REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

090061

Delays In Processing Medicare Part B Payments To Program Participants In Florida

Department of Health, Education, and Welfare

Although the carrier processed 94 percent of claims within 60 days, thousands of Floridians encountered long delays in getting claims processed--237,000 claims took over 60 days to process and 104,000 of these took over 90 days.

GAO believes that the fundamental reason for delays in processing has been a lack of attention by management to achieving satisfactory resolutions of those claims which could not be routinely processed.

MWD-76-94 090061 907305 MARCH 19, 1976

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

B-1640313(4)

The Honorable Lawton Chiles
United States Senate

Dear Senator Chiles:

This is our report on delays in Blue Shield of Florida's processing of payments under Medicare Part B in response to your request and subsequent discussions with your office.

As requested, we have not obtained written comments on this report from the Department of Health, Education, and Welfare or from Blue Shield of Florida. We did, however, discuss our findings with representatives of both of those organizations and their comments have been incorporated in the report as appropriate.

We also received a request from Congressman C. W. Bill Young for a review of delays in processing Medicare Part B payments in Florida. Therefore, we are providing a report to Congressman Young. In addition, a number of other members of the Florida delegation have written to endorse Congressman Young's request and we are providing a copy of the report to each of them.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

BHI	Bureau of Health Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO THE HONORABLE LAWTON CHILES UNITED STATES SENATE

DELAYS IN PROCESSING MEDICARE PART B PAYMENTS TO PROGRAM PARTICIPANTS IN FLORIDA

D I G E S T

Blue Shield of Florida processed nearly 4 million claims in 1974. Processing time averaged 22 days. However, thousands of participants experienced long delays in getting their claims processed--237,000 claims took over 60 days and 104,000 of these took over 90 days. (See pp. 5 and 7.)

In 1974 Blue Shield processed over 70,000 requests for informal review of the determinations made in the initial processing of claims and had over 1,000 formal hearings requested by claimants who were dissatisfied with the results of both the initial determination and the informal review. Most of the informal reviews and about 30 percent of the hearings resulted in additional payments to the claimants. Based on samples of requests being processed during 1975, the informal review process averaged 50 to 60 days and the hearing process averaged 146 days. (See pp. 18 to 24.)

GAO believes that the fundamental cause of processing delays has been a lack of management attention to resolving claims which cannot be routinely processed. (See pp. 24 to 29.)

There were a number of systemic problems in processing nonroutine claims, including

--a lack of control over claims in process to assure timely processing of the more difficult ones,

--a failure to react to persistent backlogs in the organizational units responsible for processing nonroutine claims and requests for informal review, and

--a cumbersome and inefficient document flow.

GAO suggested specific procedures and controls to better insure that

--claims which have been onhand for longer than a prescribed period are identified and processed, and section managers are held accountable for the prompt processing of such claims (see p. 25);

--backlogs are identified and reacted to daily (see p. 26); and

--the physical handling of documents is improved (see p. 28).

Blue Shield officials were generally receptive to GAO's suggestions, agreeing to adopt some and conduct studies to determine the feasibility of others. (See pp. 24 to 29.)

CHAPTER 1

INTRODUCTION

We reviewed the time required to pay claims under Part B of Medicare in Florida in response to requests from Congressman C. W. Bill Young and Senator Lawton Chiles, dated November 26, 1974, and January 9, 1975, respectively. In addition, 10 members of the Florida delegation in the House of Representatives endorsed Congressman Young's request.

On June 13, 1975, we presented an interim report to the Senate Subcommittee on Federal Spending Practices, Efficiency, and Open Government, Committee on Government Operations.

THE MEDICARE PROGRAM

Title XVIII of the Social Security Act (42 U.S.C. 1395) established the Medicare program effective July 1, 1966, to help finance health care for eligible persons age 65 and over. The Social Security Amendments of 1972 (86 Stat. 1329) extended Medicare protection, effective July 1, 1973, to persons under 65 who have been receiving social security or railroad retirement disability benefits for at least 24 consecutive months and to certain individuals with chronic kidney disease.

The Medicare program provides two basic forms of health care protection. One form of protection, Hospital Insurance Benefits for the Aged and Disabled (Part A), covers inpatient hospital services and posthospital care in skilled nursing facilities and in patients' homes. Part A benefits are generally financed by special social security taxes collected from employees, employers, and self-employed persons.

A second form of Medicare protection, Supplementary Medical Insurance Benefits for the Aged and Disabled (Part B), is a voluntary program which covers physicians' services and a number of other medical and health benefits, including outpatient hospital services and certain home health care. Part B is financed by premiums collected from eligible beneficiaries who elect to be covered by the program and by amounts appropriated from Federal Government revenues.

Under Part B the beneficiary is usually responsible for paying the first $60 for covered medical services in each year (the deductible). Medicare pays 80 percent of the reasonable charges for covered services in excess of the deductible and the beneficiary is responsible for the remaining 20 percent (coinsurance).

The Department of Health, Education, and Welfare (HEW) through the Bureau of Health Insurance (BHI) of the Social Security Administration (SSA) administers the Medicare program. Section 1842(a) of the Social Security Act authorizes the Secretary, HEW, to enter into agreements with public and private organizations and agencies to act as Medicare Part B carriers in administering the Medicare program. These carriers are responsible for receiving, processing, and paying claims submitted for Medicare Part B benefits.

HEW has contracts with about 50 Medicare Part B carriers. SSA reimburses carriers for the amount of benefits paid plus their administrative expenses. In 1974 the carriers processed about 74 million claims, paid benefits totaling about $2.76 billion, and were reimbursed about $239 million for administrative expenses. Appendix I shows the volume of claims processed in 1974 by the 10 largest Medicare Part B carriers and the average claim processing time reported by those carriers.

Section 1842(b)(3)(C) of the act [42 U.S.C. 1395 u(b)(3)(C)] provides that a carrier shall establish and maintain procedures under which individuals enrolled under Medicare Part B shall be provided an opportunity for a review (reconsideration) and a fair hearing if they are dissatisfied with the carrier's denial of a request for payment or with the amount of payment, or if they believe the carrier has not acted with reasonable promptness. Regulations issued by the Secretary, HEW, make these provisions applicable also to physicians and other persons who furnish items or services to enrollees and state, regarding the "reasonable promptness" provision of the act, that it will be deemed unreasonable if the request for payment has not been acted upon within 60 days after its receipt by the carrier.

