DOCUMENT RESUME

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Civil Service Needs To Improve Claims Review Process under the Federal Employee Health Benefits Program. HRD-78-68; B-164562. March 14, 1978. 21 pp.

Report to Rep. Gladys Noon Spellman, Chairman, House Committee on Post Office and Civil Service: Compensation and Employee Benefits Subcommittee; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs (1200); Health Programs: Reimbursement Policies and Utilization Controls (1208).
Contact: Human Resources Div.
Budget Function: Health: Health Care Services (551).
Organization Concerned: Civil Service Commission.
Congressional Relevance: House Committee on Post Office and Civil Service: Compensation and Employee Benefits Subcommittee.
Authority: Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901; P.L. 86-382). P.L. 93-246.

In a review of the Civil Service Commission's (CSC's) administration of the claims review process under the Federal Employees Health Benefits (FEHB) Program, an examination was made of: (1) a random sample of 62 closed disputed claim files from a March and April 1977 listing and an additional 62 files from cases closed during 4 days in October 1977; (2) all disputed claim files closed during December 1975 to April 1977 with required reports and records and, additionally, all disputed claim files from January to April 1977 with or without reports and records; and (3) all disputed claim files closed for December 1975 to May 1977 for the comprehensive plans (Aetna and Blue Cross and Blue Shield). In addition, a medical advisor reviewed 120 disputed claims files and the medical records for 55 of those cases. Findings/Conclusions: The CSC needs to increase the timeliness of its responses to enrollees who dispute claim denials under the FEHB program. None of the CSC divisions complied fully with the established 30-day timeliness criterion for resolving disputed claims and responding to enrollees. The Division of Government-wide Plans frequently did not review medical records as the regulations require; it often relied on summary medical reports furnished by the Federal Employee Program (FEP) office to arrive at conclusions. In view of the CSC's position that each of the five medical records advisors should be able to review an average of five cases each per day, all disputed claims of the Division of Government-wide Plans could have been reviewed. Recommendations: The Division of Government-wide Plans should be directed to: (1) require health plans to comply with the regulation that an enrollee be provided a detailed explanation of why the claim was denied; (2) rely on the plans' detailed explanations of reasons for denials in lieu of FEP office reports; (3) request the FEP office to provide records to the CSC within 5 days of receipt from the

local plans; and (4) establish a standard which would require medical records advisors to review an average of at least five records every day. (DB)

REPORT BY THE

Comptroller General

OF THE UNITED STATES

Civil Service Needs To Improve Claims Review Process Under The Federal Employees Health Benefits Program

Under the Federal Employees Health Benefits program, a participant may seek a Civil Service Commission review when a health insurance plan denies a claim.

GAO examined the Commission's administration of the review process and found that (1) responses to disputants often were untimely and (2) reviews of claims involving medical questions could be improved.

This report describes the claims review process and discusses possible improvements.

HRD-78-68
MARCH 14, 1978

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

B-164562

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

Dear Madam Chairwoman:

This is in response to your Subcommittee's interest in the Civil Service Commission's administration of the claims review process under the Federal Employees Health Benefits program.

Our review showed the Commission needs to improve its timeliness in resolving claim disputes and responding to health plan enrollees. Additionally, we found some opportunities for the Commission to make more thorough reviews of cases involving medical questions. This report contains several recommendations to the Commission to correct these matters.

We did not obtain the Commission's written comments on this report, but we have discussed its contents informally with responsible Commission officials as well as Blue Cross and Blue Shield officials who said they generally agreed with our recommendations.

As arranged with your office, we are sending copies of this report today to the Honorable John E. Moss, who has expressed an interest in Federal agencies' administration of certain compensation claims. After 14 days from the date of this report, we will send copies of the report to the Chairmen, Senate and House Committees on Appropriations, Senate Committee on Governmental Affairs, House Committee on Government Operations, and House Committee on Post Office and Civil Service; Chairman, Civil Service Commission; and the Acting Director, Office of Management and Budget.

Sincerely yours,

Comptroller General
of the United States

REPORT OF THE
COMPTROLLER GENERAL
OF THE UNITED STATES

CIVIL SERVICE NEEDS TO IMPROVE CLAIMS REVIEW PROCESS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

D I G E S T

The review process administered by the Civil Service Commission for claims denied under the Federal Employees Health Benefits program can be changed to serve participants better. The Commission needs to

--improve the timeliness with which it responds to disputants and

--give more thorough reviews to claims involving medical questions.

According to Commission regulations

--a program participant must seek a review by the insurance plan which denied the claim before seeking a Commission review;

--the health plan may then either pay it or reaffirm its denial, setting forth in detail its reasons;

--the plans have 30 days in which to respond to a Commission request for information;

--the Commission must review all "original evidence" used to adjudicate the claims; and

--the Commission has 30 days in which to respond to a disputant after receiving requested information to aid in reviewing a claim. (See pp. 2 and 3.)

