REPORT TO THE CONGRESS

More Needs To Be Done To Assure That Physicians' Services -- Paid For By Medicare And Medicaid -- Are Necessary B-164031(4)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

AUG 2, 1972

COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This is our report entitled "More Needs To Be Done To Assure That Physicians' Services--Paid for by Medicare and Medicaid--Are Necessary" The Medicare and Medicaid programs are administered by the Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U S C 53), and the Accounting and Auditing Act of 1950 (31 U.S.C 67)

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare

Elmer B. Staats

Comptroller General
of the United States

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

CHAPTER 1

INTRODUCTION

Titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 and 1396), enacted on July 30, 1965, established the Medicare and Medicaid programs to protect persons eligible to participate in the programs against the costs of health-care services.

Under Medicare eligible persons aged 65 and over may receive two basic forms of protection.

--Part A, Hospital Insurance Benefits for the Aged, covers inpatient hospital services and posthospital care in extended-care facilities and in the patients' homes Benefits paid are financed by special social security taxes collected from employees, employers, and self-employed persons

--Part B, Supplementary Medical Insurance Benefits for the Aged, is a voluntary program which covers physicians' services and a number of other medical and health benefits Benefits paid are financed by collecting premiums from beneficiaries and by matching amounts appropriated from the general revenues of the Federal Government

Under Medicaid, a grant-in-aid program, the Federal Government shares with the States the costs of providing medical assistance to persons--regardless of age--whose incomes and resources are insufficient to pay for health care.

State Medicaid programs are required by the Social Security Act to provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled-nursing-home services, physicians' services, and home health-care services. Additional services may be included in its Medicaid program if a State so chooses.

ADMINISTRATION OF THE MEDICARE AND MEDICAID PROGRAMS

The Department of Health, Education, and Welfare (HEW) has overall responsibility for administering Medicare and Medicaid. Within HEW, the Social Security Administration (SSA) administers Medicare and the Social and Rehabilitation Service (SRS) administers Medicaid at the Federal level. SSA and SRS are responsible for developing program policies, setting standards, and assuring compliance with Federal legislation and regulations.

HEW contracted with public and private organizations and agencies to act as carriers in the administration of benefits under part B of the Medicare program. The carriers' responsibilities include

--processing and paying claims,

--determining the rates and amounts of payments on a reasonable-charge basis, and

--determining the medical necessity of the services.

The States are responsible for initiating and administering their Medicaid programs. The nature and scope of a State's Medicaid program are contained in a State plan which, after approval by HEW, provides the basis for Federal grants to the State.

The States may contract with private organizations to help administer their programs. The responsibilities assigned to the contractors, referred to as fiscal agents, may vary depending on the contractual arrangements established by the States. Some States administer the entire program through their State agencies.

As of May 1972, 48 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had adopted Medicaid programs. Depending on the per capita income in each State, the Federal Government pays from 50 to 83 percent of the costs incurred by the States under their Medicaid programs.

The carriers, State agencies, and fiscal agents are hereinafter referred to as paying agents when considered jointly.

CONGRESSIONAL CONCERN OVER USE OF PHYSICIANS' SERVICES

The Congress has expressed its desire that Medicare and Medicaid provide quality care to Medicare and Medicaid patients but, at the same time, that payments be made only for medically necessary services.

The Medicare and Medicaid statutes prohibit payment for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Therefore paying agents are required to establish safeguards to assure that payments--including payments to physicians--are made only for services which are medically necessary.

SSA, in its standard contractual agreement with carriers, specifically requires that carriers

--identify patterns of services rendered by physicians and

--assure that payments for physicians' services are for covered and medically necessary care.

The Medicaid legislation initially did not require medical necessity safeguards as did the Medicare law. In 1967 the Medicaid legislation was amended to require that, effective April 1968, State plans provide safeguards against payments for unnecessary medical care and services.

The Congress has become increasingly concerned with the rising costs of physicians' services under the Medicare and Medicaid programs. Payment for physicians' services under Medicare increased from $513.3 million in fiscal year 1967 to $1.7 billion in fiscal year 1971. Under Medicaid payment increased from $203.7 million to $712.8 million during the same 5-year period. Congressional committees responsible for Medicare and Medicaid legislation believed that a part of the increasing costs may be attributable to services which were not medically necessary--referred to as over-utilization.

The staff of the Senate Committee on Finance reported in February 1970 that its analysis of data on physicians who had annually received $25,000 or more under Medicare and/or Medicaid showed a need for additional controls over the use of medical services under the programs.

Legislation is being considered by the Congress to authorize HEW to suspend Medicare and Medicaid payments to any supplier of medical services found to be guilty of program abuses. Legislation is also being considered to establish peer review organizations of local practicing physicians to perform comprehensive and ongoing reviews to assure proper use of Medicare and Medicaid services.

CHAPTER 2

OBSERVATIONS ON UTILIZATION CONTROL.

COMPLEXITIES AND CONSTRAINTS

Since the advent of the Medicare and Medicaid programs--and the legislative requirement to prevent payment for unnecessary medical services--much effort has been put forth by HEW and its paying agents to develop and implement utilization review systems.

Officials of HEW and its paying agents generally acknowledge that physicians who provide unnecessary services to patients represent a small part of the total medical community. Nevertheless they agree that efforts to prevent and recover payments for medically unnecessary services provided to Medicare and Medicaid patients are necessary and worthwhile.

Paying agents have identified many instances of services for which payments were disallowed. For example, the six Medicare carriers included in our review reported to SSA that they had disallowed payments of $8.6 million during the first 6 months of calendar year 1971 for services that were medically unnecessary. Similar data was not available for disallowances made by Medicaid fiscal agents because SRS and the States had not accumulated such data.

Illustrations of unnecessary services identified by paying agents follow.

--During a 54-month period, a general practitioner submitted Medicare claims for 251 office visits and 219 urinalyses for one patient. During the carrier's prepayment review of the claims, payments totaling $522 were disallowed for 59 office visits and 49 urinalyses. As a result of a later postpayment review of the physician's overall pattern of practice, the carrier's medical consultant--considering the patient's diagnoses--determined that 105 additional office visits and 144 urinalyses were unnecessary and additional payments of about $1,000 should be disallowed. Therefore, only 87 of the 251 office visits and 26 of the 219 urinalyses were ultimately determined to be medically necessary.

--A physician was paid for 150 visits for 28 patients over a 3-month period. Upon review by the fiscal agent's medical staff and by a peer review committee of the local medical society, 64 of the visits--for which $128 in Medicaid and $512 in Medicare payments had been made--were determined to be medically unnecessary.

HEW and paying agent officials stated that, to prevent or recoup payments for unnecessary services, the need for services provided should be evaluated both before payment of a claim--emphasizing the avoidance of an unnecessary payment--and after payment of a claim--emphasizing the analysis of paid claim data to identify those physicians with unusual patterns of services.

