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Report to the Chairmen, Committee on Commerce, House of Representatives, and the Special Committee on Aging, U.S. Senate

April 1998

MEDICARE BILLING

Commercial System Could Save Hundreds of Millions Annually

GAO/AIMD-98-91

GAO

United States
General Accounting Office
Washington, D.C. 20548

Accounting and Information
Management Division

B-277959

April 15, 1998

The Honorable Tom Bliley
Chairman, Committee on Commerce
House of Representatives

The Honorable Charles E. Grassley
Chairman, Special Committee on Aging
United States Senate

During fiscal year 1997, Medicare reported it paid about $207 billion in health care benefits for 39 million beneficiaries. Of these payments, about $44 billion was for physicians' services. Physicians use about 7,000 procedure codes to bill Medicare for payment; these codes are updated annually to reflect changes in medical practice. Because of the large number of claims and the complexity of the uniformly accepted coding system, automated claims auditing systems are necessary to help determine if the claims are appropriate.

In 1991, the Inspector General of the Department of Health and Human Services (HHS) reported that commercially available claims auditing systems could save $12 million annually at one Medicare processing site alone.[1] Similarly, in 1995 we reported that, nationally, such systems could save over $600 million annually by helping Medicare avoid paying inappropriate claims.[2]

Initially, the Health Care Financing Administration (HCFA)—the agency responsible for administering Medicare—chose to develop its own system rather than to acquire a commercial system. In February 1991, HCFA directed its carriers to begin developing claims auditing edits. In August 1994, it awarded a contract to further develop these edits, called the correct coding initiative (CCI), which it now owns and began using in January 1996.

Subsequent to our 1995 report, HCFA awarded a contract on September 30, 1996, to test a commercial claims auditing system in Iowa. At your request, we evaluated whether HCFA used an adequate methodology for testing the

[1]Manipulation of Procedure Codes by Physicians to Maximize Reimbursement, Office of Inspector General, Department of Health and Human Services, CIN: A-03-91-00019, August 30, 1991.

[2]Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

commercial claims auditing system for potential nationwide implementation with its Medicare claims processing systems.

Results in Brief

The test methodology HCFA used in Iowa was consistent with the approach used by other public health care insurers who have already implemented a commercial claims auditing system. HCFA's test covered 15 months and included extensive work, such as modifying the system's software to comply with Medicare payment policies. The test showed that the commercial claims auditing system could save Medicare up to $465 million annually with claims auditing edits that detect inappropriately coded claims.[3] These savings are in addition to any results from CCI which, according to HCFA, saved Medicare about $217 million in 1996.

While HCFA used an adequate methodology to test the system and demonstrated that commercial claims auditing edits could result in significant savings, two critical management decisions would have unnecessarily delayed implementation for several years, resulting in potentially hundreds of millions of dollars in lost savings annually. First, HCFA limited its 1996 test contract to the test, and did not include a provision for implementing the commercial system throughout the Medicare program. Thus, to acquire a commercial system for nationwide implementation, up to an additional year may be required to complete all activities necessary to plan for and award another contract. This could also result in substantial rework to adapt the system if a different contractor were to win the new contract. HCFA's administrator told us that HCFA is evaluating legal options for expediting the contracting process.

Second, in addition to the potential delay from the test contract limitation, following the test HCFA initially planned to *develop* its own claims auditing edits rather than to *acquire* commercial edits, such as those used in the test. Under this plan, HCFA would have obtained a development contractor that may, or may not, have existing claims auditing edits. If the winning contractor did not have existing edits on which to build, it could take years to complete the HCFA-owned edits. Near the conclusion of our review HCFA representatives told us this approach would have allowed them to make the edits available to the public and avoid being obligated to one vendor's commercial edits and related fees. Public health care insurers for the Departments of Defense and Veterans Affairs and several state Medicaid agencies did not take this approach, opting to lease commercial

[3]Claims auditing edits consist of a database table, which contains the rules and auditing logic that systems use to identify inappropriately coded claims. For example, these edits identify such inappropriate claims as mutually exclusive procedures.

systems instead of owning the claims auditing edits. Further, HCFA's approach (1) is not supported based on HCFA's lengthy CCI development effort and the test findings, (2) may not provide the magnitude of savings of a commercially available system, and (3) would further delay implementation of a national claims auditing system.