Disputed claims are reviewed by three Commission divisions. During 1977, the

--Division of Government-wide Plans received 4,164 disputed claims and

resolved 3,873, upholding Blue Cross and Blue Shield's denials 80 percent of the time and Aetna's denials 84 percent of the time;

--Employee Organization Plans Division received 309 disputed claims and resolved 308, upholding the plans' denials 96 percent of the time; and

--Comprehensive Plans Division received 68 disputed claims and resolved 60, upholding the plans' denials 28 percent of the time. The relatively low percentage of claim denials upheld was due in part to counting delayed payments as disputed claims. Resolution of delayed payments was always in favor of the enrollee. (See pp. 5 and 6.)

The number of claims appealed to the Commission during 1977 per 100,000 enrollees was

--52 for Aetna and 206 for Blue Cross and Blue Shield (the two Government-wide Plans),

--49 for the Employee Organization Plans, and

--23 for the Comprehensive Plans. (See p. 6.)

Before the Commission can review a claim, the plan which denied it must reconsider the original denial. Twenty-eight percent of the requests that the Commission received in 1977 had to be returned to program enrollees because they had not indicated that they had followed this required procedure.

The 1978 health plan brochures for Blue Cross and Blue Shield and Aetna, however, request that disputants enclose a copy of the local plan's letter reaffirming the denial of a claim. This change should minimize the number of claims which need to be returned to enrollees. (See pp. 8 and 9.)

None of the three Commission divisions which review claims complied fully with the requirement that they respond to disputants within 30 days after receiving from the plans all the information they needed to review a claim.

The Division of Government-wide Plans experienced the most difficulty in meeting the criterion. Of the cases GAO reviewed, only 27 percent of those closed in March and April 1977 and 39 percent of those closed during 4 days in October 1977 met the requirement.

The Comprehensive Plans Division and the Employee Organization Plans Division met the requirement in 85 and 80 percent, respectively, of the cases GAO reviewed. (See pp. 9 and 10.)

GAO also found that the Federal Employee Program office of Blue Cross and Blue Shield was not always timely in responding to the Commission's requests for information. This office, however, improved its timeliness considerably during the period covered by GAO's review. (See pp. 11 and 12.)

The Blue Cross and Blue Shield office reviews disputed claims and then provides reports to the Commission. The reviews are essentially duplicative of the required Commission reviews, although the Blue Cross and Blue Shield office uses the process to monitor the plans' performance. Blue Cross and Blue Shield representatives said that if they continued to review evidence, but did not supply the Commission with reports, they could increase their timeliness.

If local plans followed the regulations and provided enrollees with detailed explanations of why claims had been denied and if the enrollees furnished the Commission with copies of these explanations as requested in the 1978 Government-wide

Plan brochures, the Commission would still have reports on the plans' reason for denyin cliams. (See pp. 12 and 13.)

GAO's medical advisor reviewed 120 disputed claims cases to determine if the Commission's reviews had been medically appropriate. The review showed that the divisions had generally acquired appropriate medical evidence, given disputed claims proper medical review, and apparently rendered medically correct decisions. (See p. 17.)

In the Division of Government-wide Plans, however, GAO found that nurses often relied on information supplied by the disputants and furnished in the carrier's reports instead of relying on the related medical records. A division official said that more nurses were needed to review more medical records. GAO's analysis, however, showed that the division has enough nurses to review records in all cases involving medical questions. Additionally, some cases which a registered nurse had reviewed were complex enough to warrant physician review. GAO believes that the Division of Government-wide Plans should have reviewed the medical records and/or referred the dispute for a physician's review in 13 percent of the cases sampled.

RECOMMENDATIONS

GAO recommends that the Civil Service Commission improve the claims review process by directing the Division of Government-wide Plans to

--require health plans to comply with the regulation which requires that enrollees be provided a detailed explanation of why the plan denied a claim;

--rely on the plans' detailed explanations of the reasons for denials in lieu of carrier headquarters' office reports;

--request the carrier's headquarters office to provide records to the Commission within 5 days of receipt from the local plans; and

--establish a standard which would require medical records advisors to review an average of at least 5 medical records every day.

Additionally, the Commission's Medical Division should become more involved in reviews of disputed claim cases involving medical questions.

The Director of the Commission's Bureau of Retirement, Insurance, and Occupational Health generally agreed with our recommendations. The responsible carrier official said he believed that our recommendations were reasonable and feasible. (See pp. 15, 16, and 21.)

Contents

ABBREVIATIONS

CSC	Civil Service Commission
FEHB	Federal Employees Health Benefits
FEP	Federal Employee Program
GAO	General Accounting Office

CHAPTER 1

INTRODUCTION

We examined the claims review process administered by the Civil Service Commission (CSC) for claims denied under the Federal Employees Health Benefits (FEHB) program. We made our review in response to interests of the Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service. The Subcommittee was primarily concerned about how the process serves enrollees.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The FEHB program (5 U.S.C. 8901), established by the Federal Employees Health Benefits Act of 1959 (Public Law 86-382), provides health insurance coverage for about 3.3 million enrollees (Government employees and annuitants) and over 6.4 million dependents. The Government and enrollees share the program's cost which is estimated to be $2.8 billion for fiscal year 1977. CSC contracts for coverage through the following types of health plans:

--Service Benefit Plan: A Government-wide Plan under which the carrier, Blue Cross and Blue Shield, generally provides benefits through direct payments to physicians and hospitals. This plan covers about 1.9 million enrollees.