These officials also told us that utilization review, by its very nature, was difficult and complex and that the effectiveness of any system might be reduced because

--determinations that services were unnecessary were often largely judgmental,

--resolving cases identified as involving unnecessary services often involved disputes and prolonged hearing and appeal procedures; and

--costs of unnecessary services might be shifted to the patients without affecting the physicians' incomes, which resulted in limited deterrent effects to the physicians.

JUDGING MEDICAL NECESSITY OF SERVICES

HEW and paying agent officials stated that determinations of medical necessity were essentially judgmental and were difficult to make or evaluate. Some officials stated that these determinations were complicated because

--a wide range or variety of treatments might be appropriate for any given diagnosis and

--physicians' services might be best judged for necessity in light of results achieved. For example, if

> one doctor requires two office visits to successfully treat a patient while another can treat the patient--perhaps equally or even more successfully--in one visit, given the identical diagnosis, the second visit for the first doctor would not necessarily be uncalled for.

Some officials felt that the difficulty in making judgments that services were unnecessary could lead to an attitude on the part of the paying agents of pursuing a case only if it appeared to be clear-cut or gross overutilization and if significant resistance from the physician was not encountered.

Officials of some paying agents told us that one of the problems in making evaluations of whether medical services were necessary was the frequent need to request data--such as surgical reports, consultation reports, and diagnostic details--in addition to that normally furnished with a claim for payment.

RESOLUTION OF CASES INVOLVING UNNECESSARY SERVICES

HEW and paying agent officials advised us that development and resolution of cases of potential overutilization of services often involved long and tedious investigations, hearings, negotiations, or related activities before the cases were resolved or settled, because

- --paying agents must carefully review many of the physicians' claims for services to assure that they represented patterns rather than isolated instances;
- --paying agents must establish that the services were actually rendered;
- --physicians might protest rulings by paying agents, which would require arbitration of the cases by independent bodies, such as the local medical societies;
- --paying agents might not be able to develop cases because of the lack of documentation in the physicians' records,
- --patients' comments or testimony might be unreliable or not available; and
- --some physicians might be reluctant to give investigators access to records or to otherwise fully cooperate.

Officials of one paying agent advised us that processing a case from initial identification through its ultimate disposition usually required from 15 to 18 months. Our analysis of 11 problem cases investigated by another agent showed that the timespan for seven cases ranged from 7 to 44 months and averaged 21 months. As of January 1971 the remaining four cases that were still being developed by this paying agent had been under review for periods ranging from 18 to 45 months.

The following cases illustrate some of the time-consuming problems encountered by the paying agents.

--As a result of the prepayment review of claims, a carrier disallowed Medicare payments for excessive laboratory tests and excessive posthospital followup care rendered by a physician to a patient between September 1969 and February 1970. In February 1970 the physician and the patient jointly complained to the carrier and requested payment for the disallowed services. Following the complaint, the carrier reviewed the physician's claims for similar services to other patients and submitted all of his claims to a peer review committee. It was not until February 1971, 12 months later, that the case was resolved by the peer review's determination that the carrier's original action was appropriate.

--In August 1969, a carrier's review of a physician's claims for in-hospital visits showed that the physician was routinely charging for daily visits to all Medicare patients at a county tuberculosis hospital. Because of subsequent reviews by peer review committees, refusals by the physician to repay an alleged overpayment of $44,000, negotiations with the physician's lawyers, and reevaluations and recalculations of the overpayment, the case had not been resolved as of September 30, 1971--25 months after the process began.

When a physician has been determined to have rendered unnecessary services, a paying agent may take such actions as

--disallowing payments,

--collecting overpayments,

--advising the physician that his practices are questionable,

--referring the physician's name to the local medical society for censure,

--disqualifying the physician from program participation (applies to Medicaid only),[1] or

--subjecting the physician's future claims to special scrutiny before payments are made.

Officials of most of the paying agents included in our review stated that recovering money from a physician was an effective means of both correcting and preventing unnecessary services, but they stated that this was often practicable only when resistance was not encountered from the physician

COSTS OF UNNECESSARY SERVICES MAY BE PASSED ON TO MEDICARE PATIENTS

Medicare carrier officials told us that, because a physician's charge for unnecessary services could be shifted to the patient without affecting the physician's income, the physician might not be deterred from providing unnecessary services. A Medicare patient may pay the physician directly for services and then request reimbursement from the Medicare carrier. If this procedure is followed and if the carrier subsequently determines that the services were unnecessary, the patient would bear the disallowed costs.

A patient may assign his right to Medicare benefits to the physician, who requests payment directly from the carrier. If this procedure is followed and if the carrier subsequently determines that the services were unnecessary, the physician still has the option of billing the patient directly for the amount of the disallowed charges.

As a result of these procedures, a patient may ultimately pay for unnecessary services provided by a physician. This is illustrated by the following examples.

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[1]A proposal to amend the Social Security Act--to give the Secretary of HEW authority to terminate or suspend Medicare payments on subsequent claims of physicians found, on the basis of past or current claims, to be guilty of program abuses--was included in a bill under consideration by the Congress as of April 1972.

--A patient was admitted by a physician to a hospital for a 28-day stay. During the stay, another physician prescribed medication and treatment and both physicians made daily visits. Both doctors submitted claims for services, including charges for daily visits. The carrier allowed the admitting physician's claim of $209 but disallowed $285 of the $300 billed by the other physician because the admitting physician was paid for daily visits. As a result, the other physician billed the patient for the disallowed $285.

--A patient paid a physician $412 for various services, including injections, received during 1970 and submitted a claim to the carrier for the Medicare program's share of the bill. However, the carrier disallowed payment for 21 injections, reducing the reimbursement by $66.

Although the foregoing comments and examples do not reflect a complete or comprehensive description of the environment in which utilization control over medical services is exercised, the illustrations presented suggest a general context of complexity in which our specific observations and findings--discussed in the succeeding chapters--should be viewed.

CHAPTER 3

IMPROVED SAFEGUARDS NEEDED TO PREVENT PAYMENTS FOR UNNECESSARY SERVICES

SSA, SRS, and paying agents have put forth a great deal of effort to develop and implement utilization review systems. The resulting systems are based on widely varying philosophies, approaches, and methodologies. For the most part, the effectiveness of the various systems has not been evaluated by HEW to

--determine whether particular systems effectively prevent payment for medically unnecessary services;

--determine, for possible adoption on a broader scale, the methods and techniques which are most effective in identifying instances or patterns of medically unnecessary services; and

--provide a basis for assisting the paying agents in establishing and improving their systems.