The regulations provide a two-step process for appealing a carrier's initial determination--first, an informal review by the carrier of the evidence of record, including any additional information submitted by the claimant and second, a fair hearing before a hearing officer designated by the carrier. Hearings are to be held at

a time and place reasonably convenient to the requesting party. The hearing officer is to inquire fully into the disputed matters and receive in evidence the testimony of witnesses and any relevant documents. The decision of the hearing officer regarding amounts of benefits is final and binding.

MEDICARE PART B IN FLORIDA

From inception of the program in 1966 through June 30, 1975, Blue Shield of Florida was the Medicare Part B carrier for the entire State. Effective July 1, 1975, BHI contracted a second carrier to service Dade and Monroe counties, which represented about 30 percent of the Medicare Part B claims processed by Blue Shield of Florida in 1974.

In 1974 Blue Shield of Florida received 4.1 million claims, processed 3.9 million claims, paid $194.4 million in benefits, and was reimbursed $15.3 million for administrative costs.

In 1974 Florida ranked eighth in the Nation in population, but fourth in the number of Medicare Part B claims processed. This disparity results from the large number of elderly persons living in Florida--18 percent of the State's population is age 65 and over as compared to 10 percent nationwide--and the annual influx of large numbers of elderly tourists. Medicare requires that beneficiaries submit claims to the carrier for the area in which medical expenses are incurred, even though that may not be the area in which they reside.

These factors have affected the Medicare Part B workload of Blue Shield of Florida in two ways. First, the number of claims has dramatically increased--nearly doubling from 2,127,450 in 1970 to 4,130,628 in 1974. Second, there is a large seasonal variation in the number of claims received--varying in 1974 from a low of 258,821 in September to a high of 507,042 in December.

SCOPE OF REVIEW

Our review was conducted at SSA headquarters in Baltimore, Maryland; the SSA regional office in Atlanta, Georgia; and the offices of Blue Shield of Florida in Jacksonville. We also visited the offices of Congressman Young and Senator Chiles, located in St. Petersburg and Lakeland, Florida, respectively, to obtain a better understanding of the nature of their constituents' complaints concerning claims payment by Blue Shield of Florida.

We reviewed laws, regulations, and guidelines pertaining to Medicare Part B; reports submitted to BHI by the carrier; and reports by BHI and outside consultants on their reviews of Blue Shield of Florida's management of the Medicare Part B program. We reviewed samples of claims processed to determine the time required to process Medicare Part B claims and to identify factors which adversely affect processing time. We also reviewed the processing of certain claims referred to us by Senator Chiles, Congressman Young, and other members of the Florida delegation.

We discussed our findings with officials of Blue Shield of Florida and BHI, but did not submit our report for their formal review and comment.

CHAPTER 2

TIME REQUIRED TO PROCESS CLAIMS TO INITIAL DETERMINATION

Blue Shield of Florida's reported average of 22.1 days to process claims to an initial determination was computed in accordance with BHI instructions applicable to all carriers. Although serious delays occurred in processing only a small percentage of total claims--94 percent were processed within 60 days--the number of claims encountering long delays involved thousands of people--236,613 claims took over 60 days to process, and 103,766 of these took over 90 days.

CLAIMS PROCESSING PROCEDURES

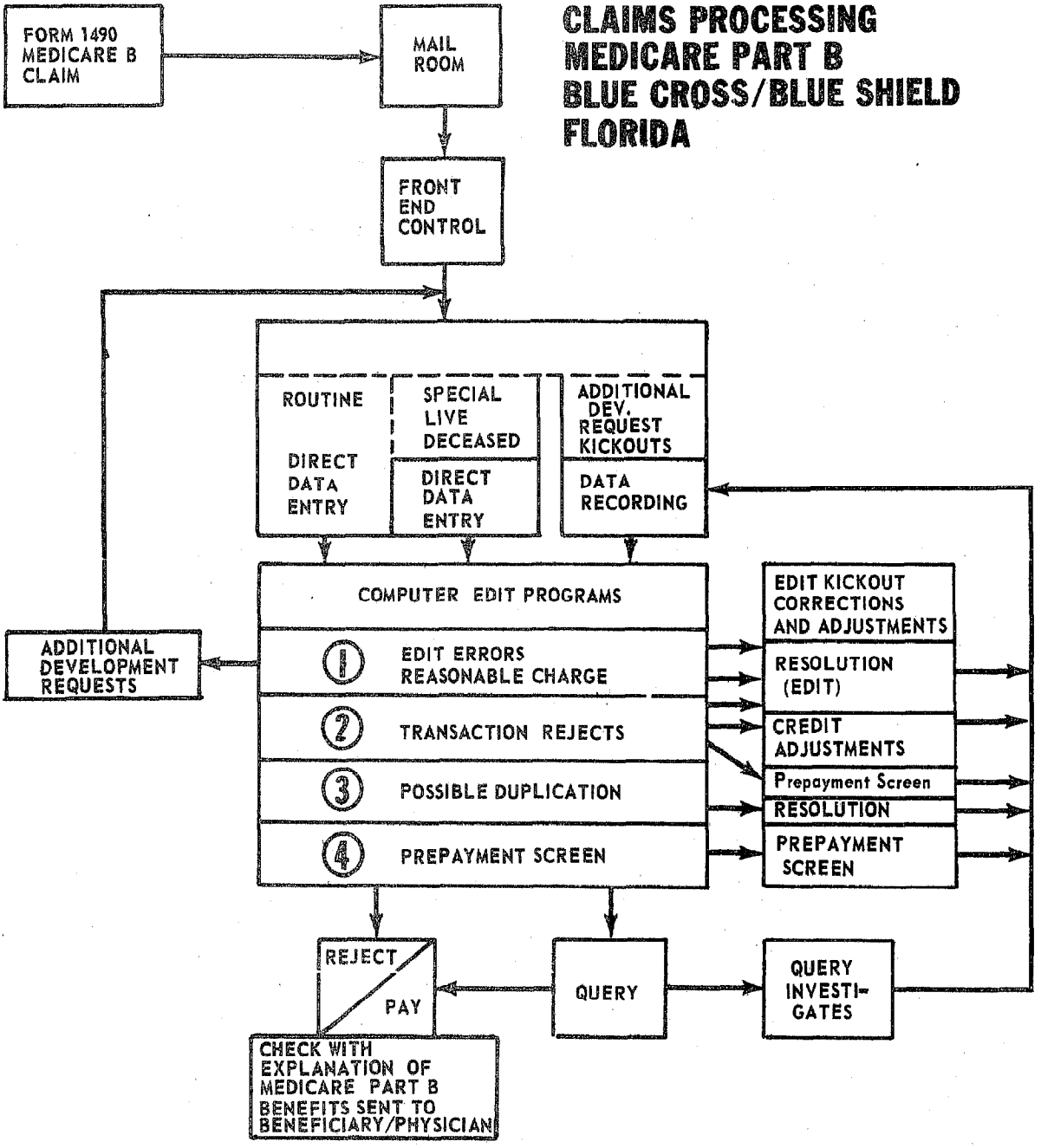
A chart depicting the flow of Medicare Part B claims is shown on page 6.

