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Report to the Chairman, Human Resources and Intergovernmental Relations Subcommittee, Committee on Government Reform and Oversight, House of Representatives

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MEDICARE

Millions Can Be Saved by Screening Claims for Overused Services

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The Honorable Christopher Shays
Chairman, Human Resources and
Intergovernmental Relations Subcommittee
Committee on Government Reform and Oversight
House of Representatives

Dear Mr. Chairman:

Medicare is the nation's largest health care insurer. Medicare spending totalled $162 billion in 1994, about 14 percent of the federal budget. Without additional controls over this spending, the Congressional Budget Office estimated in December 1995 that total Medicare outlays will reach $336 billion in 2002.

Restraining the growth in Medicare spending has proven difficult. This is in part because the fee-for-service payment system[1] provides little financial incentive for physicians or patients to consider whether diagnostic tests and some routine services are medically necessary. Moreover, physicians paid on a fee-for-service basis may have a financial incentive to increase their income by providing more services than are necessary. In addition, patients often lack the information and expertise necessary to question the medical necessity of services ordered by physicians. As a result of these two factors, preventing Medicare payments for unnecessary services calls for program safeguards to check the accuracy and medical necessity of claims.

One type of program safeguard is the use of medical policies that define the diagnostic criteria for a service. For example, a medical policy for echocardiography may allow payment if the patient's diagnosis is chronic pulmonary heart disease but deny payment if the diagnosis is indigestion. Most medical policies and diagnostic criteria are established and applied locally by each of the 29 contractors (also called carriers) that the Health Care Financing Administration (HCFA) uses to process and pay claims submitted by physicians.[2] Including these diagnostic criteria in Medicare

[1]Fee-for-service has been the traditional and predominant method of paying for health care services in both the private and public sectors. The Medicare fee-for-service payment system, which currently covers more than 90 percent of all Medicare enrollees, pays physicians a fixed amount for each service delivered. In contrast, Medicare enrollees in managed care plans receive all services in exchange for an annual prepaid fee.

[2]The 29 carriers that process Medicare part B payments for physician services are referred to as contractors in this report. Four additional carriers process Medicare claims for durable medical equipment, but those carriers were not included in this study.

claims processing systems can enable checking all claims for the service against the criteria before payment. For claims that do not meet the criteria, the claims processing systems can deny payment automatically. Diagnostic criteria implemented this way are referred to as autoadjudicated medical necessity prepayment screens. Providers may resubmit claims denied by these screens with additional or corrected information to clarify the patient's medical symptoms. Also, providers may appeal contractors' decisions to deny their claims.

In discussions with your staff, we agreed to examine (1) the extent to which contractors employ medical necessity prepayment screens for procedures that are likely to be overused nationally, (2) the potential impact of autoadjudicated prepayment screens on Medicare spending, and (3) the role that the federal government should play in reducing widespread overuse of medical procedures billed to Medicare.

To address these objectives, we reviewed payments to physicians for six groups of high-volume medical procedures,[3] which accounted for almost $3 billion in Medicare payments in 1994.[4] These procedures are considered to be widely overused: Evidence from the Office of the Inspector General (OIG) in the Department of Health and Human Services (HHS) and contractors' analyses and views indicate that providers commonly bill for these procedures when they are not warranted by medical symptoms.

We also surveyed 17 contractors to determine if they used medical necessity criteria in their claims processing systems to screen claims for the six groups of procedures in our study. For seven of the largest contractors we also used computer programs to review a sample of the claims they paid for the six groups of procedures.[5] If the contractors' claims processing systems did not screen these claims against medical necessity criteria, our programs compared the patient diagnoses on the paid claims to diagnostic criteria used in prepayment screens by various other Medicare contractors. We performed our work between August 1994 and November 1995 in accordance with generally accepted auditing

[3]We reviewed claims for the following procedures: echocardiography, eye examinations, chest X rays, colonoscopy, yttrium aluminum garnet (YAG) laser surgery, and duplex scan of extracranial arteries. See table 1 for the specific procedure codes included in our study.

[4]We limited our review to Medicare part B payments, which generally cover services provided by physicians and suppliers. In the part B program, Medicare pays 80 percent of the total charge allowed and the patient is responsible for the remainder. In this report, the total payment allowed under Medicare is referred to as the Medicare payment.

[5]Some contractors process Medicare claims from more than one state, a portion of a state, or both. Our review covered claims processed by the seven contractors in six states.

standards. Appendix I further describes our scope, data sources, and methodology.

