one-half" refers to a unique reimbursement practice that is used for multiple surgical procedures. HCFA requires that, for procedures done on the same day, carriers are to base reimbursement upon the major procedure only, or the major procedure plus partial amounts for other procedures. The purpose is to limit reimbursement for closely related procedures under the presumption that a full charge for each service is not justified for closely related multiple procedures performed at the same time.

At D.C. Blue Shield, projections from a 2-week claims sample showed that annual beneficiaries' liability was increased over $400,000 in situations involving the fee and one-half rule. At Arkansas Blue Shield, we noted that July 1980 unassigned claims involving the fee and one-half rule had reasonable charge reductions of about 40 percent or about double the overall rate of reduction for all claims.

We recommended that D.C. Blue Shield 1/ be instructed to work with the local medical society(s) to resolve the differences between physicians' charging practices and Medicare's pricing for multiple surgical procedures. We also recommended that other carriers be instructed to determine the extent that application of the fee and one-half rule increases reasonable charge reductions and, if significant, take action to reduce or eliminate such reductions.

1/In April 1981, HCFA announced that the D.C. Blue Shield contract would not be renewed when it expired on September 30, 1981.

HHS responded as follows:

"HCFA has not issued any national guidelines requiring carriers to apply a 'fee and one-half' rule to multiple or bilateral surgical procedures or to base payment for such services on the fee for the major surgery. However, the use of such rules by the carriers is not necessarily incorrect. The program assumes that, consistent with the prevailing charge concept, the carriers will pay for the additional services on the basis of their knowledge of accepted local charging practices within the medical community. In processing claims, the carriers must determine first whether the multiple or bilateral surgical services were 'reasonable and necessary.' Once coverage for the multiple or bilateral surgery is confirmed, the accepted standards of billing and reimbursement within the medical community are applied in the reasonable charge determinations. If it is the prevailing practice to allow 50 percent above the reasonable charge for the major procedure when paying for the bilateral or incidental service, the carrier should do so; if the medical community does not normally bill for the bilateral or incidental service, then carriers should only make payment for the major surgical service. However, in view of GAO's concerns, we will ask the regional offices to remind the carriers to make sure their reimbursement methodologies in this regard are consistent with established medical practices in their service areas."

Contrary to the HHS response, HCFA has issued national guidance as evidenced by part 3, section 4149 of the carrier's manual 1/ which reads:

"SURGERY - MULTIPLE PROCEDURES PERFORMED DURING THE SAME OPERATION
Guidelines must be established for use in coding charges for surgery when more than one surgical procedure is performed during the same operation, through the same opening, through a different opening or by different surgical procedures. The guidelines should establish the allowable amount

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1/This has been in the manual since at least February 1979.

based upon (1) the major procedure only or (2) the major procedure plus partial amounts for other procedures."

This instruction requires carriers to establish reimbursement guidelines for allowing only partial amounts for multiple procedures. Therefore, in order to protect the beneficiary on unassigned claims, it is important that physician charging practices match Medicare pricing policies.

Most of the HCFA response was devoted to restating our report's explanation of carrier options and responsibilities for pricing multiple surgeries rather than dealing with the problem identified. The last sentence did appear to address the issue, but the regional offices have not been issued directives or instructions as of June 29, 1981.

Use of relative value schedules for computing customary charges

Relative value schedules are a means of measuring numerically the characteristics of a medical procedure in relation to other procedures. Medicare carriers use the schedules to compute Medicare's "customary" charge for established physicians who are billing for a procedure where there is an inadequate prior charge history to establish what the doctor usually charges. For example, if a doctor's prior charge history shows that the usual charge for a procedure with a relative value of 2 is $10, the carrier assumes that the doctor's "customary" charge for a procedure with a relative value of 4, but where the doctor has an inadequate prior charge history, would be $20. For new physicians who do not have a charge history--which is necessary for customary charge computations--the 50th percentile of all physicians' customary charges are used. At D.C. Blue Shield, a sample of claims showed that the relative value method for computing "customary charges" tended to produce lower Medicare payments than the 50th percentile method.

Because beneficiaries can be financially penalized simply by the fact that they receive medical care from an established physician, we recommended that D.C. Blue Shield use the 50th percentile method for established physicians. Also, because similar situations may exist at other carriers, we recommended that carriers

still using the schedules 1/ be required to study their effect on reasonable charge computations. Where similar patterns in reasonable charge computations are noted, we recommended that the use of relative value schedules be discontinued.

HHS said that we did not develop a strong case for recommending that the use of relative value schedules be discontinued. Nonetheless, for other unstated reasons, HHS said it planned to instruct carriers to discontinue the use of the schedules. As of June 29, 1981, no instructions had been issued.

Need for more specific claims processing standards

As discussed earlier, Part B contractors are required to manually review claims where billed charges are significantly reduced for payment purposes. Our October 1980 report pointed out that carriers are given considerable latitude in meeting this requirement and that safeguards to identify for manual review large reductions in submitted charges varied.

We recommended in our October 1980 report that more specific claims processing standards be established for unassigned claims, that is, when claims are to be manually reviewed and what specific action, such as contacting the doctor's office for clarification, is to be taken as part of the review. Also, we said that HCFA should give recognition to the fact that, in making payments under Part B, carriers are dealing with two different groups--physicians on assigned claims and beneficiaries on unassigned claims. Carriers generally do not make any distinction between the two groups despite the fact physicians routinely submit Medicare forms and generally should know the program quite well. Conversely, many beneficiaries have various mental and physical impairments and infrequently fill out a Medicare claim. In our opinion, they cannot be expected to know the details of claims processing requirements.

1/HCFA allows carriers to use the 50th percentile method in lieu of relative value schedules if the latter produces unreasonable results. A survey of four HCFA regional offices showed that many carriers had discontinued the use of these schedules while others had not studied the impact that the schedules had on reasonable charge reductions.

HHS responded as follows:

"We concur that revisions to the standards be considered to assure quality claims processing. The Contractor Performance Evaluation Program (CPEP) gives equal emphasis to quality, cost, and timeliness. Individual standards within each area carry weights according to importance to beneficiaries, physicians, suppliers, and government recordkeeping requirements. Consistent with the traditional view that assigned claims are easier to process, the current standards for processing such claims are more stringent than those previously used. We will, of course, consider these recommendations during the on-going revision process to which the standards are subject. The desirability of increased manual review must be balanced against the feasibility of the process and its increased cost to administer. In general, CPEP recognizes as parameters for measuring performance any standards which have been published in national instructions to contractors.

"It should also be noted that we are given careful attention to the review and evaluation of contractor performance in carrying out current reimbursement policies, with continuing emphasis on: (1) possible improvement and refinement in claims processing standards, and (2) identifying and correcting both overpayments and underpayments."

The above HHS comments generally relate to CPEP and do not as such address the need for more specific claims processing standards for unassigned claims. Further as discussed in the first section of this report, CPEP does not specifically address the issue of large reasonable charge reductions, and we believe it should. Nevertheless, in line with our recommendations HCFA has proposed more specific standards. The revision reads as follows:

"As a minimum for non-assigned claims, if any service is reduced by more than $20 and the billed charge is more than 100 percent greater than the customary charge, that item must be reviewed to make sure the reduction is proper."

This change was submitted to carrier representative groups for comment in February 1981, and as of June 29, 1981, HCFA was reviewing the responses to the proposal.

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As requested by your office, we did not obtain written comments from HHS on this report. Also, unless you publicly announce the report's contents earlier, no further distribution will be made until 30 days from its issue date. At that time, we will send copies to the Secretary of HHS and interested congressional committees, and make copies available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director