--Indemnity Benefit Plan: A Government-wide Plan under which the carrier, Aetna Life Insurance Company, may provide benefits by either reimbursing the 491,000 enrollees or, at their request, by paying physicians and hospitals.

--Employee Organization Plans: These plans, available only to employees (and their families) who are members of the sponsoring organizations, provide benefits either by reimbursing employees or, at their request, by paying physicians and hospitals. The 12 Employee Organization Plans cover about 637,000 enrollees.

--Comprehensive Medical Plans: These 46 plans, available only in certain localities, provide (1) comprehensive medical services by physicians and technicians practicing in common medical centers or (2) benefits in the form of direct payments to physicians with whom the plans have agreements. These plans also provide hospital benefits. The plans cover about 291,000 enrollees.

CSC DISPUTED CLAIMS REVIEW PROCESS

Under the FEHB program, persons who receive health care may obtain health insurance benefits in several ways, including

--submitting a claim to their health insurance plan,

--having the health care provider submit a claim to their health insurance plan, or

--receiving care in a comprehensive health plan.

The health insurance plans review the health benefit claims to determine if they are payable under their contracts with CSC. If a plan denies a claim, however, a claimant may ask CSC to review the plan's decision.

Public Law 93-246, approved January 31, 1974, formally established CSC authority to review denied FEHB program claims. The act provides in part:

> "Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Commission [CSC] finds that the employee, annuitant, or family member is entitled thereto under the terms of the contract."

Based on regulations (5 C.F.R. 890.105), if a claim (or a portion of a claim) is denied, the local plan must reconsider its original denial whenever it receives a written request for reconsideration within 1 year of the denial. The written request should contain the reasons the disputant believes the denied claim should have been paid. Upon reconsideration, the plan may either pay the claim or must reaffirm a denial in writing setting forth in detail the reasons for not paying the claim. The insurance plan must also inform the enrollees of their right to request a CSC review whenever it reaffirms a claim denial.

If the plan either reaffirms its denial or fails to respond to the request for reconsideration within 30 days, the enrollee may ask CSC to determine whether the claim denial was proper. When CSC receives an appeal letter, claims personnel review it. If the letter does not indicate that the claim has been reconsidered by the insurance plan, CSC will advise the disputant of the regulation and request that the claimant have the insurance plan reconsider the claim. (See p. 8.) If the letter asking for a CSC review indicates the plan has reconsidered the claim, CSC will accept the claim for review.

When CSC accepts a claim for review, CSC personnel may act immediately on the claim or obtain additional information to aid their review. CSC may be able to decide a simple dispute based solely on the disputant's letter and other information the disputant provided. For example, allowability of a claim for a private hospital room when a plan pays only for semiprivate rooms except in specified circumstances might be decided based on the information provided.

In other cases, however, CSC may need additional information to determine what action to take. Cases involving disputes over "medical necessity" may be complex enough to require reviews of hospital records or other medical information. In these instances, CSC will usually acknowledge a disputant's letter and may request (1) additional information on the claim, and/or (2) a signed medical release, and/or (3) a Privacy Act authorization. The signed medical release authorizes CSC to have access to complete medical information related to the claim. The Privacy Act authorization is required by the Privacy Act of 1974. This authorization is required whenever a person other than the patient--e.g., a spouse, dependent, or attorney--writes to CSC to request a claim review. By signing this document the patient authorizes CSC to give the disputant information about the health benefits claim.

CSC may also request the insurance plan to provide a report on the case and other pertinent information, including medical records. By Federal regulations:

--Plans are required to provide the requested information to CSC within 30 days.

--CSC is required to review "copies of all original evidence and findings upon which the plan denied the claim and any additional evidence submitted to the Bureau or otherwise obtained by the plan or Bureau." 1/

--CSC is required to notify the enrollee and the insurance plan of its findings within 30 days after it receives all requested information.

1/The regulations do not define "original evidence." The term is generally applied to documentation developed during the course of adjudicating and reconsidering a claim which would help in reviewing a disputed claim. "Original evidence" may include the original claim as well as physicians' statements and other medical records and may pertain to matters of medical judgment and/or contractual benefit exclusions. The "Bureau" is CSC's Bureau of Retirement, Insurance, and Occupational Health.

Three CSC divisions review disputed FEHB program claims. They are (1) the Comprehensive Plans Division, (2) the Employee Organization Plans Division, and (3) the Division of Government-wide Plans.

The Comprehensive Plans Division and the Employee Organization Plans Division disputed claims review processes are similar. Both divisions request information directly from the insurance plans and both use CSC's Medical Division 1/ to review cases which division claims reviewers believe require a medical opinion. Neither of these divisions employs nurses.

In contrast, the Division of Government-wide Plans requests information indirectly by going through the Blue Cross and Blue Shield Federal Employee Program (FEP) office and the Aetna Government-wide Indemnity Benefit Plan office, both in Washington, D.C. These offices in turn request information from the appropriate local Blue Cross and Blue Shield plans or Aetna paying offices. The FEP and Aetna Washington, D.C., offices review the information provided by local offices and send reports of their findings and conclusions to CSC.