Results in Brief

Medicare contractors routinely pay hundreds of millions of dollars in Medicare claims without first determining if the services provided are medically necessary. For each of the six groups of medical procedures we reviewed, more than half of the 17 contractors we surveyed were not using prepayment screens to check these claims for medical necessity. Even when evidence points to overuse nationwide, each of the Medicare contractors usually decides on its own which procedures to screen. For example, although HHS' OIG advised HCFA and the contractors in 1991 to monitor the use of colonoscopies and deny claims that were not indicated by medical symptoms or supported with documentation, only 6 of the 17 contractors were screening colonoscopy claims by the end of 1994.

Millions of dollars in Medicare claims for these six groups of procedures would have been denied if all contractors had screened the claims for medical necessity. Our review of just 7 of the 17 contractors revealed that between $29 million and $150 million was paid for claims that may have been medically unnecessary. The range of these estimates reflects the variation in contractors' criteria for identifying medically unnecessary services. Because the remaining contractors also were not using medical necessity screens for some of these procedures, they also may have paid millions of dollars in Medicare claims for services that should have been denied.

Problems with controlling payments for widely overused procedures persist because HCFA lacks an effective national strategy. Although the need for national leadership is compelling, HCFA has not exercised its statutory authority to take an active role in promoting more local medical policies and prepayment screens for widely overused procedures. Instead, HCFA has relied on contractors' abilities to focus their prepayment screens on procedures where local use exceeds the national average. While this approach helps reduce local overuse of some procedures, it is not designed to control overuse of a procedure nationwide. We believe that HCFA should take several approaches to help prevent Medicare spending for unnecessary services.

Background

Medicare provides health insurance for about 37 million elderly and disabled individuals. This insurance is available in two parts: Part A covers

inpatient hospital care and is financed exclusively from a payroll tax. Part B coverage includes physician services, outpatient hospital services, and durable medical equipment. Part B services are financed from an earmarked payroll tax and from general revenues.

The Social Security Act requires that Medicare pay only for services that are reasonable and necessary for the diagnosis and treatment of a medical condition.[6] HCFA contracts with private insurers such as Blue Cross and Blue Shield plans, Aetna, and CIGNA insurance companies to process Medicare claims and determine whether the services are reasonable and necessary. The program was designed this way in part to protect against undue government interference in medical practice.[7] Thus, despite Medicare's image as a national program, each of the 29 Medicare contractors that process part B claims for physicians' services generally establishes its own medical necessity criteria for deciding when a service is reasonable and necessary.

Contractors do not review each of the millions of Medicare claims they process each year to determine if the services are medically necessary. Instead, contractors review a small percentage of claims, trying to focus on medical procedures they consider at high risk for excessive use. Contractor budgets limit the number of claims contractors can review, and over the last several years, both contractor budgets and HCFA requirements for prepayment review have been decreasing. In 1991, HCFA required contractors to review 15 percent of all claims before payment, while in 1995, contractors are only required to review 4.6 percent.

Since 1993, HCFA has required contractors to use a process called focused medical review (FMR) to help them decide which claims to review. Under the FMR process, each contractor analyzes its claims to identify procedures where local use is aberrant from the national average use.[8] Beginning in fiscal year 1995, HCFA has required each contractor to select at least 10 aberrant procedures identified through FMR and develop medical policies for those procedures. The contractors are required to work with their local physician community to define appropriate medical necessity criteria. This

[6]Medicare generally does not pay for routine screening tests such as eye examinations, hearing tests, and routine chest X rays. However, the Congress has enacted legislation allowing Medicare payment for some routine services, such as a screening mammography.

[7]Section 1801 of the Social Security Act (42 U.S.C. 1395) prohibits federal interference in the practice of medicine.