Upon receipt in the mailroom, claims are sorted and batched according to the type of claim. Each batch contains 50 similar claims--such as routine claims by physicians or other suppliers of health services (assigned claims), routine claims by beneficiaries (unassigned claims), claims for the cost of purchase or rental of durable medical equipment, or claims submitted on behalf of deceased beneficiaries. At the time of our review there were 18 categories of claims.

Front-end control involves stamping each claim form with a control number which includes the year, date, batch number, and number of that claim within the batch; microfilming the claim form and all attached documents to facilitate future reference to the claim; entering receipt of the claim in the computer control file to permit location of the claim in the processing cycle; and entering into the computer certain information from the claim which is then compared to information about the beneficiary already in the computer. The claims are then delivered to claims examiners who are responsible for the particular type of claim in each batch. About 80 percent of the claims go to the routine claims examining section; the remainder go to the special claims examining section. The claims examiners enter information from the claims into the computer.

If the claims examiner finds that some of the necessary information has not been submitted, the claim is

CLAIMS PROCESSING MEDICARE PART B BLUE CROSS/BLUE SHIELD FLORIDA



entered into the computer and sent to a separate group which obtains the additional information--either through telephone calls or through correspondence with the beneficiary or the provider.

Generally, all claims entered into the computer by 1 p.m. begin computer processing that day. Each claim is subject to several computer "screens," i.e., edit errors and reasonable charge, transaction rejects, possible duplication, and prepayment screens. If the claim fails to pass any one of the screens, it is held up until the question is resolved. (Computer screens are discussed in greater detail beginning on p. 11.)

When the computer screens have been passed, SSA records in Baltimore must be queried, for certain claims, to determine the beneficiary's eligibility or whether the deductible has been met. (Since beneficiaries might be filing claims with two or more carriers, information concerning charges incurred and applied against the deductible must be accumulated at a central location.) The Blue Shield of Florida beneficiary history files are searched initially to determine the claimant's deductible status. If the deductible has been met, the claim is released for payment; if not, the computer automatically queries the SSA beneficiary history file in Baltimore.

If the reply from Baltimore is other than an unqualified approval, the carrier must investigate any problems, correct them, and pay or reject the claim. The most common problem is that the Health Insurance Benefits number and the beneficiary's surname do not match.

After the claim has been fully developed, all computer screens satisfied, and the necessary information obtained from Baltimore, an Explanation of Medicare Benefits form and a payment check (if appropriate) are mailed to the claimant.

REPORTED PROCESSING TIME

Blue Shield of Florida reported to BHI that in 1974 it processed 3,858,535 Medicare Part B claims--80 percent were processed in 30 days or less, 14 percent in 31 to 60 days, 3 percent in 61 to 90 days, and 3 percent in more than 90 days. The average processing time reported was 22.1 days.

Fifty-nine percent of the claims were unassigned--that is, the claims were submitted by Medicare beneficiaries; 35 percent were assigned claims submitted by providers; and 6 percent were for the services of hospital-based physicians.

Using information in monthly reports prepared by the carrier, we computed the average processing time for each of these types of claims.

Claims for hospital-based physicians were processed in an average of 12.5 days, faster than the other two types. The average monthly processing time fluctuated from 9 to 16 days.

Assigned claims took a little longer, averaging 17.8 days. The average monthly processing time ranged from 11 to 26 days.

Unassigned claims had the longest average processing time, averaging 25.6 days with a monthly range of 17.5 to 37 days.

VERIFICATION OF REPORTED PROCESSING TIME

The processing time reported to BHI by Blue Shield of Florida was computed based on the number of days between the date incorporated into the claim's control number and the date of the check and/or the Explanation of Medicare Benefits form issued at completion of the processing cycle. This is in accordance with SSA instructions applicable to all carriers.

Claims normally remain in the carrier's office for some time before the control number is assigned and some time elapses between preparation of checks and Explanation of Medicare Benefits forms and their distribution to claimants.

To get a measure of the length of time between receipt of claims and assignment of control numbers, we sampled 224 claims as they were received in the mailroom during the period February 26 through March 11, 1975, and later determined the control numbers assigned to those claims. The period between the dates the claims were received and the dates they were assigned control numbers ranged from 0 to 14 days and averaged 2.3 days.

Blue Shield of Florida records showed that the period between the dates printed on benefit checks and the dates the checks actually left the carrier's office ranged from 1 to 15 days and averaged 4.5 days for all checks issued in 1974.

Thus, the average processing time of 22.1 days reported by Blue Shield of Florida understates by about 7 days the time between the carrier's actual receipt of a claim and the check's dispatch to the claimant.

We also noted that some claims distort the reported processing time because they are started through the cycle, removed, and then started again under a second claim number. The distortion results because the date in the second claim number is used in computing processing time, even though the claim may have been onhand for some time before this number was assigned to it.