The Division of Government-wide Plans refers these reports first to "health benefits specialists," persons who are required to be knowledgeable of the carriers' contracts with CSC. These specialists have authority to resolve claim disputes. The health benefits specialists review the reports and may refer cases involving medical questions to one of the division's medical records advisors. The medical records advisors are registered nurses who review disputed FEHB program claims.

If medical records advisors believe that the carrier's report is not sufficient to make a decision or disagree with the carrier's conclusions, they will visit the FEP office to review medical records and may discuss the case with an FEP nurse. According to CSC, medical records on all Aetna disputed claims are reviewed because of the small claims volume.

1/CSC's Medical Division employs about 50 persons including 12 physicians. The division's responsibilities include working with CSC's disability retirement, physical qualifications, and medical standards programs. It also provides technical examining review service and gives medical opinions on claims when requested by various CSC sources.

After completing its review, CSC will inform the disputant and the health plan of its decision. In those cases where CSC finds a health plan's denial of a claim was improper, it will instruct the plan to provide benefits. CSC's statutory responsibility and authority for review of denied FEHB program claims ends at this point. If the disputant still believes the health plan has improperly denied a claim, the claimant may take legal action.

DISPUTED CLAIMS VOLUME, DISPOSITION, AND RATE

Each of the three divisions which reviews disputed claims maintains a claims inventory and disposition record. Commission records showed that during 1977 the Division of Government-wide Plans received 3,911 Blue Cross and Blue Shield and 253 Aetna disputed claims, and resolved 3,635 Blue Cross and Blue Shield and 238 Aetna disputed claims. This division upheld the plans' denials on 80 percent of the Blue Cross and Blue Shield, and 84 percent of the Aetna disputed claims resolved. The Division of Government-wide Plans had a total of 1,566 Blue Cross and Blue Shield, and 23 Aetna disputed claims on hand at the end of 1977. 1/

The Employee Organization Plans Division received 309 disputed claims and resolved 308 during 1977. CSC upheld the plans' denials on 96 percent of the disputed claims resolved. The division had 5 disputed claims on hand at the end of 1977.

The Comprehensive Plans Division received 68 disputed claims and resolved 60 during 1977. CSC upheld the plans' denials on 28 percent of the disputed claims resolved. As of December 31, 1977, the Comprehensive Plans Division had 11 disputed claims on hand.

In explaining the relatively low percentage of claim denials upheld by the Comprehensive Plans Division, a division official told us that delayed payments at one problem plan were counted as disputed claims. This was a unique situation because a delayed payment problem is not usually counted as a dispute; the outcome of this kind of problem was always in favor of the enrollee since payment was only delayed, not denied.

1/A division may have on hand more claims than claims received less claims processed because of claims on hand at the beginning of a period.

Additionally, the disparity between the Comprehensive Plans Division and the other two divisions is explained by enrollee problems with the out-of-service-area exclusions used by some comprehensive plans. 1/ The Comprehensive Plans Division (in the "interest of equity and good conscience") often persuaded the plan to make an exceptional payment although the plan had been contractually correct in its denial. The Comprehensive Plans Division then told enrollees that other similar claims would be denied and recommended that if the enrollees were out of a plan's service area, they should change plans. Excluding these two categories of claims, a division official estimated that in 1977 about 85 percent of the disputed claims were resolved in favor of the plans.

During 1977, the disputed claims rate (the number of disputed claims appealed to CSC per 100,000 enrollees) was

--52 for Aetna and 206 for Blue Cross and Blue Shield (the two Government-wide Plans),

--49 for the Employee Organization Plans, and

--23 for the Comprehensive Plans.

SCOPE OF REVIEW

We performed our review at CSC, Blue Cross and Blue Shield's Federal Employee Program office, and Aetna's Indemnity Benefit Plan office--all in Washington, D.C.

We examined

--a random sample of 62 closed disputed claim files from a March and April 1977 listing prepared by CSC and relative to the Government-wide Plans (the listing contained 853 items) and an additional 42 files from cases closed during 4 days in October 1977;

--all disputed claim files closed during December 1975 to April 1977 on which the Employee Organization Plans Division had required reports and records from the

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1/Some comprehensive plan contracts contain provisions which exclude payment to enrollees who (1) live outside the plans' geographical service areas and (2) receive service within a specified radius of their residences outside the service area.

plans; and additionally, all disputed claim files closed from January to April 1977 whether or not reports and records were obtained from the plans; and

--all disputed claim files closed for December 1975 to May 1977 for the Comprehensive Plans.

Our medical advisor reviewed 120 disputed claim case files at CSC and reviewed medical records for 55 of those cases at the FEP office. We did not review medical records on Aetna disputed claims because of the small number of such claims which appeared in our sample.

We reviewed appropriate legislation, legislative history, and Federal regulations pertaining to the FEHB claims review process and interviewed responsible CSC and carrier officials. We made our review from April to November 1977.