In March 1998, after considering our findings and other issues, the Administrator of HCFA told us that HCFA's plans have changed, and that the agency planned to begin immediately to acquire commercial claims auditing edits.

Background

Medicare, authorized in 1965 under Title XVIII of the Social Security Act, is a federal health insurance program providing coverage to individuals 65 years of age and older and to many of the nation's disabled. HCFA uses about 70 claims-processing contractors, called intermediaries and carriers, to administer the Medicare program. Intermediaries primarily handle part A claims (those submitted by hospitals, skilled nursing facilities, hospices, and home health agencies), while carriers handle part B claims (those submitted by providers, such as physicians, laboratories, equipment suppliers, outpatient clinics, and other practitioners).

Voluminous, Complex Billing Codes Can Cause Inappropriate Payments

The use of incorrect billing codes is a problem faced both by public and private health insurers. Medicare pays part B providers a fee for each covered medical service identified by the American Medical Association's uniformly accepted coding system, called the physicians' Current Procedural Terminology (CPT).[4] The coding system is complicated, voluminous, and undergoes annual changes; as a result, physicians and other providers often have difficulty identifying the codes that most accurately describe the services provided. Not only can such complexities lead providers to inadvertently submit improperly coded claims, in some cases it makes it easier to deliberately abuse the billing system, resulting in inappropriate payment. The examples in table 1 illustrate several coding categories commonly used in inappropriate ways.

[4]Medicare's complete coding system is known as the HCFA Common Procedural Coding System, or HCPCS, and in addition to CPT includes codes for medical equipment, prescription drugs, and other services and items not covered by CPT.

Table 1: Categories of Inappropriate Coding

Category	Description
Mutually exclusive	Billing for two or more procedures usually not performed on the same patient on the same day, such as both a closed and an open treatment of a fracture.
Incidental procedure	Billing for both an incidental procedure and a more complex primary procedure, when the incidental procedure requires few additional physician resources or is clinically integral to the performance of the primary procedure, such as control of intraoperative bleeding with a tonsillectomy.
Diagnosis to procedure comparison	Billing for procedures that are unexpected for a given diagnosis, such as a corneal transplant with a diagnosis of pneumonia.

Commercial System Potential Tool for Combating Inappropriate Billing/Payment

Commercial claims-auditing systems for detecting inappropriate billing have been available for a number of years; as early as 1991, commercial firms marketed specialized auditing systems that identify inappropriately coded claims. The potential value of such a system to Medicare has been noted both by the HHS Inspector General (in 1991) and by us (in 1995). In fact, both the Inspector General and we noted that such a tool could save the Medicare program hundreds of millions of dollars annually.

Recognizing its need to address the inappropriate billing problem, HCFA directed its carriers to begin developing claims auditing edits in February 1991. In August 1994, it awarded a contract to further develop these claims auditing edits, called CCI, which it now owns and operates. According to HCFA, the CCI edits helped Medicare save about $217 million in 1996 by successfully identifying inappropriate claims. Nevertheless, inappropriate coding and resulting payments continue to plague Medicare. Last summer HHS' Office of Inspector General reported that about $23 billion of Medicare's fee for service payments in fiscal year 1996 were improper, and that about $1 billion of this amount was attributable to incorrect coding by physicians.[5]

On September 30, 1996, HCFA initiated action to improve its capability to detect inappropriate claims and payment. It awarded a contract to HBO & Company (HBOC), a vendor marketing a claims-auditing system, to test the

[5]Report on The Financial Statement Audit of The Health Care Financing Administration For Fiscal Year 1996, Office of Inspector General, Department of Health and Human Services, A-17-95-00096, July 17, 1997.

vendor's system in Iowa and evaluate whether it could be effectively used throughout the Medicare program.

Objective, Scope, and Methodology

Our objective was to determine if HCFA was using an adequate methodology for testing the commercial claims auditing system in Iowa for potential implementation with its Medicare claims processing systems.