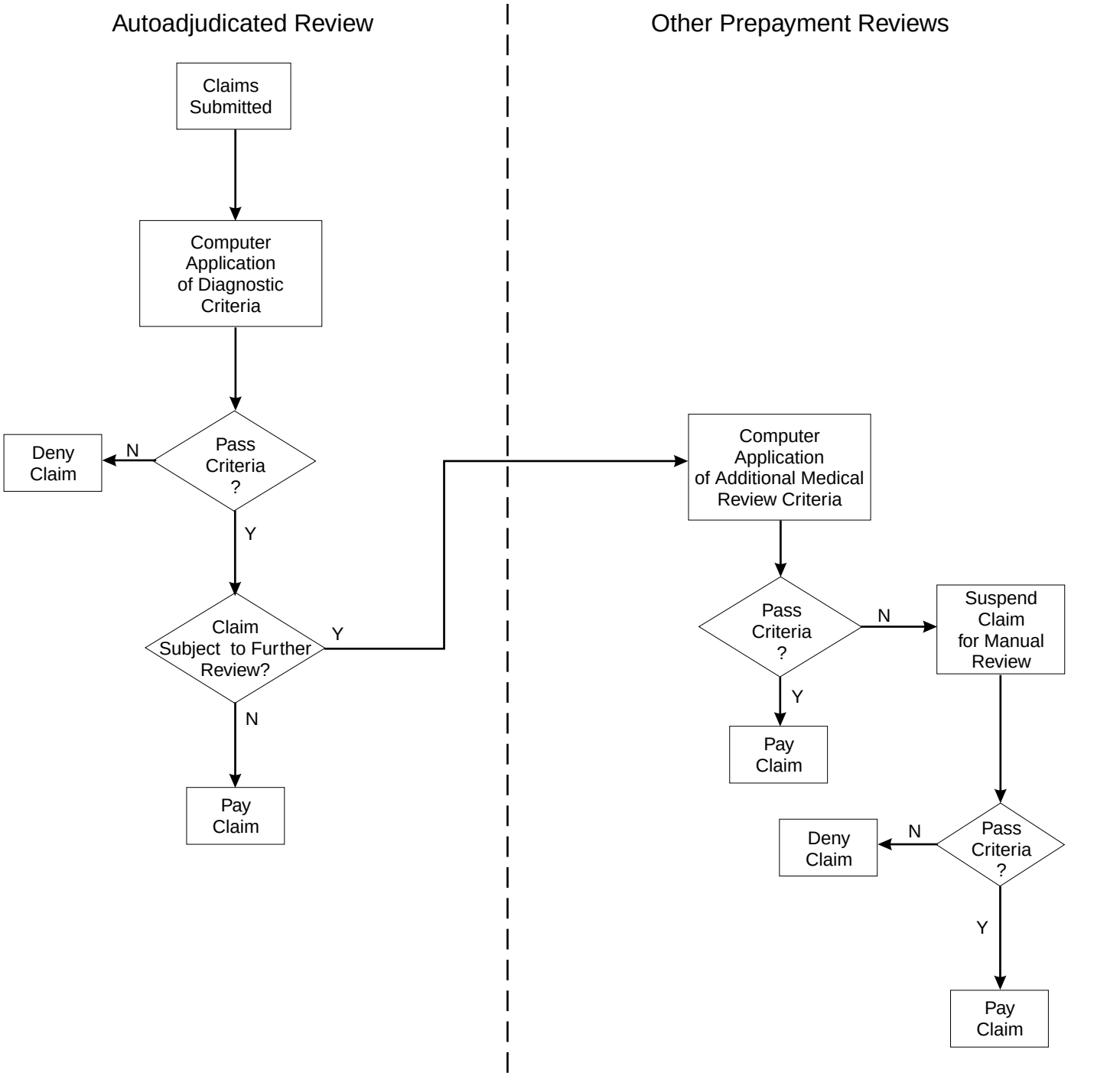
[8]Some contractors receive permission from HCFA to identify aberrant procedures using alternative methods, such as trend analysis.

arrangement allows contractors to take local medical practices into consideration when establishing criteria for reviewing claims. Once physicians have had an opportunity to comment on a medical policy, the contractor publishes the final criteria.

Each contractor generally decides which medical procedures to target for review and what types of corrective actions to implement to prevent payments for unnecessary services. Contractors currently concentrate on educating physicians about local medical policies, hoping to decrease the number of claims submitted that do not meet the published medical necessity criteria. Contractors also use computerized prepayment reviews, called screens, to check claims against the medical necessity criteria in medical policies. When screens identify claims that do not meet the criteria, two alternative actions are possible: first, autoadjudicated screens may deny the claim automatically; second, all other screens may suspend the claim for review by claims examiners, who may request additional documentation from the physician before deciding to pay or deny the claim.

Autoadjudicated screens usually compare the diagnosis on the claim with the acceptable diagnostic conditions specified in the corresponding medical policy. For example, an autoadjudicated screen for a chest X ray would pay the claim if the patient diagnosis was pneumonia but deny the claim if the only patient diagnosis was a sprained ankle. Because this type of screen is entirely automated, it can be applied to all the claims for a specific procedure at a lesser cost than reviewing claims manually. This type of screen is most effective for denying claims that do not meet some basic set of medical necessity criteria. Claims denied by these screens can be resubmitted by providers or appealed. As shown in figure 1, claims that pass these basic criteria may be further screened against more complex medical criteria to identify claims that warrant manual review.