CHAPTER 2

OPPORTUNITIES FOR IMPROVING DISPUTED CLAIMS REVIEW PROCESSES

CSC needs to increase the timeliness of its reponses to enrollees who dispute claim denials under the FEHB program. None of the CSC divisions complied fully with the established 30-day timeliness criterion for resolving disputed claims and responding to enrollees. The Division of Government-wide Plans, which reviews claims disputed by enrollees in the two largest plans--Blue Cross and Blue Shield and Aetna--had the most difficulty meeting this criterion.

The FEP office in Washington, D.C., also was untimely in responding to CSC requests for information. However, a comparison of disputed claims resolved during two different periods covered by our review (March and April, and October 1977) showed the FEP office improved its timeliness considerably.

In our opinion, the number of disputed Aetna claims which appeared in our March and April and our October 1977 samples was too small to permit any generalizations regarding the timeliness of Aetna's responses.

PROVIDING ENROLLEES INFORMATION ON CLAIMS REVIEW PROCEDURES

The individual health insurance plan brochures which are available to Federal employees include explanations of the steps required to obtain a CSC review of a plan's denial of a claim.

A large number of claimants, however, have not been following the required procedures. One reason for this may be that the health plan brochures prior to calendar year 1978 did not specify that enrollees should indicate whether the local plan had reconsidered the claim denial when seeking a CSC review. Additionally, CSC had not established any formal mechanism to ascertain that the enrollee had obtained the required local reconsideration.

During 1977, CSC received 6,278 requests for reviews of claims. Of this number, however, 28 percent (1,737 requests) did not indicate whether the required local plan reconsiderations had been obtained. As a result, the requests were returned to disputants for referral to the plan which had originally denied the claim.

The Division of Government-wide Plans had to return 29 percent of the disputed claims requests it received. However, the language in the 1978 brochures for the two Government-wide Plans should help correct this problem. The brochure language was changed to state that the claimant should submit with the request for a CSC review "a copy of your letter to the plan and its reply, if any." Requesting a copy of the letter to the plan should help assure that enrollees follow the required steps. A copy of the disputant's letter to the plan will inform CSC that the disputant had asked the plan to reconsider the claim.

The Employee Organization Plans Division returned for reconsideration about 7 percent of the claims received in 1977 while the Comprehensive Plans Division did not return any requests to enrollees for local plan reconsideration. Neither of these divisions' health plan brochures specify that the request for a CSC review should indicate that the local plan had reconsidered the claim.

TIMELINESS OF DISPUTED CLAIMS REVIEW COULD BE IMPROVED

Two of the three CSC divisions which review disputed claims were timely in over 80 percent of the cases we reviewed. The Division of Government-wide Plans, however, fell far short of meeting the established timeliness criterion.

The following table shows the average number of days it took the three divisions to (1) acknowledge a request for review of the claim and (2) resolve the dispute. The number of cases used for the computation of averages varies because not all documents were dated and could not therefore be used in every computation.

Division	Average number of days to respond to enrollee after receipt of the disputed claim	(cases)	Average number of days from receipt to resolution of the disputed claim	(cases)
Government-wide Plans	17.8	52	142.1	56
Employee Organization Plans	7.1	32	45.3	43
Comprehensive Plans	11.5	33	68.1	38

According to the regulations, CSC must notify the disputant and the health plan of its findings within 30 days after receiving all the information it requested to aid in reviewing the case. Based on our March and April 1977 sample, the Division of Government-wide Plans was in compliance with the regulation in only 27 percent of the cases. In contrast, the Comprehensive Plans and the Employee Organization Plans Divisions complied with the regulation in 85 percent and 80 percent, respectively, of the cases we reviewed. We found that when medical records advisors in the Division of Government-wide Plans were involved in the review process,

--an average of 44 days elapsed before the medical records advisors initiated reviews of information received from the carriers and

--it took an average of 25 more days after the medical records advisors' reviews before final responses were mailed.

During our review, the Division of Government-wide Plans staff worked overtime to eliminate claims backlog. Additionally, a fourth medical records advisor was added to the division's staff at the beginning of our review. 1/ Because of these factors, we examined 42 disputed claim cases closed during 4 days in October 1977 to determine if the division had improved its timeliness. The division's performance had improved but still fell short of meeting the 30-day timeliness criterion. Specifically, we noted

--overall improvement in that the division met the timeliness criterion for 39 percent of the cases;

--that the improvement was attributable to reviews where only health benefits specialists were involved; and

--that in cases which the medical records advisors reviewed, CSC met the 30-day criterion only 10 percent of the time; in no case where the medical records advisors reviewed the medical records as well as the carriers' reports did CSC meet the criterion.

Based on our review of the 42 cases closed during 4 days in October 1977, we believe the Division of Government-wide Plans still needs to improve its performance. We also believe that most potential for improvement is in the medical records advisors' reviews.

1/The division also hired a fifth medical records advisor in late October 1977.

Factors associated with untimely responses on claim disputes

Delays in resolving disputed claims and responding to enrollees have occurred both at the FEP office and at CSC's Division of Government-wide Plans. Although the regulations require plans to supply CSC with information on disputed claims within 30 days after a CSC request, the claims we reviewed showed FEP took an average of 69 days to respond to CSC on claims closed in March and April 1977 and 43 days to respond to CSC on claims closed during 4 days in October 1977.