To do this, we analyzed documents related to HCFA's test, including the test contract, test plans and methodologies, test results and status reports, and task orders. This analysis included assessing the limitations of the test contract, size of the test claims processing sample, representation of users involved with the test, and information provided to management in its oversight role. We also met with HCFA staff responsible for conducting the test to obtain further insight into HCFA's test methodology. While we reviewed the reports of HCFA's estimated savings, we did not independently validate the reported savings by validating the sample of paid claims used as the basis for projecting them. However, the magnitude of HCFA's estimated savings is in line with our earlier estimate of potential annual savings from such systems.

We observed operations at the test site in Des Moines, Iowa, and assessed the carrier officials' role in the test. We visited HBOC offices in Malvern, Pennsylvania, and the Plano, Texas, headquarters of Electronic Data Systems (EDS), the part B system maintainer, into whose system the claims-auditing system was integrated. During these visits, we documented these companies' roles and responsibilities in testing the system. Also, in August 1997 at a 3-day conference at HCFA headquarters, we observed the test team's effectiveness and objectivity in discussing the progress made to date and in developing solutions to issues still needing resolution.

We compared the adequacy of HCFA's test methodology with the methodologies used by other public health care insurers to test and integrate a commercial claims-auditing system. We visited offices of these insurers and analyzed documents describing their test and integration approach. Finally, we compared the approach used by these insurers with HCFA's. The insurers whose methodologies we analyzed consisted of the Department of Defense's TRICARE support office (formerly called the Civilian Health and Medical Program of the Uniform Services (CHAMPUS)) in Aurora, Colorado; Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) in Denver, Colorado; and the

Kansas and Mississippi state Medicaid agencies in Topeka, Kansas, and Jackson, Mississippi, respectively.

To evaluate HCFA's decisions regarding national implementation of a commercial claims-auditing system, we reviewed the contract and other documents related to the test and evaluated their impact on HCFA's ability to implement a claims-auditing system nationally. We also discussed HCFA's rationale for these decisions with senior HCFA officials.

Finally, to assess HCFA's experience in acquiring and using the HCFA-owned CCI claims auditing edits, we reviewed the CCI contract (and related documents). We discussed this project and its results with cognizant HCFA officials. We performed our work from July 1997 through March 1998, in accordance with generally accepted government auditing standards. HCFA provided written comments on a draft of this report. These comments are presented and evaluated in the "Agency Comments and Our Evaluation" section of this report, and are included in appendix I.

HCFA Test Methodology Adequate, Similar to That of Other Public Health Insurers

HCFA used a test methodology that was comparable with processes followed by other public insurers who have successfully tested and implemented such commercial systems. HCFA's test showed that commercial claims auditing edits could achieve significant savings.

Other public insurers—CHAMPVA, TRICARE, and the Kansas and Mississippi Medicaid offices—each used four key steps to test their claims-auditing systems prior to implementation. Specifically, they (1) performed a detailed comparison of their payment policies with the system's edits to determine where conflicts existed, (2) modified the commercial system's edits to comply with their payment policies, (3) integrated the system into their claims payment systems, and (4) conducted operational tests to ensure that the integrated systems properly processed claims. These insurers' activities were comprehensive and required significant time to complete. CHAMPVA took about 18 months to integrate the commercial system at one claims processing site. TRICARE took about 18 months to integrate the system at two sites. It allowed about 2 years to implement the modified system at its nine remaining sites.

HCFA's methodological approach was similar. From the contract award on September 30, 1996, through its conclusion on December 29, 1997, HCFA and contractor staff made significant progress in integrating the test commercial system at the Iowa site and evaluating its potential for

Medicare use nationwide. HCFA used two teams to concentrate separately on the policy evaluation and technical aspects of the test.

The policy evaluation team consisted of HCFA headquarters individuals and Kansas City (Missouri) and Dallas regional office staff knowledgeable of HCFA policies and the CPT billing codes, as well as individuals representing the Iowa carrier and HBOC. This team conducted a detailed comparison of the commercial system's payment policy manuals with Medicare policy manuals to identify conflicting edits. The reviews identified inconsistencies that both increased and decreased the amount of Medicare payments. For example, the commercial system pays for the higher cost procedure of those deemed mutually exclusive, while Medicare policy dictates paying for the lower cost procedure. Conversely, the commercial claims-auditing system denies certain payments for assistant surgeons, whereas Medicare policy allows these payments. These and all other conflicts identified were provided to the vendor, who modified the system's edits to be consistent with HCFA policy.