DIFFERENT APPROACHES WITHIN HEW FOR CONTROLLING UTILIZATION

SSA and SRS took different approaches in their efforts to prevent payments for medically unnecessary services. These differences were reflected in the requirements and guidance each gave to its paying agents.

Prepayment controls provide for the identification of claims to be suspended from normal processing and payment for closer scrutiny because they exceed certain established criteria or have other uncommon characteristics. After a special review of such claims, which may include a request for additional information, the paying agents decide whether to pay, disallow, or reduce the amounts claimed.

Postpayment controls provide for comparing a physician's pattern or volume of services with the norms or standards based on practices of other physicians in the locality.

Those physicians whose practice patterns or volume of services exceed the norms or standards are identified by such comparisons for possible further investigation.

Differences in SSA's and SRS's guidance and requirements existing at the time of our review follow.

--SSA placed equal emphasis on the use of prepayment and postpayment review techniques; SRS emphasized the use of postpayment techniques. (In April 1972 SRS officials advised us that prepayment techniques are included in the model Medicaid information system. See p. 23 for a description of the system.)

--SSA's requirement for prepayment review of physicians' claims was limited to the number of physicians' visits and injections which the carriers considered medically appropriate. SRS did not require its fiscal agents to make prepayment reviews of claims for any specific services and had not instructed them on techniques for detecting claims involving services for which the need may have been questionable.

--SSA required all paying agents to produce quarterly data on individual physicians, such as number of services provided by, and the amounts paid to, physicians to identify those with unusual patterns of services through postpayment reviews of claims. SRS did not require such data.

Both SSA and SRS generally required paying agents to establish some kind of utilization controls, but they left it to the agents to determine what represented "unusual" patterns of services and the frequency or level of services to be used as norms or standards for evaluating physicians' claims in the prepayment and postpayment reviews. An exception to this procedure was SSA's designation of parameters for physicians' visits to nursing homes.

UTILIZATION REVIEW ACTIVITIES OF PAYING AGENTS

The paying agents' utilization review systems varied widely with respect to methodology and to the relative

emphasis on prepayment and postpayment reviews. The agents generally developed their systems on the basis of their private insurance experience. Of the seven paying agents included in our review, three used systems which emphasized the prepayment evaluation of the medical necessity of services because of

--the problems in attempting to review the necessity of services long after they had been rendered and

--the difficulty in obtaining a refund, if the services were found to be unnecessary after payment had been made.

The other four paying agents concentrated on postpayment reviews of claims because of

--the difficulty in completing the prepayment review of specific claims in a reasonable time and

--the problem of identifying unnecessary services in the prepayment review of claims because the period covered by the claims being reviewed was frequently not sufficient to identify questionable patterns of services.

Two of these agents concentrated on postpayment review of claims also because of the availability of a postpayment-oriented computer program for utilization review.

In one State, which began participating in Medicaid in January 1970, the paying agent was making prepayment reviews of Medicare and Medicaid claims. However, as a result of a study by a public accounting firm, the State agency was considering the adoption of a postpayment review system and the elimination of all prepayment reviews of Medicaid claims because they were considered to be too costly.

Some of the paying agents were attempting to achieve greater balance between prepayment and postpayment reviews. Officials of these agents expressed the belief that the key to utilization control over medical services would be a sound prepayment review system supplemented by postpayment reviews. Others felt that such measures as requiring

authorization for certain services before they were provided--as practiced in some States under Medicaid--were the most effective method of preventing unnecessary utilization of services.

Prepayment detection and resolution

The prepayment review systems used by the seven paying agents included in our review provided for the detection of claims for possible unnecessary services and the review of questionable items to decide whether the services performed were medically necessary.

Although SRS did not require a prepayment review of claims and SSA required a prepayment review only of the number of physician visits and injections, most of the paying agents had developed varying types of utilization controls for particular types of services.

The following table shows the more common services for which prepayment reviews had been established by the seven paying agents.

	Paying agents									
	Medicare						Medicaid (note a)			
	A	B	C	D	E	F	C	E	F	G (note b)
Physicians' services										
Surgery	X	X	X	X	X		X	X		
Surgical assistance	X	X	X	X			X	X		
Anesthesia	X		X	X		X	X		X	
Radiotherapy	X		X			X	X		X	
Consultations	X	X	X	X		X	X	X	X	
Physical therapy	X	X	X			X	X		X	
Injections	X	X	X	X		X	X		X	
Podiatry	X	X	X			X	X		X	
Tests·										
Laboratory	X	X	X	X		X	X	X	X	
X-ray	X	X	X	X		X	X		X	
Electrocardiogram	X	X	X				X		X	

[a]Under the Medicaid program some State agencies require prior authorization for certain services, such as examinations for eyeglasses, dental work, or X-rays Prior authorizations were not considered to be prepayment reviews for purposes of this table.

[b]This fiscal agent had not established prepayment reviews for these services and tests.

The complexity of the reviews for the same services also varied widely. Some paying agents had very simple review procedures for the detection of possible unnecessary services, such as procedures for questioning instances when a physician's visits exceeded a specified number of visits a month. For example·

--One agent questioned the need for more than four office visits a month.

--Another agent did not question the need for visits unless they exceeded 10 a month.

Other agents developed detailed review procedures which allowed for variations in the number of physicians' visits considered reasonable, depending upon the nature and duration of a patient's illness. For example, one paying agent would question the need for visits when they exceeded

--one a day during the first week of the illness,

--three a week during the second week of illness,

--two a week during the third week of illness,

--one a week during the fourth or fifth week of illness, and

--one a month thereafter.

Paying agents also had varying procedures on the extent that a patient's past medical history was used in reviewing current claims. For example·

--Two carriers did not use past medical history but relied solely on the current claims.

--One carrier considered all medical services provided to a patient during the preceeding 60 days in reviewing the need for a specific service.

--Two carriers considered a patient's complete medical history in reviewing the necessity for a service.

All but one of the Medicare carriers included in our review had established prepayment review systems which appeared to meet SSA's requirements. The other carrier's system did not appear to comply because the number of physicians' visits to be considered questionable was not specified; instead, the system merely referred to "frequent" or "a large number of" visits.

Postpayment computer detection of unusual patterns of services

The paying agents' postpayment review systems provided for identifying physicians with unusual patterns of services as opposed to reviewing individual claims. Examples of the widely varying methods used follow.

--One paying agent prepared quarterly listings showing for each physician (1) the number of patients, (2) the total and average charges for each patient, and (3) the average number of visits and surgeries (no other services were considered) for each patient. These listings were reviewed manually to identify those physicians who exceeded at least three of five predetermined standards or norms for this data.

--A second paying agent was developing a computer program to analyze all services and to identify the types of services which showed unusual fluctuations from prior periods and/or predetermined standards. For the identified services, the providing physicians were then to be identified and selected for investigation.