As previously noted, CSC is required to respond to enrollees within 30 days after receiving all requested information. Our sample showed the Division of Government-wide Plans took an average of 58 days for cases closed in March and April and 47 days for cases closed in October 1977 to respond to enrollees, after the information was received.

FEP office

When responding to a CSC request for information on a disputed claim, the FEP office in Washington, D.C., obtains relevant information from local Blue Cross and Blue Shield plans. The claims and other evidence are reviewed by nonmedical personnel or by nurses as is appropriate to the nature of the dispute. The FEP office then prepares a report for CSC describing the case and giving its conclusions.

When the FEP office review indicates the plan should have paid the claim, the office will instruct the plan to pay, and the report to CSC will indicate this. In such cases, CSC has only to write the enrollee stating that the disputed claim has been resolved in favor of the claimant In cases where the FEP office review and report conclude that the plan denied the claim properly, CSC must evaluate the FEP office response and determine the appropriateness of the plan's decision.

The FEP office review is essentially a duplication of what Federal regulations describe as the CSC review--a review of the evidence to determine if the claim had been properly adjudicated. An FEP office representative pointed out, however, that the reviews also provide managerial oversight of the local plans' performance. Additionally, the FEP office official said that in some cases the FEP office will direct the plan to pay the claims, thereby eliminating the need for a CSC review. According to FEP office statistics, the office reversed local plans' decisions in 3.7 percent of all cases reviewed in the first quarter of calendar year 1977. (More recent comparable statistics were not available from the FEP office.)

According to the senior CSC medical records advisor, the FEP office reviews of disputed claims and reports on the reviews were helpful because the FEP office categorized and summarized only the relevant information. Additionally, the division chief said that maintaining medical information at the FEP office (where the local plans send it and where CSC medical records advisors review it) lessened the danger of unwarranted disclosure.

Based on claims closed in March and April 1977, the FEP office took an average of 29 days after receiving responses from local plans to report to CSC. An FEP official said that the time involved in this process had been reduced to 10-15 days by October 1977. The official said that for cases where the FEP office concurred with the plans' denials, his office could provide CSC the records, but not reports, within 5 days.

Providing only the records to CSC would enable the FEP office to meet the timeliness criterion more often while still maintaining oversight of the local plans. The regulations require local plans, after reconsidering a denied claim, to set out "in detail the reasons" for maintaining the denial. These required explanations could substitute for the FEP reports, as a starting point for CSC review, if the local plans provided the required detail. As the following examples illustrate, however, the local plans do not always provide detailed explanations. One claimant who disputed a local plan's decision to deny a 9-day hospital stay received the following reply:

> "This will acknowledge your communication concerning the denial of benefits for the above hospitalization.
>
> "This case has again been reviewed in its entirety. As a result of this further medical review we find that we must continue to deny benefits in this instance.
>
> "If you are not in agreement with our determination on this case, you may ask for a review by writing to [the Civil Service Commission]."

Another claimant who had disputed a local plan's decision to deny benefits for a 7-day hospital stay received the following reply:

"The additional information regarding the above noted patient along with the medical history has been re-reviewed by our Medical Advisors. We regret to advise that there has been no change in the decision; the admission remains declined as primarily diagnostic. If the subscriber feels the decision is incorrect he should refer to page 4 of the Government-wide Service Benefit Plan brochure for details in obtaining a review on his behalf. Thank you for your cooperation."

Letters such as those noted above do not provide enrollees with the detail required by the regulations and would not prove very useful as reports to CSC. If CSC is to use the plans' letters in lieu of the FEP office reports, plans must provide the required detailed explanations.

Division of Government-wide Plans

The Division of Government-wide Plans met the established 30-day timeliness criterion in only 27 percent of the 62 cases we sampled from a March and April 1977 listing and in 39 percent of the 42 October cases we reviewed. Twenty-nine of the 62 March and April cases and 29 of the 42 October 1977 cases we reviewed were referred to medical records advisors. The improvement between April and October resulted largely from reviews of claims which were not referred to the medical records advisors. This improvement may have been due to the elimination of a typing backlog through overtime work. Our review of the October cases showed that CSC met the 30-day timeliness criterion 10 percent of the time when medical records advisors reviewed only enrollee-supplied information and carrier reports and never when they reviewed medical records at the carriers' headquarters.

As indicated on page 3, the regulations require reviews of "original evidence" for disputed claims cases. In instances where the disputes involve medical judgments, original evidence may include hospital records, nurses' notes, and other medical information. The cases we reviewed showed that the medical records advisors reviewed medical records in about 59 percent of the March and April cases and 79 percent of the October cases referred to them. For the remaining Blue Cross and Blue Shield cases, the medical records advisors relied on carrier reports and information supplied by enrollees. In contrast we noted that the five FEP office nurses review medical records and prepare reports for CSC on all the disputed claims with medical questions.

According to the senior CSC medical records advisor and other CSC officials, a medical records advisor can review

--about 15 cases a day when only carrier reports and enrollee information are reviewed at CSC and

--about 5 cases a day when carrier reports and medical records are reviewed at the carrier's office.