The technical team consisted of staff from HCFA's headquarters and its Kansas City (Missouri) and Dallas regional offices; HBOC; EDS; and the Iowa carrier. This team prepared and carried out three critical tasks. First, it developed the design specifications and related computer code necessary for integrating the commercial system into the Medicare claims-processing software. Second, it integrated the claims auditing system into the Medicare part B claims-processing system. Finally, the team conducted numerous tests of the integrated system to determine its effect on processing times and its ability to properly process claims. HCFA management was kept apprised of the status of the test through biweekly progress reports and frequent contact with the project management team.

HCFA reported that the edits in this commercial system could save Medicare up to $465 million annually by identifying inappropriate claims. Specifically, the analysis showed that the system's mutually exclusive and incidental procedure edits could save about $205 million, and the diagnosis-to-procedure edits would save about $260 million. HCFA's analysis was based on a national sample of paid claims that had already been processed by the Medicare part B systems and audited for inappropriate coding with the HCFA-owned CCI edits. While we reviewed the reports of HCFA's estimated savings, we did not independently verify the national sample from which these savings were derived. However, the magnitude of savings when added to the savings from CCI, which HCFA

reported to be about $217 million in 1996, is in line with our earlier estimate that about $600 million in annual savings are possible.[6]

Test officials also concluded that the claims-processing portion of the test system's software provides little, if any, added value since the existing part B claims processing system already handles this function. Further, the test showed that integrating the commercial system's claims-processing function with the existing claims processing system could significantly increase processing time and delay payment.

On November 25, 1997, HCFA officials notified the administrator about the success of the commercial system test. They reported that the test showed that the system's claims auditing edits could save Medicare up to $465 million annually, which is in addition to the savings provided by the CCI edits.

Management Decisions Could Have Cost Months and Hundreds of Millions of Dollars

Despite the success of the test, two key management decisions, if left unchanged, could have significantly delayed national implementation. One decision was to limit the test contract to the test, and not include a provision for nationwide implementation, thus delaying implementation of commercial claims auditing edits into the Medicare program. The second—HCFA's initial plan following the test to award a contract to develop its own edits rather than acquiring commercial edits such as those used in the test—would have potentially not only required additional time before implementation, but could well have resulted in a system that is not as comprehensive as commercially available edits.

In March 1998, the Administrator of HCFA, told us that HCFA's plans have changed. She said HCFA (1) is evaluating legal options for expediting the contracting process, and (2) now plans to begin immediately to acquire commercial claims auditing edits.

Limited Test Contract Delays National Implementation

HCFA limited the use of the test system to its Iowa testing site—just one of its 23 Medicare part B claims-processing sites and did not include a provision for implementation throughout the Medicare program. As a result, additional time will be needed to award another contract to implement either the test system's claims auditing edits or any other approach throughout the Medicare program. A contracting official

[6]As with any claims editing, some of the denied items will likely be appealed and paid. The estimates are not adjusted for this. In addition, diagnosis-to-procedure edits have not yet been reviewed for consistency with Medicare policies.

estimated that it could take as much as a year to award another contract using "full and open" competition—the contracting method normally used for such implementation. This would involve preparing for and issuing a request for proposals, evaluating the resulting bids, and awarding the contract. HCFA's estimated savings of up to $465 million per year demonstrate the costs associated with delays in implementing such payment controls nationwide.

Awarding a new contract could result in additional expense to either develop new edits or for substantial rework to adapt the new system's edits to HCFA's payment policy if a contractor other than the one performing the original test wins the competition. If another contractor became involved, this would mean that much of the work HCFA performed during the 15-month test would have to be redone. Specifically, this would involve evaluating the new claims auditing edits for conflict with agency payment policy.

Instead of limiting the test contract to the test site, HCFA could have followed the approach used by TRICARE, which awarded a contract that provided for a phased, 3-year implementation at its 11 processing sites following successful testing. In March 1998, HCFA's administrator told us that HCFA is doing what it can to avoid any delay resulting from this limited test contract. She said HCFA is evaluating legal options to determine if other contracting avenues are available, which would allow HCFA to expedite national implementation of commercial claims auditing edits.