Our verification of the processing time reported by Blue Shield of Florida was based upon analysis of a random sample of 1,961 Medicare Part B claims processed in 1974, extracted for us by the carrier's electronic data processing department. We are satisfied that the program used in extracting the sample produced a random sample, and Blue Shield of Florida officials agreed that the sample was representative of claims processed in 1974.

We verified that the cycle times on the computer printout of the claims in the sample represented the number of days elapsed between the date in the control number and the date on the check issued. In addition, we obtained the original copy of every 20th claim in the sample to verify that the control number, which is used in computing cycle time, was the same on both the claim and the printout.

AREAS WHERE DELAYS OCCUR

In our sample of 1,961 claims, 377 required over 30 days to process. To determine where and why the delays occurred, we selected half--or 189--of these claims for detailed analysis. We were unable to obtain sufficient data on three of the claims to permit meaningful analysis and three others had been delayed for extended periods at the direction of SSA. Because these extended periods distorted our sample, they were eliminated from our results. The 183 remaining claims took 9,925 days to process; an average of about 54 days. About 77 percent were processed in 31 to 60 days and an additional 16 percent were processed in 61 to 90 days.

Processing time was as follows:

--Thirty-five percent in "routine manual processing," which includes receiving, sorting, stamping, microfilming, examining, and entering the claim into the computer for further processing.

--Sixteen percent in "additional development," which involves obtaining from the beneficiary or the provider additional information required to properly process the claim.

--Six percent in "data processing" before being kicked out or paid.

--Twenty-eight percent in "edit kickouts" resulting from computer screens of such items as reasonable charges, possible duplicate charges, and accuracy of the data entered.

--Fifteen percent in "queries" of SSA central files to determine the beneficiary's eligibility and the status of the deductible.

We analyzed the processing time required for additional development and for edit kickout. We did not analyze time in routine manual processing because those procedures had recently been altered, nor did we analyze time in queries because processing time in this area generally is outside of the carrier's control.

Additional development

If a claim does not contain all the necessary information, SSA guidelines require that in most cases the carrier attempt to develop the needed information rather than return the claim. Blue Shield of Florida obtains the information by telephone when possible, but sometimes letters must be used.

In 1974 BHI reported that 19.4 percent of Medicare Part B claims handled by Blue Shield of Florida required additional information before they could be processed. This is almost double the national average of about 10 percent. In our sample of 183 claims, 69--or 38 percent--required additional information.

To determine the type of information being requested by the claims examiners, we reviewed these 69 cases plus

250 others which were being processed during our review and for which the claims examiners had needed 480 pieces of additional information.

The additional information requested in about 60 percent of these 480 instances was either an itemized breakdown of the services performed and the related charges, or a statement of the diagnosis of the medical condition which necessitated the services. The remaining requests involved any of 19 types of information, none of which occurred in more than 9 percent of the requests reviewed. The additional information requested appeared necessary for a proper determination of benefits.

For the 69 cases, it took an average of 23 days to obtain the additional information. However, 15 of the days elapsed before additional information was requested. We believe that a similar delay was still occurring during our fieldwork.

Edit kickouts

According to Blue Shield of Florida officials, about 35 to 40 percent of all claims processed kick out of the normal processing flow because they do not pass one or more of the computer screens or because additional information is needed.

Of the 183 claims we analyzed, 125--or 68 percent--were kicked out because they did not pass a computer screen. These claims were out of the processing cycle a total of 2,788 days because of this action. Forty-six percent of this time was associated with the edit error screen, 23.5 percent with the reasonable charge screen, 14 percent with the prepayment screen, 9 percent with the transaction reject screen, and 7.5 percent with the duplicate payment screen.

Edit error screen

The edit error screen compares the information which has been entered into the computer about a particular claim with certain rules of logic. For example, the date of service for which the claim is being made must precede the date on which the claim entered the process or the amount of the physician's charge must be shown in numerals rather than letters. There are nearly 100 reasons why a claim might be kicked out for edit errors.

About 12.5 percent of all claims processed kick out as a result of the edit error screen. We reviewed 225 kickouts which had been corrected and reentered into the

computer on June 3, 1975, and found that they had been out of the processing cycle an average of about 10 days.

Our analysis of the classification of 320,575 edit errors, which caused 220,299 claims to be kicked out from April 14 to May 30, 1975, showed that 57 percent were attributed to errors made by Blue Shield of Florida personnel.

BHI reports, based on samples of claims processed each week to identify errors which remain undetected at completion of the processing cycle, show that Blue Shield of Florida's error rate is among the highest of all carriers.

We believe that Blue Shield of Florida's high error rate resulted, at least in part, from its high personnel turnover rate. During 1974 Blue Cross and Blue Shield of Florida had a 48.4-percent turnover rate. The organizational elements directly associated with Medicare Part B had a 65.1-percent rate and, in the Medicare Part B claims examining sections, the turnover rate was 77 percent.

One apparent cause of the high attrition of Medicare Part B claims examiners was that they were paid less than claims examiners in other parts of the carrier's organization. In May 1975, the classification of Medicare Part B examiners was raised to correspond with that of other claims examiners. At the completion of our fieldwork, it was too early to tell whether this change would decrease the turnover rate.

Reasonable charge screen

The reasonable charge screen kicks out claims when there is a significant difference between the allowable charge for a service and the physician's charge for that service as entered into the computer. For example, before May 1, 1975, if the amount charged by the physician exceeded the allowable charge by 75 percent or more, the claim would be kicked out for manual verification of the amount entered into the computer.

Our analysis of the reasonable charge kickouts indicated that by raising the screen from 75 to 125 percent of the allowable charge, the number of kickouts could be reduced by about 50 percent and still permit detection of 80 percent of the errors presently being detected. The carrier's edit department had made a similar analysis and had drawn similar conclusions.

As a result of our joint recommendation to program management, the reasonable charge screen was raised to 125 percent of the allowable charge on May 1, 1975. Before the change, about 20,000 of the 45,000 claims kicked out each week were for reasonable charge. During the week ended May 8, 1975, total reasonable charge kickouts were reduced from 20,597 to 11,353. This change should reduce total kickouts by about 20 percent. BHI agrees the advantages of the change will outweigh the disadvantages of increased errors in payments that may result because of fewer kickouts.