Figure 1: Overview of Prepayment Medical Review Process



Many Contractors Do Not Screen Claims for Overused Services

Most of the contractors we surveyed routinely pay claims for procedures suspected to be widely overused without first screening those claims against medical necessity criteria. We looked at six groups of procedures that providers frequently perform on patients who lack medical symptoms appropriate for the procedures. These procedures also rank among the 200 most costly services in terms of total Medicare payments and accounted for almost $3 billion in Medicare payments in 1994.[9] (See table 1 below.) Four of the procedures—echocardiography, eye examinations, chest X rays, and duplex scans of extracranial arteries—are noninvasive diagnostic tests. Colonoscopy can be either diagnostic or therapeutic, and YAG laser surgery is sometimes used to correct cloudy vision following cataract surgery.

Table 1: Medicare Services and Payments for Six Medical Procedures (1994)

Procedure (procedure codes)	Medicare services (in thousands)	Medicare payments[a] (in millions)
Echocardiography (93307, 93320, 93325, 93350)	8,976	$851
Eye exams (92002, 92004, 92012, 92014)	14,400	686
Chest X rays (71010, 71020)	34,597	507
Colonoscopy (45378, 45380, 45385)	1,416	478
YAG laser surgery (66821)	895	325
Duplex scan of extracranial arteries (93880)	1,513	143
Total	**61,797**	**$2,990**

[a]The total payments allowed under Medicare for each procedure code.

In the first quarter of fiscal year 1995 (Oct. 1-Dec. 31, 1994), we surveyed 17 contractors to determine whether they were using any type of medical necessity prepayment screens to review claims for these six groups of procedures. As shown in table 2, the use of prepayment screens among the contractors was not uniform, and for each of the six procedures fewer than half the 17 contractors were using such screens.

[9]All procedure codes for these six medical services ranked among the top 200 most costly services in 1994, except code 92002 (eye examination for a new patient).

Table 2: Use of Medical Necessity Screens for Six Procedures by 17 Medicare Contractors (Oct. 1-Dec. 31, 1994)

Contractor	Echocardiography	Eye exams	Chest X ray	Colonoscopy	YAG laser surgery	Duplex scan of extracranial arteries
1	X		X			X
2	X		X			X
3		X	X			
4	X			X		X
5		X				
6		X				X
7	X					X
8		X		X		
9		X	X	X		X
10						
11	X			X		
12	X				X	X
13						
14		X	X			
15				X	X	
16						
17	X		X	X	X	X
Total	**7**	**6**	**6**	**6**	**3**	**8**

For each group of products in our study, we found the following:

- Only 7 of the 17 contractors we surveyed had prepayment screens to review echocardiography for medical necessity, even though echocardiography is often performed on patients with no specific cardiovascular disorders. Ten contractors lacked such screens, even though echocardiography is the most costly diagnostic test in terms of total Medicare payments and despite an increase of over 50 percent in the use of the echocardiography procedures listed in table 1 between 1992 and 1994.
- Only 6 of the 17 contractors used prepayment screens to prevent payment for medically unnecessary eye examinations. These contractors have medical necessity criteria to deny claims for routine eye examinations and to allow payments only for certain conditions, such as cataracts, diabetes, and hypertension.
- Only 6 of the 17 contractors had prepayment screens to review chest X ray claims for medical necessity, although HCFA had alerted Medicare

contractors that providers frequently bill for chest X rays that are not warranted by medical symptoms and are thus medically unnecessary.

- Only 6 of the 17 contractors had medical necessity prepayment screens to review colonoscopy claims. In 1991, HHS' OIG reported that nationwide almost 8 percent of colonoscopies paid by Medicare were not indicated by diagnosis or medical documentation.
- Only 3 of the 17 contractors had prepayment screens for YAG laser surgery even though federal guidelines exist that indicate the diagnostic conditions for performing this surgery. Also, at a national meeting of Medicare contractors in 1994, HCFA officials discussed the need to avoid paying for unnecessary YAG laser surgery following cataract removal.[10]
- Only 8 of the 17 contractors had implemented prepayment screens for duplex scans even though HCFA had alerted Medicare contractors that providers commonly bill for noninvasive vascular tests such as duplex scans without adequately documenting the patient's medical symptoms.

A primary reason all contractors do not screen claims for nationally overused procedures is that, following HCFA's instructions for FMR, contractors have been targeting procedures that are overused locally, based on comparisons with national average use. The shortcomings of this approach are discussed later in this report.