--Two other paying agents identified, on a quarterly basis, the physicians whose medical services exceeded established norms. The norms established for each type of service were computed on the basis of the number of times a service had been provided per 100 patients and per 100 services. Each physician's services in excess of the norms were assigned numerical values in accordance with an established table of values. The 200 physicians having the highest values were subject to possible further investigation.

--Another agent did not analyze physicians' specific services but only identified those physicians whose payments exceeded $2,000 a month.

Because the paying agents' systems varied widely, a physician with patterns of potentially unnecessary services identified under one system would not necessarily be identified under the other systems.

At the time of our fieldwork, two of the six Medicare carriers had systems which appeared to meet the postpayment review requirements specified by SSA, three carriers were developing procedures intended to meet these requirements. Officials of the remaining carrier advised us that they did not believe there was a need for producing--each quarter--computer data summarizing the practices of all physicians providing services to patients as required by SSA. Although this carrier's system was capable of providing the SSA-required quarterly data, these officials said that they did not plan to meet the SSA requirement. Instead, data was developed for physicians with only those medical specialties believed by the carrier as having the most potential for involving unnecessary services.

Although agreeing with SSA goals, individual carriers expressed reluctance to revise their existing systems to meet SSA requirements because they believed their own systems to be more effective.

OTHER SYSTEM DEVELOPMENT EFFORTS

Both SSA and SRS had developed, or were developing, model systems of utilization controls for optional use by paying agents. As of October 1971

--the SSA model system was being used by 11 carriers and

--SRS was in the process of developing a model Medicaid management information system.

Although SSA and SRS gave some consideration to the paying agents' existing systems, these systems had not been evaluated as a basis for building specific effective features into the model systems.

The procedures in SSA's model utilization review system provide for the postpayment analyses of physicians' patterns of services. These procedures were consistent with SSA's instructions to carriers for use in developing their systems. However, the model system did not provide for prepayment detection of questionable claims. SSA officials advised us that a carrier was in the process of developing a computer

program employing prepayment detection procedures which, if successful, would be offered to the carriers using the SSA model system.

The SRS utilization review system is to be a part of the model Medicaid management information system currently being developed. The objective of this model system is to provide for the effective processing, control, and payment of claims and to provide the States with information necessary for administering their Medicaid programs. The surveillance and utilization review section of the model system--which includes both prepayment and postpayment procedures--is designed to detect misuse of the program and provides for

--the preparation of summaries to show beneficiaries' and providers' medical service histories and to identify those who deviate from specified parameters or norms,

--the review and investigation of deviants to determine whether the medical services were appropriate or whether misuse had occurred, and

--the use of appropriate corrective measures in those instances involving overutilization.

SRS officials advised us in April 1972 that all jurisdictions having a Medicaid program had been given an orientation on the model system and that one State was in the process of implementing the model system, which should be operational in that State by October 1972.

In one State included in our review, the State Medicaid agency had contracted with several insurance companies--including a Medicare carrier--to develop a computerized system of patient and physician service history data for use in reviewing the medical necessity of services.

EFFECTIVENESS OF SYSTEMS NOT EVALUATED

The following groups within HEW are responsible for reviewing the operations of paying agents.

--HEW's Audit Agency, an independent organization which is responsible for reviewing, among other things, the activities of SSA, SRS, and paying agents.

--SSA's Contract Performance Review teams, which are responsible for reviewing Medicare operations.

--SRS's Program Review and Evaluation Project teams, which are responsible for reviewing Medicaid operations at States and fiscal agents.

The reviews by these groups usually have not dealt with the effectiveness of controls for preventing payments for unnecessary medical services but usually have dealt with determining whether required controls had been established. Some examples of these reviews follow.

--In August 1969 the HEW Audit Agency reported on its review of the utilization controls established under Medicaid by States and fiscal agents at 16 locations. The report stated that controls to prevent payments for unnecessary medical services had not been established at 12 of the 16 locations. The report did not discuss the effectiveness of the controls at the four locations where they had been established.

--A July 1970 SSA Contract Performance Review team report showed that a carrier had not established adequate review procedures for use by claims processors or that existing procedures were too general. The report did not show that an analysis had been made of the effectiveness of those procedures which had been established

--A March 1971 SRS Program Review team report commented on the Medicaid utilization review activities of a State agency. The report stated that the major difficulty confronting the State's utilization review program was the lack of a computer system and the

reliance on inadequate sampling of claims because the reviews were performed manually.

Although the effectiveness of the paying agents' utilization review systems have not been evaluated, SSA--unlike SRS--has assigned resident representatives to monitor the operations of its Medicare carriers These onsite representatives are responsible for the overall surveillance of the carrier's Medicare claim-processing operations, including utilization controls

LIMITED BASIS FOR EVALUATING EFFECTIVENESS OF UTILIZATION REVIEW SYSTEMS

Little specific information was available on the costs, features, and results of paying agents' utilization review systems. For example, most of the paying agents could not identify the number of claims which, under their prepayment review systems, had been suspended from normal processing and subjected to further review. Although monthly statistics were gathered to show the total number of Medicare claims and the amount of disallowances due to unnecessary medical services, these disallowances usually could not be readily related to specific claims or services or could not be identified as having resulted from prepayment reviews of claims. One of the Medicare carriers included in our review, however, had implemented a computerized prepayment control system in September 1970 which provided such information to give management a basis for evaluating and reviewing the criteria used for detecting unnecessary utilization of services.

Paying agent officials told us that the costs of utilization review activities generally could not be identified because they usually were included in other claim-processing costs. With few exceptions--such as overpayments for unnecessary services identified by peer review committees--the paying agents did not have sufficient management control over the activities and results of specific utilization controls.

Paying agents' officials generally told us that they had not refined their systems of management information to develop cost and statistical information which would be useful in evaluating the utilization review systems, because

HEW had not established such requirements and because other subjective measures of performance could be used. However, they generally agreed that such information would be beneficial. In March 1972 HEW officials advised us that the model Medicaid management information system had the capability to produce the information necessary to measure the effectiveness of the various utilization controls built into the system.

Although HEW had not evaluated the various utilization review systems implemented under the Medicare and Medicaid programs, SSA issued a directive in June 1970 relating to quality control over utilization safeguards. This directive requires each Medicare carrier to (1) periodically review the application and adequacy of utilization guidelines used for identifying questionable claims for further review and (2) evaluate any other mechanisms which are employed to detect unnecessary services.