A division official told us that if the division had more medical records advisors, it would be able to review medical records for all cases involving medical questions, as the regulations require. In view of CSC's position that one medical records advisor should be able to review an average of 5 cases daily (or 15 carrier reports daily), it appears the division's 5 medical records advisors should be adequate. Five medical records advisors working 220 days a year and averaging 5 cases a day would be able to review 5,500 cases annually. The division received only 4,164 disputed claims in 1977, not all of which were referred to the medical records advisors.

CONCLUSIONS

We believe that the FEHB program claims review process can be changed to serve program participants better. There are opportunities for (1) speeding up the processes which occur before CSC begins its review and (2) improving the timeliness and increasing the depth of the CSC reviews.

During 1977, CSC had to return to disputants about 28 percent of the requests for claims reviews. This was because the disputants frequently did not indicate that they had obtained the required local plan reconsideration of the claim. A language change in the 1978 Government-wide Plan brochure should reduce this problem.

If the plans adhere to the requirement that they provide enrollees with detailed explanations of reasons for claim denials and if disputants provide CSC copies of these explanations, CSC should be able to initiate more quickly its adjudication of disputed claims. CSC could

--use the local plans' detailed explanations for claim denials in lieu of the carrier reports, as a starting point for its review, and

--obtain more quickly the documentation it needs to adjudicate the claims.

Although the problem of returning claims for local plan reconsideration at the Employee Organization Plans Division has not been as great as in the Division of Government-wide Plans, this division should consider clarifying the procedures to be followed by those who dispute claim decisions.

CSC timeliness varied among its divisions. The Employee Organization Plans Division and the Comprehensive Plans Division met the 30-day timeliness requirement in 80 and 85 percent of the cases we reviewed. The Division of Government-wide Plans improved its timeliness during our review but still failed to meet the requirement in over 60 percent of the cases we examined.

Moreover, the Division of Government-wide Plans frequently did not review medical records as the regulations require. Rather, it often relied on summary medical reports furnished by the FEP office to arrive at its conclusions. The division's medical records advisors should be able to review medical records on all disputed claims if they maintain the productivity rate which they say is possible.

RECOMMENDATIONS TO THE CHAIRMAN, CSC

To improve both the timeliness of the claims review process and the evidential basis on which CSC arrives at decisions on disputed FEHB program claims, we recommend that the Chairman direct the Division of Government-wide Plans to

--require health plans to comply with the regulation which requires that an enrollee be provided a detailed explanation of why the plan denied a claim,

--rely on the plans' detailed explanations of the reasons for denials in lieu of FEP office reports,

--request the FEP office to provide records to CSC within 5 days of receipt from the local plans, and

--establish a standard which would require medical records advisors to review an average of at least 5 records every day.

In commenting informally on our draft report, the Director of CSC's Bureau of Retirement, Insurance, and Occupational Health said he generally agreed with our recommendations. Specifically, he said that

--CSC was already moving toward requiring plans, when appeals are received, to provide enrollees with detailed explanations of why claims had been denied;

--the division's reliance on the plans' detailed explanations in lieu of FEP office reports would be a workable method of operation;

--the recommended requirement that the FEP office provide records to CSC within 5 days after the FEP office had received them was a reasonable goal; and

--the medical records advisors should be subject to a standard of output. The exact requirements, however, cannot be established until his office fully examines the work required of the individual medical records advisors.

The responsible FEP office official said he believed our recommendations were reasonable and practicable.

CHAPTER 3

MEDICAL APPROPRIATENESS OF CIVIL SERVICE COMMISSION CLAIMS REVIEWS

In an effort to determine whether CSC's reviews of disputed health benefit claims were--from a medical viewpoint--sufficiently comprehensive, our medical advisor reviewed 120 disputed claim cases. The 120 cases reviewed included 23 cases in the Employee Organization Plans Division and 42 cases in the Comprehensive Plans Division. In addition, a sample of 55 disputed cases was reviewed in the Division of Government-wide Plans. Our medical advisor also reviewed the available medical records used by the FEP office to resolve the disputed Blue Cross and Blue Shield claims. We believe that, in general, the divisions had acquired appropriate medical evidence, provided disputed claims with proper medical reviews, and rendered appropriate medical decisions.

In the Division of Government-wide Plans, however, our medical advisor identified 7 instances (13 percent of our sample of 55 cases) in which the division's review was not sufficiently comprehensive from a medical perspective and concluded that better medical reviews of 5 of these cases might have led CSC to instruct plans to provide some additional benefits.

Our medical advisor identified

--four instances where the division had reviewed only carrier reports when the reports themselves indicated the need, from a medical viewpoint, for a review of actual records associated with the cases, and

--five instances (including 2 cases also categorized above) which were reviewed only by the division's medical records advisors but which were of sufficient complexity to warrant referral to a physician.

The chief of CSC's Medical Division concurred with our medical advisor's findings and opinions regarding the 7 cases identified as not having received sufficiently comprehensive medical reviews.