Our survey of the 17 contractors represents a snapshot of the use of prepayment screens for these procedures in the first quarter of fiscal year 1995. Typically, contractors turn screens on and off depending on their local circumstances. For example, one contractor began using a screen for echocardiography in March 1995, and another contractor implemented screens for chest X rays and eye examinations in January 1995 because these procedures were overused locally. By contrast, one contractor discontinued using an autoadjudicated screen for eye examinations in February 1995 because the diagnostic criteria for payment in the screen were considered too narrow.[11] Nonetheless, these fluctuations in contractors' use of screens do not reflect a coordinated approach to screening nationally overused procedures.

[10]On October 6, 1995, HCFA published a draft national medical policy that specifies the Medicare medical criteria for payment of YAG laser surgery claims.

[11]The discontinued autoadjudicated screen was not among those used in our tests.

Contractors Without Screens Pay Millions for Services That May Be Unnecessary

Seven large Medicare contractors[12] paid millions of dollars in claims for services that may have been unnecessary. These contractors did not use diagnostic medical criteria to screen claims for some of the six groups of procedures in our study. The claims paid for these services included a range of patient diagnoses that did not meet the criteria established by other contractors. For example, a chest X ray was paid for a patient with a diagnosis of injuries to the hand and wrist, an echocardiogram was paid for a patient with a diagnosis of chronic conjunctivitis, and a therapeutic colonoscopy examination was paid for a patient with a mental health diagnosis of hysteria. If the seven contractors had used autoadjudicated diagnostic screens for the six groups of procedures, they would have denied between $38 million and $200 million in claims for services in 1993, as shown in table 3.

Table 3: Medicare Payments That Would Have Been Denied by Autoadjudicated Screens[a]

Dollars in thousands

Procedure (procedure code)	Lowest estimate	Highest estimate
Echocardiography (93307, 93320, 93325, 93350)[b]	$10,475	$74,632
Eye exams (92002, 92004, 92012, 92014)	611	931
Chest X rays (71010, 71020)	819	37,166
Colonoscopy (45378, 45380, 45385)	5,798	61,886
YAG laser surgery (66821)	14,934[c]	14,934[c]
Duplex scan of extracranial arteries (93880)	5,971	10,710
Total	**$38,608**	**$200,259**

[a]Medicare payments were calculated by multiplying the estimated number of denied services by the average allowance under Medicare for the procedure at the contractor. The estimates are based on a 5-percent sample of beneficiaries at each of seven contractors. We used claims paid for services provided in 1993.

[b]We combined the results from two echocardiography screens to estimate payments that would have been denied for all four echocardiography procedure codes.

[c]We used only one prepayment screen for YAG laser surgery. Therefore, the lowest and highest estimates are the same for payments that would have been denied.

The range of estimated payments for claims that would have been denied reflects differences among contractors' criteria for identifying medically unnecessary services. Although different contractors had screens for the same procedure, they used different diagnoses to determine medical necessity. For example, a colonoscopy screen we used from one

[12]Of the 17 contractors we surveyed, we selected the 7 contractors that processed the most Medicare claims. In table 2, the 7 contractors we selected are numbered 1 through 7.

contractor paid claims with a diagnosis of gastritis, while another contractor's screen denied such claims. Because of these differences among the contractors' screens, we applied screens from two or three different contractors for each group of procedures, except for YAG laser surgery.[13] Thus, our test results show a range of estimated payments for claims that would have been denied, depending on the medical necessity criteria used. The tables in appendix II list the estimated payments for claims that would have been denied by each of the tested screens.

The seven contractors we reviewed were among the largest in terms of the number of claims processed, accounting for about 37 percent of all Medicare part B claims, and almost 38 percent of all the claims for the six groups of procedures in our study. To estimate the paid claims that would have been denied, we applied autoadjudicated screens developed by several contractors in our survey to a sample of the 1993 claims paid by the seven contractors.[14] We only applied these screens if the tested contractor did not have a medical necessity diagnostic screen of its own in place in 1993 for the specific procedure tested. We used autoadjudicated screens because decisions to pay and deny claims based on medical necessity criteria are automated and, therefore, do not require additional medical judgment. Appendix I provides additional details on our methodology.

When claims are denied by prepayment screens, the billing physician can (1) resubmit the claim with additional or corrected information or (2) appeal the denial. In either case, the contractors may ultimately pay claims that they have initially denied. Contractors' claims processing systems generally do not track the claims denied by autoadjudicated prepayment screens to determine if they are resubmitted or appealed and then paid. However, based on a limited analysis of claims denied by contractors with autoadjudicated screens, we estimate that about 25 percent of the denied claims were ultimately paid.[15] Assuming that the 25-percent rate is typical for autoadjudicated screens, about 75 percent of the payments in table 3, or between $29 million and $150 million, were for

[13]For YAG laser surgery we only applied the one screen that we had identified at the time we began our analysis.