Early in fiscal year 1972, SSA compiled data on the prepayment criteria used by its carriers for evaluating physicians' visits. The data showed considerable variations--as did our review--in the number of physicians' visits used as prepayment criteria. As a result, SSA concluded that the mere existence of criteria was not an indication of an effective system to control unnecessary utilization of medical services. SSA also recognized that, to evaluate the carriers' prepayment review systems, additional data would be needed, such as

--whether the criteria were effective in identifying unnecessary services,

--how efficiently the prepayment criteria were applied in reviewing claims,

--what actions were taken on claims identified as involving potential unnecessary utilization of medical services, and

--whether the prepayment review systems resulted in some reduction of unnecessary utilization of such services.

Our review showed, however, that such information generally had not been obtained--or required--by either SSA or SRS.

CONCLUSIONS

Although much has been done to develop and implement utilization review systems for preventing payment for unnecessary medical services, little is known about the effectiveness of the systems in use HEW guidance to paying agents has focused on assuring that review systems have been implemented, but it has not provided paying agents with meaningful assistance in the development of the systems or the type of controls which are most effective.

So that HEW can be assured that the paying agents' utilization review systems are producing the most meaningful and productive benefits, more emphasis should be placed on the development of information by the agents on the costs of, and results achieved under, their systems. This information should enable HEW to evaluate and compare existing systems with a view toward promoting the adoption, on a broader scale, of those systems or features of systems found to be most effective.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that HEW--through the coordinated efforts of SSA and SRS--evaluate the overall effectiveness of the paying agents' utilization review systems to identify the more effective features or procedures of each system and provide information to the paying agents as to which systems and/or procedures are most effective and should be adopted.

AGENCY COMMENTS AND ACTIONS

In a letter dated March 29, 1972 (see app. I), HEW concurred with our recommendation and acknowledged that SSA and SRS had been more concerned with assuring that all paying agents had developed systems for preventing payments for unnecessary medical services than with the effectiveness of the systems being used. HEW attributed this to (1) the need to get the program underway, (2) the lack of sufficient previous experience in controlling unnecessary utilization,

and (3) the absence of standards for measuring the systems being used

HEW also pointed out that:

> "These considerations, when combined with the sensitivity of the professional community to being questioned on matters of medical judgment, the complexity of utilization issues and the lack of general medical consensus of the extent of and circumstances under which services should be provided have made the development of effective claims control of improper utilization under Medicare and Medicaid very difficult."

HEW stressed, however, that despite these problems great progress had been made toward the development and implementation of effective utilization safeguard systems. Although we agree with HEW, we believe that improved safeguards are needed for minimizing costs under the Medicare and Medicaid programs.

CHAPTER 4

NEED FOR INVESTIGATING PHYSICIANS WITH UNUSUAL PATTERNS OF MEDICAL SERVICES

Each of the Medicare and Medicaid paying agents included in our review had established methods and procedures--of some type--to identify physicians with unusual patterns of medical services. However, these unusual patterns--which indicate that physicians may be providing unnecessary services--often were not investigated by the paying agents to determine whether

--unnecessary services had been provided,

--future claims by these physicians should be closely reviewed, or

--refunds should be sought.

At our request, three Medicare carriers reviewed the medical necessity for services provided to selected patients by certain physicians who had been identified by the carriers' systems as having unusual patterns of services These physicians had not previously been investigated by the carriers. The reviews made by the carriers' medical consultants resulted in the determination that a significant number of these physicians warranted investigations, which the carriers agreed to make

HEW had not assured itself that paying agents were putting forth sufficient effort to investigate and resolve cases in which the medical services provided to patients appeared to be questionable and that such efforts were directed to those cases with the most potential for reducing program costs.

Such followup and retrospective analysis--based on professional medical judgment--is needed as a basis for

--subjecting future claims of specific physicians or patients to special scrutiny,

--monitoring the effectiveness of the prepayment controls so that appropriate action may be taken to make changes when warranted, and

--determining overpayments for which refunds should be sought.

GUIDANCE TO PAYING AGENTS FOR IDENTIFYING AND INVESTIGATING CASES

SSA, in its instructions to carriers, indicated that they should produce postpayment data for identifying physicians whose patterns of services fell outside established norms, so that

--consideration could be given to the need for professional medical review of the physicians' services and

--future claims by the physicians could be given special prepayment review.

SRS, in its instructions for fiscal agents, directed that postpayment reviews be made of physicians' claims for services but did not provide guidance as to the nature and extent of investigations to be made after unusual patterns of services were identified.

Neither SSA nor SRS had provided any specific guidance to paying agents to insure that the investigative resources available were being used to investigate those cases with the greatest potential for disclosing program abuses or achieving program savings. Furthermore, they had not evaluated the adequacy of the investigations made by paying agents of physicians found to have unusual patterns of services.

INVESTIGATIONS OF PHYSICIANS WITH UNUSUAL PATTERNS OF SERVICES

Although paying agents, through their postpayment utilization review systems, had identified many physicians with unusual patterns of services, only a few had been investigated to determine whether any unnecessary services had been provided. For example.

--During calendar year 1970, of 539 physicians whose services exceeded quarterly postpayment norms established by one paying agent, only 12 were investigated

--Two paying agents, under their postpayment detection systems, each produced data showing that about 800 physicians a year had unusual patterns of services. One agent investigated about 40 physicians a year, the other investigated 285.

--Another paying agent had produced, under its postpayment review system, a listing of 645 physicians in a single month which was to be used as a basis for detecting potential cases warranting further investigation, however, none had been investigated

Nature and results of paying agent investigations

When paying agents did investigate potential cases of overutilization of medical services that were detected through their postpayment utilization review systems, the results usually indicated that some of the cases involved unnecessary services. (See p. 9.) Such investigations usually led to specific action by the paying agents, such as closely monitoring future claims submitted by the physicians involved or attempting to recover overpayments.

Most of the paying agents' investigations included evaluations by medical consultants to establish the necessity of the services. However, this practice was not followed in all cases. For example, the investigations made by the paying agent who investigated 12 of 539 physicians who had been identified as possibly providing unnecessary services usually consisted of verifying that the claimed services were documented in the physicians' records. Opinions of medical experts were not obtained for evaluating the medical necessity for the services, and, as a result, no cases of questionable medical services were disclosed.

At our request this paying agent's medical staff reviewed the medical necessity for a sample of services provided by nine of the 12 physicians who had been investigated and concluded that five had provided unnecessary services.