Prepayment screen

The prepayment screen kicks out claims which would result in the claimant's exceeding certain limits which have been established to indicate possible overuse of the program. Examples of such limits would be 24 office visits or 26 chiropractic treatments in a year.

Reviews associated with prepayment screen kickouts appear necessary to insure the program's integrity. Claims disallowed as a result of such reviews totaled about $3 million in 1974 and about $750,000 in the first quarter of 1975. However, the claims in our sample which were kicked out by the prepayment screen were out of the process an average of about 33 days.

We examined a sample of claims kicked out by the prepayment screen in March and April 1975. In terms of processing time, these claims fall into three groups: "fast screened" claims which can be resolved rather simply by reference to a few, readily available documents; "routinely screened" claims which require more documentation and review to arrive at a determination; and claims for chiropractic services.

The fast screened claims in our sample were out of the processing cycle about 11 days. The routinely screened claims were out about 38 days, 10 days of which were spent awaiting a microfilm copy of the original claim and 21 days in writing up the case and obtaining review by a consultant physician. The overall average for both fast screened and routinely screened claims was about 23 days.

About 8 percent of all prepayment screen kickouts relate to claims for chiropractic services. These claims are out of the cycle significantly longer than other claims kicked out by the prepayment screen. Substantiating evidence and X-rays proving the necessity of chiropractic services must be obtained before the package is forwarded

to a consultant chiropractor in Jupiter, Florida, through the Blue Shield Office in Fort Lauderdale by way of two courier runs. After the consultant's determination, the claims are returned by the same route. An average of about 54 days was required to process these claims.

One obvious way to speed up the determination of chiropractic claims would be to hire a more conveniently located consultant chiropractor.

Transaction reject screen

The transaction reject screen kicks out claims for which information entered in the computer differs from information already in the computer files about the beneficiary, as well as claims from those few beneficiaries (1,646 at the time of our review) who have been identified as overusing the program. These latter kickouts are called "beneficiary flags."

In our sample of 183 claims which took longer than 30 cays to process, 10 were kicked out by the transaction reject screen. Seven of these were beneficiary flags. The other three claims kicked out for three different reasons. Thus, we limited our analysis of transaction screen kickouts to beneficiary flags.

We believe that beneficiary flags are necessary to insure the program's integrity. The beneficiary flags in our sample were out of the processing cycle an average of about 27 days.

We examined a further sample of beneficiary flags kicked out in March and April 1975. These claims fell into two groups: so-called quick release cases in which a clerk could make a determination regarding overuse and those which required review by a consultant physician. The quick release cases were out of the processing cycle for an average of about 33 days. At the time of our sample, the consultant physicians had not reviewed any beneficiary flag cases for over a week so we could not determine processing time for the more complicated claims.

Duplicate charge screen

When information in a line item of a claim being processed matches information relating to a service previously allowed and paid for, the claim is kicked out by the duplicate charge screen to permit a determination as to whether the line item in question is a duplicate charge. Carrier personnel told us that about 35 percent of such kickouts occur because only the last two digits of the procedure code differ from those of the code for a service previously allowed and

that in almost 99 percent of these cases, the item in question is a duplicate charge and payment is denied.

We suggested to carrier officials that the computer program be revised to automatically deny payment when all items match except the last two digits of the procedure code. Such a change should reduce the number of duplicate charge kickouts by about 35 percent without materially changing the number of erroneous rejections. Carrier officials advised us that this change was made effective June 2, 1975.

CASES REFERRED BY MEMBERS OF THE FLORIDA DELEGATION

Several members of the Florida congressional delegation provided us with examples of complaints they had received from Medicare Part B beneficiaries throughout the State. Although time did not permit an indepth analysis of each case, we did review 12 cases, involving 19 claims, which related to the time required to process claims to an initial determination.

Seven of the 19 claims--which had been delayed from 90 to 182 days--involved payments for chiropractic services. Claims for chiropractic services were suspended from processing from October 28, 1974, to December 16, 1974, by direction of Blue Shield of Florida's board of directors. Furthermore, it appears, based upon the dates of receipt of the claims reviewed, that a processing slowup of this type of claim began in July 1974. This slowup and ultimate suspension of processing caused a substantial backlog of chiropractic claims being carried into 1975 and in protracted delays in payments to thousands of beneficiaries.

Blue Shield of Florida attributes the suspension to a lack of sufficient guidance from SSA concerning the definition of a subluxation, the only chiropractic procedure for which Medicare benefits are allowed. Also the carrier was reluctant to hire a consultant chiropractor because of positions stated by both the American Medical Association and the Florida Medical Association to the effect that willing professional association of doctors of medicine with chiropractors was unethical.

Six of the 19 claims were delayed for long periods awaiting development of additional information. One of these stayed in the additional development section for 90 days, apparently because the telephone operators were on a quota system but didn't receive credit for these claims.

Carrier officials told us that the quota system was revised to give credit for such claims. Five of the six claims stayed in the additional development section over 45 days.

In another case, the claimant appealed to his Congressman in early February 1975 when in fact the carrier had not received the claim until January 15, 1975. This claim was paid on May 19, 1975--requiring 124 days to process. This was a fairly complex claim, but we could not tell from the records why it took so long to process. The claim was in the special claims examining section until April 3, when it was sent to the additional development section. It was returned to special claims examining on April 29, entered into the computer on May 1, and kicked out on the same date by the edit error screen.

One of the 19 claims took over 9 months to process. This claim was in special claims examining from late May 1974 to early February 1975, with no indication of why it was there so long. Personnel of the section speculated that it had been lost or misfiled. The claimant had telephoned Blue Shield of Florida twice but apparently no action was taken to resolve the claim until a Congressman interceded on her behalf. The claim was paid 1 month after receipt of the Congressman's letter. Another case took over 7 months to process because Blue Shield of Florida could not obtain the necessary additional information. The carrier requested the information four times but apparently only the last request reached the provider.