[14]We obtained all the tested screens from some of the 17 contractors in our initial survey. Some of the screens were obtained from one of the seven contractors included in our tests.

[15]As described in appendix I, we estimated the percentage of denied claims that would be ultimately paid by analyzing claims for echocardiography processed by one contractor and claims for duplex scans processed by another contractor. In each case, the contractors used autoadjudicated screens for these services.

services that would be considered unnecessary using the criteria established by various contractors.

Our estimates of payments for unnecessary services involve only six groups of procedures and cannot be statistically generalized beyond the 7 contractors included in our analysis. However, all 29 contractors—not just the 7 whose claims we reviewed—operate under FMR requirements designed to correct local rather than national overutilization problems. Therefore, the other 22 contractors also may lack screens for some of these procedures and, hence, may have paid millions of dollars in claims for services that should have been denied.

For widely overused procedures such as the six we tested, autoadjudicated screens can be a low-cost, efficient way to screen millions of claims against basic medical necessity criteria. Contractor officials said that these screens are much less expensive to implement than screens that suspend claims for manual review. Consequently, as funding for program safeguards declines, autoadjudicated screens can be used to maintain or even increase the number of claims reviewed. Moreover, for procedures where the medical review decisions can be automated, autoadjudicated screens can quickly identify and deny claims where the patient diagnosis is inconsistent with the procedure performed. In contrast, when claims examiners manually review claims, the risk exists that the medical necessity criteria may be misinterpreted and applied inconsistently. However, for certain procedures or medical policies, autoadjudicated screens may not be appropriate. For example, some medical policies are not easily defined with diagnostic codes and require manual review of documentation, such as medical records, to determine if a service is medically necessary.

Denying claims using autoadjudicated or other prepayment screens can increase administrative costs if providers frequently resubmit denied claims or appeal the denials. Contractor officials said that these costs can be minimized if providers are educated to bill appropriately in the first place. By combining direct provider education with screens that enforce agreed upon medical criteria, contractors can, over time, reduce the number of claims submitted for unnecessary services.

Greater HCFA Leadership Is Needed

HCFA does not have a national strategy for using prepayment screens to deny payments for unnecessary services among Medicare's most highly overused procedures. HCFA does periodically alert contractors about some of these procedures at semiannual national contractor meetings and through occasional bulletins. However, the agency does not identify widely overused procedures in a systematic manner. Moreover, the agency does not ensure that contractors implement prepayment screens or other corrective actions for these procedures.

Medicare legislation does not preclude HCFA from requiring its contractors to screen claims for nationally overused procedures. However, HCFA has chosen to avoid the appearance of interfering in local medical practice. HCFA usually does not establish medical policies or tell the contractors which procedures warrant medical policies or prepayment screens.[16] Instead, HCFA relies primarily on the contractors' local FMR efforts to identify and prevent Medicare payments for unnecessary services. This process, according to HCFA officials, allows contractors to take medical practice into consideration when making medical necessity determinations.

Although FMR can work well for overutilization problems that are truly local, the process is not designed to address nationwide overutilization of a medical procedure. The national average use of a procedure generally serves as a benchmark for identifying local overutilization problems, but the benchmark itself may already be inflated by millions of dollars in payments for unnecessary services. For example, in several states the use of echocardiograms greatly exceeded the 1992 national average of 101 services per 1,000 beneficiaries.[17] Some of the contractors servicing those states have designed and implemented prepayment screens for this procedure. Meanwhile, other contractors targeted different procedures and allowed unconstrained use of echocardiograms. This focus on local overuse may be one of the factors that led to a national 12-percent increase in echocardiography use by 1994—and a new benchmark of 113 echocardiograms per 1,000 beneficiaries.

[16]HCFA has mandated that contractors use medical necessity prepayment screens for four procedures (routine foot care, mycotic nails, chiropractic visits, inpatient rehabilitation medicine visits) and an injection (Epoetin Alpha). Contractors can request a waiver to alter or eliminate mandated screens, except screens for mycotic nails and inpatient rehabilitation medicine visits.

[17]This example is based on echocardiography procedure code 93307, complete real-time echocardiography with two dimensional image documentation, with or without M-mode recording (a form of ultrasound).