Initial HCFA Plan to Develop Own Claims Auditing Edits Would Have Been Costly and Could Have Been Ineffective

In reporting the test results, HCFA representatives recommended that the HCFA administrator award a contract to develop HCFA-owned claims-auditing edits, which would supplement CCI, rather than to acquire these edits commercially. They provided the following key reasons for this position. First, they said this approach could cost substantially less than commercial edits because (1) HCFA would not always be required to use the same contractor to keep the edits updated, (2) it would not be required to pay annual licensing fees, and (3) the developmental cost would be much less than using commercial edits. Second, they said this approach would result in HCFA-owned claims-auditing edits, which are in the public domain, allowing HCFA to continue to disclose all policies and coding combinations to providers—as is currently done with the CCI edits. They also explained that if a vendor of a commercial claims auditing system chooses to bid, wins this contract, and agrees to allow its claims auditing edits to be in the public domain as they are with CCI, HCFA will allow the

vendor to start with its existing edits, which should shorten the development time.

We do not agree that this approach is the most cost-effective. First, upgrading the edits by moving from the contractor who develops the original edits to one unfamiliar with them would not be easy and could be costly because this is a major task, which is facilitated by a thorough clinical knowledge of the existing edits. For example, the Iowa test system contains millions of edits, which would have to be compared against annual changes in the CPT codes. Second, the annual licensing fees that HCFA would avoid with HCFA-owned edits would be offset somewhat by the need to pay a contractor with the clinical expertise offered by commercial vendors to keep the edits current. Third, while the commercial edits could cost more than HCFA-owned ones, this increased cost has been justified by HCFA's test results, which demonstrated that commercial edits provide significantly more Medicare savings than HCFA-developed edits.

Regarding HCFA's initial plan to fully disclose the HCFA-owned edits as they are with CCI, this policy is not mandated by federal law or explicit Medicare policies, nor is it followed by other public insurers, and it could result in potential contractors declining to bid. In a May 1995 memorandum from HHS to HCFA, the HHS Office of General Counsel concluded that federal law and regulations do not preclude HCFA from protecting the proprietary edits and related computer logic used in commercial claims auditing systems. Further, according to HCFA's deputy director, Provider Purchasing and Administration Group, HCFA has no explicit Medicare policies that require it to disclose the specific edits used to audit providers' claims. Likewise, other public health care insurers, including CHAMPVA, TRICARE, and the two state Medicaid agencies we visited, do not have such a policy, and are indeed using commercial claims-auditing systems without disclosing the details of the edits. Rather than disclose the edits, these insurers notified providers that they were implementing the system and provided examples of the categories of edits that would be used to check for such disparities as mutually exclusive claims. This approach protects the proprietary nature of the commercial claims auditing edits.

Finally, the development time would likely be shortened if a commercial claims auditing vendor is awarded this contract and uses its existing edits as a starting point. However, if the request for proposals requires that these edits be in the public domain, it is doubtful that such vendors would bid on this contract using their already developed edits. An executive of a

vendor that has already developed a claims auditing system told us that his company would not enter into such a contractual agreement if HCFA insists on making the edits public, because this would result in the loss of the proprietary rights to his company's claims auditing edits.

Although HCFA's then director of the Center for Health Plans and Providers, recommended that HCFA develop its own edits, he also acknowledged that this approach could result in a less effective system than use of a commercial one. In a November 25, 1997, memorandum to the administrator assessing the results of the commercial test, the director stated that there were several "cons" to developing HCFA-owned edits. He concluded that "the magnitude of edits approved for national implementation could potentially be less [than using commercial edits], depending on the number of edits developed and reviewed for acceptance prior to the implementation date." He also stated that "there could be a perception that HCFA is unwilling to take full advantage of the technology and clinical expertise offered by [commercial system] vendors."

Furthermore, HCFA's initial plan to develop its own claims-auditing edits was inconsistent with Office of Management and Budget (OMB) policy in acquiring information resources. OMB Circular A-130, 8b(5)(b) states that in acquiring information resources, agencies shall "acquire off-the-shelf software from commercial sources, unless the cost-effectiveness of developing custom software to meet mission needs is clear and has been documented." HCFA has not demonstrated that its plan to develop HCFA-owned claims auditing edits is cost-effective. A key factor showing otherwise is HCFA's estimate that every year it delays implementing claims auditing edits of the caliber of those used in the commercial test system in Iowa, about $465 million in savings could be lost.