ILLUSTRATIONS OF CASES NEEDING MORE COMPREHENSIVE MEDICAL REVIEWS

The Division of Government-wide Plans' goal is to review records in all medical cases. However, division officials, including the chief, maintained that there were not enough medical records advisors to achieve this goal. According to the senior CSC medical records advisor, the division's current practice is to review medical records on denied claims which involve private duty nursing, custodial care, 1/ concurrent care, 2/ and mental and nervous care. Additionally, the practice is generally not to review records for denied claims involving diagnostic admissions and impacted teeth. As stated on page 14, our review showed that CSC's staff of medical records advisors should be able to review records in all medical cases.

The following cases are illustrative of instances where the medical records associated with the disputed claims should have been reviewed by division medical records advisors to insure that CSC had conducted a comprehensive medical review of the claims.

--A claim for a 9-day hospital stay was denied because "hospitalization was not medically necessary," and the denial was upheld by CSC after a health benefits specialist (not a medical records advisor) had reviewed only the carrier's report. The patient was a 59-year-old male admitted for "impending delirium tremens." The carrier's report to CSC noted the patient had detoxified rapidly and had requested less medication early in his stay; further, the patient had not actually suffered from delirim tremens; and no specific treatments were rendered.

1/"Care primarily to provide room and board (with or without routine nursing care, training in personal hygiene and other forms of self-care) and supervisory care by a doctor for a person who is mentally or physically disabled and who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care, or when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced."

2/Concurrent care is care provided by more than one physician during a single hospital admission.

The carrier's report indicated to our medical advisor that the patient should have been admitted to the hospital since detoxification often requires an inpatient setting, though usually not for 9 days. Examination of the records associated with the case showed that the patient had never before been admitted for alcoholism, that he was admitted in a wheelchair, and that five drugs were administered to him. These facts, available in the records but not in the carrier's report, substantiated that the patient should have been admitted. Additionally, the records attributed the patient's request for less medication to his fear of addiction, another pertinent fact which was not disclosed in the report. Our medical advisor believes that the medications prescribed for the patient may have prevented him from experiencing delirium tremens. The names of the 5 drugs were not given in the carrier's report to CSC and no such assessment could have been made from the report.

--A claim for a 29-day psychiatric hospital stay was denied because the plan determined that none of the services rendered required an overnight hospital bedpatient setting. A CSC medical records advisor reviewed only the carrier's report and upheld the plan's determination. The report noted, however, that the patient had undergone three severely traumatic experiences and had been released from a psychiatric unit only a week before this admission.

Our medical advisor said that the carrier report suggested the possibility of a suicidal patient and did not demonstrate that the patient should not have been admitted. We believe that the medical records in this case should have been reviewed to determine if, in fact, the patient was possibly suicidal and might have required some time in the hospital. A review of the records confirmed that the patient was possibly suicidal and that the patient should have been admitted.

Division officials told us that since CSC's disputed claim review process was instituted in late 1975, the division had referred only about 35 disputed claims cases to physicians because of the time and expense involved and the difficulty of getting useful physician input to resolve specific disputed items in the claims. Following

are two illustrations of instances where we believe a physician should have been involved in the review process.

--A claim for a 6-day hospital stay was denied by a plan on the grounds that the patient did not require an overnight hospital bedpatient setting. The CSC medical records advisor reviewed both the carrier's report and the case records, and CSC upheld the plan's denial. The records showed an acutely ill 61-year-old female admitted with several complaints. The records also showed that a plan physician had once urged the claim be paid, and our medical advisor believed that this factor indicated a complex case which should have been referred to a physician for review.

--A claim for a 7-day hospital stay was denied by a plan because the treatments and medications provided to the patient did not require an acute hospital bedpatient setting. The CSC medical records advisor reviewed both the report and the medical records. The 52-year-old male patient had been admitted because of severe chest pain. Given the suspected heart attack and the patient's age, our medical advisor concluded that (1) a physician's judgment would be necessary before denying the claim in full and (2) the patient was appropriately admitted.

CONCLUSIONS

With only a few exceptions, CSC acquired appropriate medical information to review disputed claim cases. The divisions usually gave the cases proper medical review.

The Division of Government-wide Plans, however, could improve its reviews of claims which involve medical questions. Review by the division's medical records advisors of medical records in all disputed cases involving medical questions would not only insure the division's compliance with the regulations but would also be appropriate from a medical viewpoint. The implementation of the recommendation on page 15 of this report should produce this result.

We believe that there should be increased involvement of physicians in the division's disputed claims review process. In our opinion, such increased physician involvement should include having CSC's Medical Division periodically review samples of the division's decisions

on cases involving medical judgments to insure that complex cases are receiving the proper level of attention within CSC.

RECOMMENDATION TO THE CHAIRMAN, CSC

CSC should require its Medical Division to evaluate the decisions made on disputed medical claims involving the Government-wide Plans. The Medical Division should periodically review samples of such cases to insure that complex medical claims are receiving proper CSC attention.

The Director of CSC's Bureau of Retirement, Insurance, and Occupational Health concurred with the recommendation and said that he intended to establish a process for quality control of CSC decisions made on disputed claims involving medical judgments.

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