One case involved four claims, two of which were for chiropractic services which required 143 and 137 days to process. The remaining two claims were processed in 34 and 15 days.

One case involved two claims which the beneficiary said had been submitted in July 1974 and for which she had not been paid as of January 1975. However, one of these claims was rejected because it was for noncovered services and the beneficiary had been so notified in October 1974. The other claim was for chiropractic services. It was paid February 7, 1975, after being subjected to the previously discussed slowup and suspension of chiropractic claims. This claim required additional development and was kicked out by the prepayment screen because the claimant had claimed reimbursement for 35 chiropractic visits between August 1973 and June 1974.

During our review we examined data sheets which displayed the claims histories of most of the beneficiaries

involved in the 12 cases. In 1 case, the beneficiary had submitted 24 claims over a 15-month period, and the great majority of these had been paid within 15 to 30 days. This fact was not mentioned in the beneficiary's letter to the Congressman.

Another beneficiary failed to mention in his complaint that Blue Shield of Florida had processed 15 claims for him during the past 15 months and that most were paid within 15 to 30 days.

CHAPTER 3

TIME REQUIRED TO PROCESS APPEALS OF INITIAL DETERMINATIONS

Blue Shield of Florida does not record the time required to process appeals of initial determinations. We could not determine average processing time for all the types of informal reviews conducted by the carrier, but we did determine average processing time for samples of two types of informal reviews and of fair hearings. One type of informal review which included, among other things, appeals involving clerical errors in the initial determination, was in-house an average of 49.3 days before the appeal was resolved. The other type of informal review, which required medical determinations, took an average of 59.3 days. Fair hearings took an average of 146 days.

APPEALS PROCESSING PROCEDURES

The carrier considers any written inquiry concerning an initial determination as a request for an informal review.

All such requests are routed initially to the Medicare Part B correspondence section, where they are reviewed to determine the basis for the appeal and whether additional information is required for a proper response. If additional information is required, the correspondence section initiates action to obtain it and holds the request until it is received.

Requests pertaining to claims denied because the services were not covered by Medicare and on which no new evidence is presented are assigned to individual correspondence clerks for response. Other requests are forwarded to the reprocessing section, the credit adjustment section, or the medical review section.

The reprocessing section handles requests for informal reviews involving

--claims on which the allowable charge was less than the actual charge,

--claims on which clerical errors were made in initial processing, or

--claims on which new evidence has been presented.

The credit adjustment section handles requests for informal reviews involving claims which were partially or entirely denied because the claimant was not covered by Medicare Part B.

The medical review section handles requests for informal review of

--claims which were reduced after medical review,

--claims which were denied after medical review because the charge was for a noncovered service,

--claims which were denied because the charge should have been included in the basic charge for another service,

--claims which were reduced or denied because of multiple surgery, and

--any claim which requires medical consultation.

Medical review clerks initially review all requests referred to the section and make the determination in those cases which can be resolved on the basis of the information of record without further medical opinion. All other requests are referred to consultant physicians for further medical review.

Upon receipt of a request for a fair hearing, personnel of the fair hearing section obtain the case file prepared during the informal review. (An informal review is a prerequisite to a fair hearing.) Once they have determined that the claimant is entitled to a fair hearing, they send an acknowledgement letter to the claimant specifying the various alternative methods available for handling the hearing.

While awaiting the claimant's response, the carrier begins gathering the data necessary to evaluate the case, prepares the necessary summary sheets, and prepares the case rationale for the hearing officer. The case is then turned over to a medical consultant who reviews the rationale and, if he agrees, the case is forwarded to the hearing officer.

A hearing is scheduled for a time and place convenient to the claimant. In the hearing, the claimant is given the opportunity to offer oral and written evidence, to examine and reply to evidence relied upon by the carrier

as the basis for its action, and to present and examine witnesses. The rules of evidence established for the hearing procedure offer sufficient flexibility so that all relevant and material evidence can be considered without regard to its admissibility under the rules of evidence applicable to court proceedings.

After a hearing, the hearing officer prepares a decision, which contains a statement of the issues, a statement of the evidence, a statement of rationale, specific findings of fact, and a conclusion. The carrier mails a copy of the decision to each party to the hearing and, if the decision was favorable to the claimant, additional payment is processed on his behalf.

TIME REQUIRED FOR INFORMAL REVIEWS

We took samples of requests for informal reviews which were received in the reprocessing section and in the medical review section during the time of our fieldwork. It was not feasible to sample the types of requests handled in the correspondence and credit adjustment sections.

Reprocessing

Blue Shield of Florida reprocessed 35,284 claims during 1974. Of these, 23,960, or 68 percent, were revised in favor of the claimant and an additional $484,485 in benefits was paid out. Based on these figures, the average revision was about $20; however, a number of small dollar value revisions during the third quarter distorted the average. Normal revisions average about $48.

A Blue Shield of Florida official informed us that assignments of responsibility for reprocessing were revised during 1974. Reprocessing was initially performed by correspondence section personnel but, in May 1974, the function was transferred to the special claims examining section because of lack of employees in the correspondence section. In November 1974, Blue Shield of Florida transferred the reprocessing function to the editing section because the workload was too large to be handled by the special claims examining section. We were told that there was a 3-month backlog at the time of the latter transfer. As of December 29, 1974, there was a backlog of 15,288 claims in the reprocessing section.

Representatives of the National Association of Blue Shield Plans noted this situation during a January 1975 survey of Blue Shield of Florida's Medicare Part B

operation. They reported a 4-week backlog of claims awaiting initial determination and a 10-week backlog in reprocessing. The team recommended that Blue Shield of Florida assign a task force of claims examiners to eliminate the reprocessing backlog. In February, Blue Shield of Florida, acting on the team's recommendation, assigned 14 employees to reprocessing and reduced the backlog of claims from over 15,000 to about 7,000 by March 3, 1975.

Our analysis of the backlogs in the various functional areas each week during the first 6 months of 1975 showed that throughout the entire period reprocessing had a tremendous backlog as compared with other areas. (See p. 26.) The analysis also showed that the backlog, in terms of production during the 6-month period, was reduced from 55 workdays around the first of February to 13 workdays around the first of March. However, by early July 1975 the backlog in reprocessing had risen to over 30 workdays.