Officials of this agent stated that they had not understood that the paying agent's investigative role should include obtaining medical opinions on the necessity for medical services but that they now recognized this need and such evaluations would be obtained in future utilization investigations

We also selected, at three of the five carriers included in our review, samples of services provided by 42 physicians to 230 patients and referred them to the carriers' medical staff for evaluation In the opinion of the medical staff, the patterns of services for 17 of these 42 physicians indicated that unnecessary services had been provided and that an investigation of the physicians should have been made The services questioned most often by the medical staff were physician visits, laboratory tests, and injections

Carrier officials agreed that the results of the medical evaluation of the sampled services indicated that that further action was needed, but they stated that they had not investigated more of the identified physicians because of insufficient staff and higher priorities for investigations involving specific allegations or complaints

Regional SSA officials stated that, except for special investigations requested by the SSA central office or specific complaints received by SSA, the establishment of priorities for determining physicians to be investigated was a carrier responsibility

SRS regional officials told us that the States were responsible for the development and operation of utilization control systems, including the necessary followup actions. They advised us also that they did not get involved with the day-to-day operations of the States' Medicaid programs In March 1972 HEW officials advised us that this approach had not produced very satisfactory results and that it was necessary to help the States by developing the model Medicaid management information system (See p 23.)

CONCLUSIONS

The effectiveness of the paying agents' utilization review systems in preventing payment for unnecessary physicians' services provided to Medicare and Medicaid patients is dependent upon the actions taken by the paying agents to investigate suspect cases Such actions should include a medical evaluation of the need for the services provided

Although paying agents, through their utilization review systems, have identified many physicians who had unusual patterns of medical services, relatively few physicians have been investigated to determine whether the services provided were necessary, whether refunds should be sought, or whether future claims for services should be closely reviewed.

The investigations made of physicians with unusual patterns of services have resulted in the recovery of overpayments from physicians found to have provided unnecessary services A further benefit that should result from such investigations is the deterring effects on the physicians being investigated and on others who might be providing unnecessary medical services

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that HEW.

--Provide guidance to paying agents for identifying patterns of medical services which warrant further investigation to determine whether unnecessary services were provided

--Encourage paying agents to investigate those patterns of services to the fullest extent possible

--Require that the paying agents' evaluations of the need for medical services be based on professional medical judgment

AGENCY COMMENTS AND ACTION

In its letter of March 29, 1972 (see app. I), HEW concurred with our recommendation and advised us that it was actively working toward its full implementation.

CHAPTER 5

NEED FOR GREATER COORDINATION AND EXCHANGE OF INFORMATION BETWEEN MEDICARE AND MEDICAID

Not only are Medicare and Medicaid administered by separate organizations within HEW, but in many States different paying agents are responsible for processing claims for all or a portion of the medical services provided under both programs. Physicians often provide care to both Medicare and Medicaid patients and are paid for the respective services by different paying agents. Because different agents often are responsible for making payments for medical services under the programs, one agent may have identified--without the other agent's knowledge--a physician as having abused the program or as having an unusual or questionable pattern of services.

Although a finding that certain physicians have provided unnecessary services under one program does not necessarily mean that they have done so under the other program, we believe that more exchange of information about utilization of services among the various paying agents is needed. This information could serve as a basis for the other agent's giving particular attention to the medical need for the care provided by these physicians.

Within each program information on hospital stays and physician services provided to patients while in the hospital should also be exchanged and compared so that the medical necessity of the total medical care furnished to a particular patient can be evaluated. Paying agents responsible for processing both Medicare and Medicaid claims for inpatient care may determine that the length of a patient's institutional stay is unnecessary and may deny benefits for that period. However, claims for the services rendered by the patient's attending physician are often processed by other paying agents. If these paying agents were made aware of the denial of the patient's institutional stay, this information could serve as a basis for a critical review of the medical necessity for the services provided by the attending physician(s) during the period of denial.

Although the denial of a patient's institutional stay may not necessarily obviate the need for the attending physician's(s') services during the period of denial, paying agents who did obtain such information told us that, in some instances, they had determined that the attending physician's(s') services had been unnecessary.

PAYING AGENTS' INVESTIGATIONS OF SERVICES PROVIDED BY PHYSICIANS

The paying agents' investigations of services provided by physicians were usually concerned with claims for services that were not rendered (suspected fraud) or for services that were not medically necessary.

Because of confidentiality restrictions, SSA regulations initially precluded the release of information on Medicare "problem" physicians to State agencies responsible for Medicaid administration. The regulations were amended on January 20, 1970, to eliminate this restriction and to permit release of Medicare data to State Medicaid agencies. However, procedures had not been implemented for the exchange of such information in two States included in our review where claims under Medicare and Medicaid were paid by different agents.

The following examples--developed from records maintained by separate Medicare and Medicaid paying agents--show what happened when effective coordination was not maintained.

--In December 1966 an investigation by a State Medicaid agency showed that a physician had submitted claims for home and office visits which were not made. rather than face legal proceedings, the physician voluntarily withdrew from the Medicaid program on January 30, 1967, but continued submitting claims under the Medicare program and received payments of about $112,000 from 1967 through 1970.

At our request, the Medicare carrier's medical consultant reviewed a sample of the physician's claims for office visits and determined that his pattern of services was indicative of a utilization problem.

We were advised by carrier personnel that an investigation would be made. In October 1971 we were advised that the investigation had been completed and that the case was being referred to the State medical society for review.

--Another physician was barred from the Medicaid program on March 31, 1966, due to large discrepancies between his claimed number of visits and the number verified by the patients. On June 1, 1968, the physician was reinstated under the Medicaid program but was warned that any additional abuses would result in his being permanently barred from the program.

This physician was also participating in the Medicare program under which he was paid about $99,000 from 1967 through 1969. As a result of a patient's complaint, the Medicare carrier, in April 1969, initiated a special investigation of the physician's practice and referred the case to SSA officials in September 1969 for suspected fraud. Nevertheless, Medicaid payments of $10,240 were made to the physician during 1970. We were advised by carrier officials that the case was forwarded to the U.S. attorney for prosecution.

--Between October 1967 and May 1970, a Medicaid fiscal agent recommended to a State agency that 10 physicians by suspended from participation in the Medicaid program because of utilization problems. As of June 30, 1971, the Medicare carrier's review had identified only four of these as problem physicians. During the first 6 months of calendar year 1971, the carrier paid the other six physicians $34,950 for services provided under the Medicare program. In discussing this matter with carrier officials, we were advised that reductions in the amounts paid probably would have been made if the physicians had been subjected to special reviews.

--During the period July 1966 to May 1969, 14 physicians were suspended from participation in the Medicaid program in one State due to utilization and billing problems. By June 30, 1971, the Medicare carrier

had become aware that these physicians warranted special scrutiny. The carrier, however, had made substantial payments during the period--ranging up to 53 months--in which the physicians had been suspended from the Medicaid program.

In two States where the same paying agent paid claims for physician services under both Medicare and Medicaid, paying agent officials informed us that when a problem was identified under one program they also determined the effect of the problem under the other program. For example, a physician partnership agreed to refund Medicare payments of about $23,000 and Medicaid payments of about $1,500 on the basis of a paying agent's investigation--triggered by a complaint from a Medicare beneficiary--of the partnership's laboratory test practices.