HCFA can take a more active role in controlling spending for widely overused procedures without intruding on the contractors' responsibilities to establish their own prepayment screens. HCFA has an oversight responsibility to monitor and evaluate contractors' screens and other efforts to prevent payments for unnecessary services. Yet HCFA does not know (1) which contractors have diagnostic screens for which medical procedures, (2) the medical necessity criteria used in these screens, or (3) the effectiveness of the screens in denying claims for unnecessary services. Furthermore, without this information HCFA cannot identify best practices and promote approaches such as autoadjudicated medical necessity screens where they can be a cost-effective alternative or complement to screens that flag claims for manual review.

HCFA funded a central database on local medical policies, but this resource is not being effectively used. HCFA has encouraged the contractors to use the database to research other contractors' medical policies before drafting their own. However, according to some contractors, the usefulness of the database is limited because it is not regularly updated. Moreover, HCFA has not taken the initiative to use the database to evaluate the contractors' medical policies and identify those worthy of consideration by all contractors for controlling widely overused procedures.

HCFA can also encourage greater use of medical necessity criteria for widely overused procedures by providing contractors with more model medical policies. About 2 years ago, HCFA established clinical workgroups composed of contractor medical directors to develop model medical policies that the contractors can adapt for local use. Specifically, contractors can work with their local medical community to review model policies, adapt them to reflect local medical practice, and implement them in prepayment screens. This has been an important step in promoting greater efficiency in developing local medical policies. However, since the workgroups' inception, only one model policy has been published.[18] According to HCFA and contractor officials, progress has been limited in part because HCFA often takes longer to review draft model policies than its goal of 45 days.

HCFA officials said that they are considering provisions for greater use of autoadjudicated screens in a new, national claims processing system. However, full implementation of that system is scheduled for late in 1999. In addition, what types of screens will be included in the system remains

[18]The model policy covers noninvasive vascular studies.

unclear, as well as how the contractors will chose which screens to modify, implement, and use and how HCFA will monitor and evaluate the effectiveness of the screens. Meanwhile, HCFA continues to allow contractors to pay millions of dollars for services that may be unnecessary.

Conclusions

While the rapid increase in Medicare costs threatens the long-term viability of the Medicare program, many Medicare part B contractors continue to routinely pay claims for widely overused services, without first determining if the services are reasonable and necessary. Even when evidence indicates that problems with payments for specific medical procedures are widespread, HCFA has not ensured that contractors help correct national problems as well as local aberrancies. More specifically, HCFA policies do not encourage contractors to reduce a national norm already inflated by millions of dollars in payments for unnecessary services.

Our tests of paid claims against criteria used by some of the contractors show that millions of dollars are being paid for services that do not meet basic medical necessity criteria. Although our tests were limited to seven contractors, our survey of 17 contractors indicates that nationally, additional millions of Medicare dollars may have been paid for claims that should have been denied.

Prepayment screens are an important tool in preventing payments for unnecessary services. Funding for program safeguards, such as medical policies and prepayment screens, has been declining, however, while the volume of Medicare claims is increasing. In this environment, autoadjudicated diagnostic screens offer a low-cost way to ensure that all claims for selected procedures pass a basic medical necessity test before payment. Greater use of autoadjudicated screens could complement, rather than replace, the contractors' efforts to use FMR and other types of prepayment screens to address local overutilization problems.

To forestall widespread overuse of specific medical procedures, HCFA can help the contractors much more than it has. HCFA has begun to capitalize on the knowledge and skills of the contractor medical directors by using contractor workgroups to develop model medical policies. More model policies can help contractors control spending for nationally overused procedures by providing them with generally accepted criteria for identifying and denying claims for unnecessary services. However, HCFA

needs to support the efforts of the workgroups and review model policies on a more timely basis so that these efforts can succeed. Also, to exercise stronger leadership by promoting best practices, HCFA needs to collect and evaluate information on the medical criteria and prepayment screens now being used by the contractors.

Recommendations

To help prevent Medicare payments for unnecessary services, we recommend that the Secretary of HHS direct the Administrator of HCFA to

- systematically analyze national Medicare claims data and use analyses conducted by HHS' OIG and Medicare contractors to identify medical procedures that are subject to overuse nationwide;
- gather information on all contractors' local medical policies and prepayment screens for widely overused procedures, evaluate their cost and effectiveness, and disseminate information on model policies and effective prepayment screens to all the contractors; and
- hold the contractors accountable for implementing local policies, prepayment screens (including autoadjudicated screens), or other corrective actions to control payments for procedures that are highly overused nationwide.

Agency Comments

We provided HHS an opportunity to comment on our draft report, but it did not provide comments in time to be included in the final report. However, we did discuss the contents of this report with HCFA officials from the Bureau of Program Operations, including the Director of Medical Review and the Medical Officer. In general, they agreed with our findings.