To determine the delays being experienced by beneficiaries in getting their claims reprocessed, we sampled 120 requests for review which had arrived at the carrier's office during April 1975. By July 17, 1975, 116 of the requests had been completed, with an average of 49.3 days being required to reprocess each request. However, the requests had been in the carrier's office an average of 23.2 days before they were sent to reprocessing.

Medical review

Blue Shield of Florida quarterly reports show that 35,063 requests for informal review were processed by the medical review section during 1974. Of these requests, 17,071 resulted in partial or complete reversals in favor of the claimant and $1,283,120 in additional benefits were paid.

A total of 5,845 requests for review were pending at the end of the year. Based on the indicated productivity of about 675 requests a week, the medical review section had an 8-½-week backlog at the end of 1974.

To determine a current cycle time for appeals processed by the medical review section, we sampled medical reviews completed during July 1975. An average of 47.7 days elapsed from the time the medical review section received the requests until the decision letters were written to the beneficiaries. (Personnel of the medical review section conducted a similar sampling of reviews completed between July 3 and July 10, 1975, and arrived at an average

cycle time of 46.1 days.) The requests in our sample had been in-house from 1 to 75 days, or an average of 11.6 days, before arriving at the medical review section. Thus, an average of 59.3 days elapsed between the carrier's receipt of the request for informal review and resolution of the request.

Credit adjustment

A Blue Shield of Florida official stated that records were not maintained on the number of claims originally denied because of nonentitlement and subsequently reviewed by the credit adjustment section. However, she estimated that each week the credit adjustment section received about 200 requests pertaining to claims which had been partially or entirely denied because of nonentitlement. She further stated that when the claims are reexamined, it is found that in most cases the beneficiaries are entitled to the amounts claimed.

Because of insufficient documentation we did not attempt to determine the length of time required to adjust claims of this type; however, we were informed that 2 to 4 weeks are required to obtain a response from SSA concerning the correct date of a beneficiary's entitlement.

TIME REQUIRED FOR FAIR HEARINGS

Blue Shield of Florida reported that it held 1,038 fair hearings during 1974. There were 478 fair hearings pending at the beginning of the year, 1,877 requests were received during the year, and 1,317 fair hearings pending at the end of the year. Based on the indicated productivity of about 20 hearings a week, the fair hearing section had a 66-week backlog at the end of 1974.

Blue Shield of Florida officials said that two factors adversely affected completion of fair hearings during 1974. During the late spring, all employees in the fair hearing section had either quit or transferred to other sections, with a resultant lag in training replacements. Second, the personnel who prepare cases for fair hearings also prepare cases for peer review, and in late summer of 1974 there was a large backlog of peer review cases (799 cases representing 17 physicians).

We examined all the fair hearings decisions issued during June 1975. The 28 cases for which we could obtain valid data took an average of 146 days--ranging from 49

to 350 days--between the date of receipt of the request for a fair hearing and the date of the hearing officer's decision.

The total time these claims had been in the offices of Blue Shield of Florida--from receipt of the initial claim, through informal review, to issuance of a decision at the conclusion of a fair hearing--averaged 334 days, from a low of 147 days to a high of 624 days. The initial determination took an average of 66 days--from 11 to 195 days--and the informal review took an average of 122 days--from 23 to 295 days.

CHAPTER 4

CAUSES OF DELAY

We believe that the fundamental cause of delay in processing Medicare Part B claims by Blue Shield of Florida has been a lack of attention by management to obtaining a satisfactory resolution of those claims which cannot be routinely processed. Management's attention has been focused on routine claims, apparently because claims requiring longer than 60 days to process represent a relatively small percentage of total claims processed.

We do not suggest that management's attention to processing the mass of claims be lessened. However, the carrier's management should devote greater attention to the problem cases--the quarter of a million claims that took longer than 60 days to process in 1974 and the 70,000 requests for review of initial determinations.

Related to--and essentially a part of--the lack of management attention are a number of systemic problems in the processing of nonroutine claims. These problems include insufficient control over claims in process to assure timely processing of the more difficult claims, a failure to react to persistent backlogs in the organizational units responsible for processing nonroutine claims and requests for informal review, and a cumbersome, inefficient document flow.

LACK OF CONTROL OVER CLAIMS

Blue Shield of Florida had no system for insuring that claims were processed on a first in-first out basis. This, coupled with the use of production quotas, was conducive to the more complicated claims becoming "lost" in the system. There was no system for informing section managers of those claims which had been in their sections for an overly long time and no accountability of section managers for the processing of such claims.

In early 1974 the carrier developed an aged claim report which listed the Medicare Part B claims inventory by location. Processing time frames were established for each section, based on volume and average processing time required for that section, and all claims exceeding the established time frames were printed out weekly. A small centralized group of control analysts attempted to determine the cause of delays in processing the listed claims, but

for a number of reasons, including insufficient personnel, their success was limited.

Suggestions to the carrier

We suggested to the carrier that two aged claim reports be prepared weekly--one listing claims which have been in-house for longer than a prescribed length of time and one listing claims which have been in a particular section for longer than a normal time. We suggested that the claims on the first list continue to be searched out and reviewed by the centralized control analyst staff and that the second list be provided to section managers. We further suggested that section managers be required to report weekly on their success in processing the listed claims.

As a final way to insure that claims flow smoothly through the processing cycle, we suggested that steps be taken to insure that departments process the oldest claims first and move the claims along without regard to the backlog in the next department.

Carrier's response

After our suggestion, Blue Shield of Florida began using a new aged claim report which identifies all claims in-house over 50 days and their current location in the process. Section managers are responsible for clearing up the lists with assistance from the control analyst staff as needed. Carrier officials said that the first report contained over 60,000 claims. They said that such a large number of claims could not be cleared in one week, but that their goal was to clear the list each week.

The new aged claim report should improve control over claims. However, control would be further improved if the carrier implements our suggestion for providing section managers with aged claim reports showing claims that have been in a particular section for an undue length of time.