NEED FOR COORDINATION BETWEEN PAYING AGENTS RESPONSIBLE FOR INPATIENT HOSPITAL SERVICES AND PAYING AGENTS RESPONSIBLE FOR PHYSICIANS' SERVICES

Our review disclosed instances in which the exchange of information on hospital and physicians' services between Medicare part A fiscal intermediaries--paying agents for inpatient hospital services--and part B carriers could have been beneficial. Such exchange of information would have provided a correlation and comparison of Medicare payments for inpatient hospital services and the corresponding physician services as a means of evaluating the equity of payments made by the individual paying agents for the complete health care provided. Similar benefits could be achieved under Medicaid when different paying agents are responsible for hospital care and physician services.

Of the seven paying agents (three of which were responsible for both Medicare and Medicaid) included in our review, two Medicare and two Medicaid agents had procedures for correlating a patient's hospital stay with the physician's services rendered during that stay. If services were denied in one benefit area, a corresponding reduction was considered in the other benefit area. For example.

--A Medicare patient was hospitalized for a 39-day period for which part A hospital benefits were claimed. The paying agent determined that the last 25 days of hospitalization were not medically necessary and denied payment. The paying agent was also responsible for processing claims for part B physician services and forwarded the information about the part A denial to the part B claim-processing group. This action resulted in the amounts claimed for surgical services being reduced from $475 to $350 and in those for daily visits by a general practitioner being reduced from $860 to $70 because the services provided during the denial period were determined to be medically unnecessary.

However, the other paying agents did not consider the possible implications of physicians' services provided during periods of unnecessary hospital stays. For example:

--One paying agent, who processed and paid claims for physicians' services, was not informed of the specific hospital days that the agent processing Medicare part A and Medicaid hospital claims had determined to be medically unnecessary. In fiscal year 1970 the amounts claimed for the hospital days disallowed by this agent totaled about $962,000 under Medicare and $1,359,000 under Medicaid. Officials of this paying agent and SSA regional representatives told us that such information would have been useful in determining the medical necessity of physician services rendered during periods of unnecessary hospital stays.

--One Medicaid fiscal agent regularly received advice from two other fiscal agents when they denied payment of Medicaid hospitalization claims. Although this information was not used by the recipient fiscal agent to identify physicians whose services might warrant investigation--because such a Medicaid requirement did not exist--fiscal agent officials indicated to us that it would be feasible and desirable to use the information for that purpose.

CONCLUSIONS

The exchange of information by paying agents on known or potential problem physicians would allow the investigations and utilization reviews made by one paying agent to supplement, or indicate the need for, reviews by another paying agent. This exchange would also result in providing paying agents with information for use in identifying instances of possible unnecessary medical services which might otherwise go undetected.

The identification and investigation of such cases should result in reductions in the cost of the Medicare and Medicaid programs.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that HEW.

--Establish procedures for the effective exchange of

data on known or potential utilization problems among the various paying agents under the Medicare and Medicaid programs.

--Monitor the exchange of data to assure that paying agents follow through on potential problem cases.

AGENCY COMMENTS AND ACTIONS

In its letter of March 29, 1972, HEW concurred with our recommendation and advised us that draft instructions had been completed which provided for the exchange of information. HEW advised us also that both SSA and SRS would review the effectiveness of this data exchange as part of their monitoring of paying agents' performance. (See app. I.)

CHAPTER 6

SCOPE OF REVIEW

Our review was directed toward an assessment of the problems involved in establishing, and the opportunities for improving, controls over payments for physicians' services which were not medically necessary. The review included (1) a study of Medicare and Medicaid legislation and related regulations, (2) an examination of instructions issued by SSA and SRS, (3) an appraisal of the roles SSA, SRS, and paying agents played in minimizing payments for physicians' services which were not medically necessary, and (4) an examination and test of the results of efforts to minimize payments for unnecessary services.

Our review was made in five States and was concerned with the activities of

--three carriers responsible for Medicare only,

--three organizations which served both as Medicare carriers and Medicaid fiscal agents,

--a State agency responsible for Medicaid only;

--regional offices of SSA and SRS; and

--central headquarters offices of SSA and SRS in Baltimore, Md., and Washington, D.C.

These carriers and fiscal agents made benefit payments in fiscal year 1971 of about $376.4 million under the Medicare program and about $285 million under the Medicaid program.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
WASHINGTON, D C 20201

OFFICE OF THE SECRETARY

MAR 29 1972

Mr. Dean Crowther
Associate Director, Civil Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Crowther

The Secretary has asked me to reply to Mr. Philip Charam's letter dated December 27, 1971, which transmitted copies of your draft report, "Opportunity to Improve Procedures for Assuring that Physicians' Services Paid for Under the Medicare and Medicaid Programs are Medically Necessary "

We are enclosing a statement setting forth the Department's comments with respect to the findings and recommendations contained in the report.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosure

OPPORTUNITY TO IMPROVE PROCEDURES FOR ASSURING THAT PHYSICIANS' SERVICES PAID FOR UNDER THE MEDICARE AND MEDICAID PROGRAMS ARE MEDICALLY NECESSARY (GAO DRAFT REPORT TRANSMITTED DECEMBER 29, 1971)

We are in general agreement with GAO regarding the need for improvements in the utilization safeguard systems used by paying agents under the Medicare and Medicaid programs to detect and control unnecessary physician services To put the matter into perspective, however, it should be kept in mind that prior to the enactment of these programs, third-party payers had a long tradition of accepting the physician's order as conclusive evidence that utilization was proper Thus, there was little useful experience that could be drawn upon These considerations, when combined with the sensitivity of the professional community to being questioned on matters of medical judgment, the complexity of utilization issues and the lack of general medical consensus on the extent of and circumstances under which services should be provided have made the development of effective claims control of improper utilization under Medicare and Medicaid very difficult Nevertheless, despite these problems, great progress has been made towards the development and implementation of effective utilization safeguard systems Some illustrations of this progress are as follows

-In February 1970, SSA issued Part B Intermediary Letter No 70-5 which outlined certain minimum prepayment and postpayment utilization controls that were to be adopted by the carriers It required that carriers establish prepayment screens to detect overutilization of medical services in four categories--office or home visits, hospital visits, ECF visits, and nursing home visits Intermediary Letter 70-5 also required carriers to produce quarterly postpayment profiles for each physician showing the number of services rendered in several categories, the number of beneficiaries served, ratios between these services and the number of beneficiaries, and the amounts paid for services rendered by the physician These profiles were to be analyzed to identify physicians who were overutilizing These are the minimum controls carriers are expected to have but many have additional screens as a result of experience in their private business or through their usage of one of the several model claims processing systems