Developing comprehensive HCFA-owned claims auditing edits could take years, during which time hundreds of millions of dollars could be lost annually due to incorrectly coded claims. To illustrate: HCFA began developing its CCI database of edits in 1991 and has continued to improve it over the past 6 years. While HCFA reported that CCI identified about $217 million in savings (in the mutually exclusive and incidental procedure categories) in 1996, CCI did not identify an additional $205 million in those categories identified by the test edits nor does it address the diagnosis-to-procedure category, where the test edits identified an additional $260 million in possible savings. Furthermore, HCFA has no assurance that the HCFA-owned edits would be as effective as available commercial edits.

In March 1998, after considering our findings and other factors, the Administrator, HCFA told us that she now plans to take an approach consistent with the test results. She said she plans to acquire and implement commercial claims auditing edits.

Conclusions

HCFA followed an approach in testing and evaluating the commercial claims auditing system that was consistent with the approach used by other public health care insurers. This test showed that using this system's edits in the Medicare program can save up to $465 million annually. However, the Medicare program is losing millions each month that HCFA delays implementing such comprehensive claims auditing edits.

Two critical HCFA decisions could have unnecessarily delayed implementation for several years and prevented HCFA from taking full advantage of the substantial savings offered by this technology. These decisions—to limit the test contract to the test and not include a provision for national implementation, and to develop HCFA's own edits rather than acquiring commercial ones—would have resulted in costly delays and could have resulted in an inferior system. However, we believe these decisions were appropriately changed by the administrator in March 1998. The administrator's current plans for expediting national implementation and acquiring commercial claims auditing edits should, if successfully implemented, help HCFA take full advantage of the potential savings demonstrated by the commercial test.

Recommendations

To implement HCFA's current plans to expeditiously realize dollar savings in the Medicare program through the use of claims auditing edits, we recommend that the Administrator, Health Care Financing Administration

- proceed immediately to purchase or lease existing comprehensive commercial claims auditing edits and begin a phased national implementation, and
- require, in any competition, that vendors have comprehensive claims auditing edits, which at a minimum address the mutually exclusive, incidental procedure, and diagnosis-to-procedure categories of inappropriate billing codes.

Agency Comments and Our Evaluation

HCFA agreed with our recommendations in this report and stated that it is proceeding immediately with a two-phased approach for procuring and

implementing commercially developed edits for the Medicare program. During the first phase, HCFA plans to immediately implement procedure-to-procedure edits, such as those described in the mutually exclusive and incidental procedure categories in table 1. According to HCFA, the second phase will be used to complete its determination of the consistency of diagnosis-to-procedure edits with Medicare coverage policy—which was begun during the test—and then implement the edits as quickly as possible. HCFA added that, as part of this process, it will also consider modifying national coverage policy, where appropriate, to meet program goals. It cautioned that the amount of the projected savings from the commercial test may decrease once its full analysis is complete.

We are encouraged that HCFA concurs with our recommendations and is proceeding immediately to take advantage of this commercial claims auditing tool, which can save Medicare hundreds of millions of dollars annually. HCFA's comments and our detailed evaluation of them are in appendix I.

As agreed with your offices, unless you publicly announce its contents earlier, we will not distribute this report until 30 days from the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services; the Administrator, Health Care Financing Administration; the Director, Office of Management and Budget; the Ranking Minority Members of the House Committee on Commerce and the Senate Special Committee on Aging; and other interested congressional committees. We will also make copies available to others upon request.

If you have any questions, please call me at (202) 512-6253, or Mark Heatwole, Assistant Director, at (202) 512-6203. We can also be reached by e-mail at *willemssenj.aimd@gao.gov* and *heatwolem.aimd@gao.gov*, respectively. Major contributors to this report are listed in appendix II.