NEED TO MONITOR AND REACT TO BACKLOGS

The carrier has permitted substantial backlogs to persist for long periods in those sections involved in the processing of other than routine claims. Although top Medicare Part B management received a daily report showing the number of claims received, worked, and pending in each section, we saw little indication that they acted on this

information. The report showed neither the productive capacity of the various sections nor the backlog of claims in terms of number of workdays in each section.

Using the daily reports for 25 weeks during the first 6 months of 1975, we computed average backlogs in terms of workdays for various sections. A summary of our findings follows:

Section	Number of weeks backlog was 5 days or less	6-10 days	11-15 days	16-20 days	Over 20 days
Additional development:					
Telephone requests	11	14	0	0	0
Written requests	19	6	0	0	0
Routine claims:					
Assigned	25	0	0	0	0
Unassigned	25	0	0	0	0
Special claims	0	18	7	0	0
Edit sections 1 and 3 (note a)	2	22	1	0	0
Edit section (note a)	5	19	1	0	0
Microfilm retrieval	21	4	0	0	0
Reprocessing	0	0	11	3	11

[a]The edit sections handle claims kicked out by the computer screens.

Our sample of claims processed indicated that there were similar backlogs in 1974.

Suggestion to the carrier

We suggested that the carrier develop a daily report showing both the productive capacity of each functional area and the backlog of claims in each area so that management could shift personnel and take other corrective actions as warranted on a daily basis rather than waiting for a crisis to develop.

Carrier's response

Blue Shield of Florida officials agreed to use a report such as we suggested and said they would strive to keep the backlog to 2 days or less in most areas.

NEED TO IMPROVE DOCUMENT FLOW

During our review it became apparent that a cumbersome, inefficient physical flow of claims forms through the carrier's offices contributed significantly to processing delays. The flow of claims requiring additional development will serve as an example.

When the claims examiners completed their initial examination of claims in a particular batch, all claims in the batch--including those which required additional development--were returned to the batch folders and taken from the claims examining section on the 16th floor to the Medicare Part B files area in the basement. During computer processing of the claims entered each day, suspense forms were generated for those claims needing additional development and for those which failed to pass one of the computer screens. These suspense forms were sent from the 19th floor to the files area in the basement where they were grouped on top of boxes in which the claims forms were filed. The boxes of claims forms and suspense forms were then sent back to the 19th floor where the suspense forms were matched with the appropriate claims forms.

All edit error and reasonable charge kickouts were then worked before the claims needing additional development were sent to the additional development section on the 15th floor. Once the additional information was obtained on these claims, the claims were returned to the 16th or 17th floor where the claims examiner who had initially examined the claim made the necessary changes on the suspense form, sent the claim back to the basement to be refiled, and sent the suspense sheet to a data recording machine on the 17th floor for reentry into the computer.

We could not analyze this document flow in sufficient detail to establish its precise effect on processing time. We believe, however, that this shuffling of claims from place to place is a significant factor in the delay of Medicare Part B claims.

Suggestion to the carrier

We suggested that, to provide more effective control, all claims be sent to a 60-day intermediate holding area on the 19th floor immediately after being worked by the claim examiners. We also suggested that claims examiners leave claims requiring additional development out of the batches to be matched with suspense sheets upon kickout and forwarded early the next morning to the additional development area. This action should reduce cycle time for nearly 20 percent of the claims being processed by 12 to 15 days.

An intermediate holding area would provide greater accessibility to original claims and reduce the pressure on the microfilm retrieval unit which had a 2 to 7 work-day backlog during most of the time of our review.

We further suggested that once the additional required information has been obtained, the additional development clerks make the necessary changes to the suspense sheets and send them directly to the data recording machines for reentry into the computer rather than returning them to the original claims examiners.

To help speed consideration of requests for an informal review, we suggested that each correspondence team be augmented by personnel trained in various aspects of the informal review process. Thus, each correspondence team would be an autonomous unit and could resolve each question without passing the requests back and forth.

Carrier's response

Blue Shield of Florida has revised its procedures so that claims are forwarded directly to the 19th floor to be matched to suspense sheets and worked; however, it will continue to work edit error and reasonable charge kickouts before sending the claims to the additional development section. Carrier officials explained that the system currently in use greatly facilitates the matching of suspense sheets and claims, which is a vital part of the flow. Officials further stated that they would be gathering data to determine the period of time claims can or should be held on the 19th floor before transfer to the files storage area. They said that they were establishing much tighter control on the files area.

Carrier officials were reluctant to complete claims in the additional development area unless the additional

development clerks could be trained to perform the completions. For the present, they will continue returning claims to the original claims examiner but will require that they be entered into the computer within 24 hours.

With respect to our suggestion for shortening the time for processing requests for informal reviews, carrier officials stated that the concept of a team approach to answering inquiries was being studied but until sufficient information was collected, they did not believe the moving of personnel from other areas to the correspondence area would be feasible. They said that they had combined the reprocessing and review sections and were providing cross-training to all clerks, an action which will consolidate the knowledge and decisionmaking for these two appeals processes. Additionally, they were evaluating the possibility of establishing a central control area to screen all inquiries and appeals for assignment to the proper location--thereby, stopping double screening and establishing responsibility for prompt completion.

TEN LARGEST CARRIERS BASED ON VOLUME OF CLAIMS PROCESSED IN 1974

	Carrier	Claims processed (note a)	Average processing time (days)
1	Blue Shield of California	6,100,048	16.1
2	Blue Cross-Blue Shield of Greater New York	5,511,034	16.0
3	Group Medical and Surgical Service (Tex.)	3,796,921	19.0
4	Blue Shield of Florida, Inc.	3,628,551	22.7
5	Pennsylvania Blue Shield	3,256,325	16.3
6	Blue Shield of Michigan	3,092,170	13.0
7	Occidental Life Insurance Co. of California	2,948,506	23.1
8	Blue Shield of Massachusetts, Inc.	2,391,294	11.4
9	Nationwide Mutual Insurance Co. (Ohio)	2,263,981	17.9
10	The Prudential Insurance Co. of America (N.J.)	2,227,963	22.9

[a]Excludes claims for services by hospital-based physicians.