-SRS developed a Medicaid Management Information System (MMIS) and began an analysis of systems conditions in each State in September 1971 SRS is continuing to evaluate the States' systems on a State-by-State basis and is helping them incorporate all or portions of the MMIS, where requested As of 3/1/72, SRS has provided all Medicaid jurisdictions a MMIS orientation and 35 of the jurisdictions have requested additional SRS assistance in the systems area The MMIS specifically addresses most of the points about utilization controls raised in the report The Surveillance and Utilization Review subsystem represents a very refined and effective method for monitoring improper Medicaid utilization Copies of the MMIS have been furnished to GAO

-Several model claims processing systems containing utilization controls have been developed and are currently being used in the Medicare program These include the system developed by Electronic Data Systems (EDS), the SSA Model System, and the Applied Systems Development Corporation (ASDC) system The EDS system is now being used at 10 carriers, six of which use the systems utilization control features These controls fall into three categories screens on a per claim basis which are a dollar limitation, screens based on the number of occurrences of a particular service in a month, and screens which check for concurrent care and after care In the postpayment area, EDS analyzes physician profiles on the basis of frequency of occurrence of a

procedure per 100 services rendered The SSA Model B System is currently used at 14 carrier sites The prepayment utilization module offers several categories of screens, including screens for excessive visits, concurrent care and procedures not related to diagnosis The testing of this module was just completed and it began operation at one carrier site in February When the necessary adjustments are made, it will be made available at the other carriers using the system In the postpayment area, the Model System produces physician profiles in the format required by Intermediary Letter 70-5 The ASDC system, which four carriers use, has prepayment computer screens for concurrent care and excessive visits and the capability of producing physician profiles with the data outlined in Intermediary Letter 70-5

The Department has been developing a number of demonstration projects from which it is hoped that the kinds of sophisticated utilization review techniques and standards of measurement and evaluation will emerge One reason for the concentration on the development of demonstration projects is that there is a good possibility that legislation may be enacted requiring the establishment of Professional Standards Review Organizations (PSRO) throughout the country through which practicing physicians would assume the responsibility for reviewing utilization of services billed for under Medicare and Medicaid The effect of this legislation would be to shift much of the responsibility for professional review of claims from the carriers and intermediaries to PSROs To ensure reasonably early success with legislation for a full-scale PSRO program, approaches for implementing such legislation are being developed If the PSRO legislation is not enacted, we would anticipate that those techniques tested by demonstration projects and proven to be effective could be incorporated into the existing Medicare and Medicaid claims review process

Our comments on GAO's specific recommendations are as follows

1. Recommendation We recommend that the Secretary of HEW--through the coordinated efforts of SSA and SRS--take advantage of the many control systems that have been developed by evaluating the overall effectiveness of these systems, identifying the more effective controls of each system, and providing information to the paying agents as to which methods or procedures are most effective and should be adopted (Page 33)

It is true that previous efforts of SSA and SRS have been more concerned with assuring that all paying agents under Medicare and Medicaid had, and used, a system for preventing payment for unnecessary medical services than with evaluating the effectiveness of the controls being used This is attributable (1) to the need to get the programs underway, (2) to the lack of sufficient previous third-party payor experience in controlling unnecessary utilization and (3) to the absence of standards for measuring the effectiveness of the systems being used We would, however, concur with GAO's recommendation that there is a need for continued evaluation of the various systems currently used under Medicare and Medicaid so that the controls proven to be most effective could be determined and communicated to all paying agents We would also agree that, where feasible, there should be coordination between SSA and SRS in this effort SSA and SRS have initiated this coordinated effort by exchanging information about the various model systems in use in each program so that a comparison could be made of the relative effectiveness of each system

While acknowledging the need for further evaluations of the effectiveness of the various utilization safeguard systems in use, we think the report might give the erroneous impression (1) that because the systems have generally been developed independently of each other, there is no similarity between them, (2) that, until the present time, there has not been any real evaluations of the systems in use and (3) that it is feasible or desirable to begin to develop a total national system applicable to Medicare and Medicaid

While it is generally correct that the various utilization safeguard systems were developed independently of each other, there are many basic similarities between the systems In the Medicare program, Part B Intermediary Letter 70-5 contributed to the uniformity of carrier systems by establishing the minimum prepayment and postpayment utilization controls that were required In addition, Part B Intermediary Letter No 71-18 established functional standards for carrier claims processing operations Secondly, there has already been some evaluation of the adequacy of the various utilization control systems established by the paying agents under Medicare and Medicaid SRS, for example, is currently evaluating the present State systems across the country using the MMIS as a model and is helping States to incorporate its control features into their systems Furthermore, efforts have been made to communicate information about methods or procedures that seem effective As an example, SRS, through its Technical Assistance Series, distributes information about exemplary administrative practices to all the States Last, it should be recognized that some of the differences between the systems that have been established reflect differing patterns of medical practice in different areas Since the question of medical necessity is a judgmental one, since accepted standards of medical practice vary from area to area, and since there generally is no national medical concensus on appropriate utilization of specific services, it is appropriate for reliance to have initially been placed on the carriers' medical staffs in identifying questionable patterns of practice in their service areas It should be noted that the same approach would be utilized under the proposed PSRO legislation which provides for each PSRO to develop norms of care and treatment based on typical patterns of practice in the PSRO's area

2 Recommendation We recommend that the Secretary of HEW

--provide guidance to its paying agents for identifying the types of situations which warrant further investigation to determine whether unnecessary services were provided,
--encourage its paying agents to investigate these cases to the fullest extent of available resources, and
--assure that evaluation of the need for medical services are based on professional medical judgment (Page 40)

We concur with this recommendation and are actively working towards its full implementation.

3 Recommendation We recommend that the Secretary of HEW establish procedures for effective exchange of data on known or potential utilization problems among the various paying agents under the Medicare and Medicaid programs Since the responsibilities for claims processing and utilization review are contracted out to many organizations, we recommend also that HEW monitor the data exchange to assure that paying agents follow-up on potential problem cases (Page 48)

We concur with this recommendation SSA has completed draft instructions, presently in the review process, which provides for the exchange of information between carriers paying for physician services and fiscal intermediaries paying for institutional care SRS provides for the exchange of similar information between fiscal agents separately responsible for hospital care and physician services through the MMIS SSA and SRS will review the effectiveness of this data exchange as part of their monitoring of performance of paying agents SSA is also providing SRS and the State agencies information on utilization problems uncovered in the Medicare program, including data on physicians earning in excess of $25,000 in Medicare reimbursement, information on cases involving questions of program integrity, and data on physicians and providers where benefits are suspended

[See GAO note.]

GAO note: Deleted comments relate to matters which were presented in the draft report but have been revised in this final report.

APPENDIX II

PRINCIPAL OFFICIALS

OF

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES

DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
ADMINISTRATOR OF SOCIAL AND REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970

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