Joel C. Willemssen
Director, Civil Agencies Information Systems

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Abbreviations

CCI	Correct Coding Initiative
CHAMPUS	Civilian Health and Medical Program of the Uniform Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CPT	Current Procedural Terminology
EDS	Electronic Data Systems
HBOC	HBO & Company
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OMB	Office of Management and Budget
TRICARE	Formerly the Civilian Health and Medical Program of the Uniform Services

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: APR 2 1998

TO: Gene L. Dodaro
Assistant Comptroller General
Accounting and Information Management Division

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: GAO Draft Report, "Medicare Inappropriate Billing: Commercial System Could Save Hundreds of Millions Annually"

We appreciate the opportunity to review your draft report to Congress concerning the use of commercial claims auditing systems. We concur with the report recommendation. Our detailed comments are attached.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report: Medicare Inappropriate Billing: Commercial System Could Save Hundreds of Millions Annually"

GAO Recommendation

We recommend that the Administrator of HCFA:

- proceed immediately to purchase or lease existing comprehensive commercial claims auditing edits and begin a phased national implementation, and

- require in any competition that vendors have comprehensive claims auditing edits, which at a minimum address the mutually exclusive, incidental procedure, and diagnosis-to-procedure categories of inappropriate billing codes.

HCFA Comment

See comment 1.

We concur. HCFA is consulting with the Congress and proceeding immediately with efforts to procure a commercially developed database of edits and to implement the edits nationally. The first phase will be immediate implementation of procedure-to-procedure edits, followed by diagnosis-to-procedure edits as quickly as possible. The full analysis of the diagnosis-to-procedure edits against Medicare coverage policies was not completed during the Iowa project. These edits must still be reviewed to determine their consistency with Medicare coverage policy. We will consider modifying national coverage policy, where appropriate, to meet program goals. The amount of the projected savings from the commercial edits identified in the GAO report may decrease once our full analysis is complete.

Technical Comments

See comment 2.
Now on p. 4.

* On page 7, last sentence, the report references the HHS Office of Inspector General's FY 1996 audit which estimated Medicare made $1 billion in improper payments to physicians due to incorrect coding. These improper payments were detected by a "look-behind" review performed by medical review staff. We would like to clarify that no commercial systems could detect all the coding errors discovered in the OIG's audit. The improper payments found during the OIG's audit were discovered by manual review of physicians' files. In these instances, the files indicated that the physician billed for a service that was not supported by appropriate documentation. In fact, the OIG's audit found that 99 percent of the

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time, Medicare contractors paid the claim correctly according to the information submitted on the face of the claim. We are actively exploring the use of the commercial software in an effort to find a method of detecting incorrect coding prior to payment.

See comment 3. (p. 7.)

* On page 12, line 4, substitute "conducted" for "completed."

See comment 3. (p. 7.)

* On page 13 , of the report, the phrases in the second paragraph should be changed from "would save" to "could save." At the bottom of the page add the following statement to footnote #6: "In addition diagnosis-to-procedure edits need to be reviewed for consistency with Medicare policies. "

See comment 3. (p. 9.)

* On page 16, line 17, substitute "representatives" for "officials."

See comment 3. (p. 11.)

* On page 20 of the report, the phrases in the first paragraph and second paragraph should be changed from "will be lost" to "could be lost." The phrase "an additional $260 million in savings" should be changed to "an additional $260 million in possible savings."

The following are GAO's comments on the Department of Health Care Financing Administration's letter responding to a draft of this report.

GAO Comments

1. We are encouraged that HCFA concurs with our recommendations and is proceeding immediately to take advantage of this commercial claims auditing tool. If effectively implemented, according to test results, commercial claims auditing edits should save Medicare hundreds of millions of dollars annually. Further, we are pleased that, in addition to determining that the commercial edits are consistent with HCFA policy, HCFA also plans to evaluate its national coverage policy to determine if it also needs modification. This dual assessment should improve the overall effectiveness of the final implemented edits. Finally, although the amount of HCFA's projected savings may decrease once its full analysis is complete, its projected annual savings of $465 million is so large that, most likely, even a reduced figure will still be significant.

2. As stated, the HHS Office of the Inspector General identified its findings through a manual review. The Inspector General's report findings included examples of improper billing for incidental procedures. Thus, commercial systems could have detected some of the errors identified in the Inspector General's report. While HCFA is correct in asserting that other identified problems would not typically be identified by the type of commercial claims editing system discussed in this report, other types of automated analytical claims analyses systems are available to examine profiles of provider submitted claims for targeting investigations of potential fraud. See our reports titled Medicare: Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud (GAO/AIMD-95-77, Aug. 11, 1995) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

3. We considered HCFA's suggested wording changes and have incorporated them as appropriate.

Major Contributors to This Report

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