We obtained written comments on our draft report from several part B contractor medical directors who serve on the Contractor Medical Director Steering Committee. We selected this committee as a focal point for obtaining contractor comments because of its role as a liaison between the contractors and HCFA and the communication network for the contractor medical directors. Their comments support our conclusions (see app. III). In summary, they suggested the development of contractor workgroups to rapidly produce model medical policies for the six groups of procedures in our study.

As agreed with your office, unless you release its contents earlier, we plan no further distribution of this report for 30 days. At that time, we will send

copies to other congressional committees and members with an interest in this matter, the Secretary of Health and Human Services, and the Administrator of the Health Care Financing Administration. We will also make copies available to others upon request.

This report was prepared by William Reis, Assistant Director; Teruni Rosengren; Stephen Licari; Michelle St. Pierre; and Vanessa Taylor under the direction of Jonathan Ratner, Associate Director. Please call me on (202) 512-7119 or Mr. Reis on (617) 565-7488 if you or your staff have any questions about this report.

Sincerely yours,

Sarah F. Jaggar
Director, Health Financing
and Public Health Issues

Contents

Abbreviations

FMR	focused medical review
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of the Inspector General
YAG	yttrium aluminum garnet

Scope, Data Sources, and Methodology

We reviewed HCFA's statutory authority and responsibilities for administering the Medicare program and HCFA's regulations and guidance to contractors on the development of local medical policies and the implementation of prepayment screens. We also discussed HCFA's oversight of these functions with officials at its Bureau of Program Operations.

Before selecting the six groups of medical procedures included in our study, we reviewed previous GAO and HHS OIG reports, HCFA guidance, and other studies on overused medical services. We also reviewed HCFA's list of 200 medical procedure codes, ranked by total Medicare-allowed charges, and obtained Medicare contractors' views on procedures that are likely to be overused. Based on the information gathered from these sources, we selected six groups of procedures generally considered widely overused.

Because little centralized information exists on Medicare contractors' use of prepayment screens or the medical necessity criteria included in those screens, we contacted 17 of the 29 contractors that process Medicare part B claims for physician services. We also visited three of the Medicare contractors and attended two of the semiannual contractor medical director conferences. In the course of these contacts, we decided to limit our collection of detailed information on medical necessity criteria and prepayment screens to 17 contractors who could provide us the information we needed.

To estimate the Medicare payments for unnecessary services that could be prevented by broader use of prepayment screens, we tested autoadjudicated prepayment screens on claims paid by seven contractors in six states. The seven contractors in our analysis were among the largest contractors in terms of the number of claims processed in 1993 and they did not use a medical necessity prepayment screen for some of the six groups of procedures in our study.

We based our tests on data from the Medicare Physician Supplier Component of the 1993 HCFA 5 Percent Sample Beneficiary Standard Analytic File. The Physician Supplier Component contains all Medicare part B claims for a random sample of beneficiaries. Our analysis is based on all paid claims in the database for the seven contractors and the six groups of procedures in our review.

For each screen and tested contractor, we estimated the services and payments that would have been denied by

- simulating the screen using a computer algorithm to determine the number of services in the sample that would have been denied by the screen,[19]
- weighing this number to reflect the universe of services, and
- multiplying this weighted number by the average Medicare allowance for the procedure at the contractor.

The average Medicare-allowed amount for each procedure code at each contractor in 1993 was calculated based on data from HCFA's part B Extract Summary System.

For five of the procedures, we applied two or three different autoadjudicated diagnostic screens currently used by other contractors in order to illustrate the impact of using different screens. By applying multiple screens, we were able to examine the range of services that would have been denied depending on the medical necessity criteria used. For example, one of the colonoscopy screens paid claims with a diagnosis of gastritis, while another did not. For YAG laser surgery, however, we only applied the one screen that we had identified at the time we began our analysis. We only applied a particular screen to a contractor's claims if that contractor did not have a medical necessity diagnostic screen in place in 1993 for the specific procedure being tested. We obtained our tested screens from several of the 17 contractors in our initial survey. Some of the screens we used were obtained from one of the seven contractors that we subsequently tested.

Because our estimates were based on a sample of claims, our estimates are subject to sampling error. We calculated 95-percent confidence intervals for each of our estimated payments for services that would have been denied by the tested screens. This means the chances are about 19 out of 20 that the actual payments for services that would have been denied at each of the tested contractors would fall within the range covered by our estimate, plus or minus the sampling error. Sampling errors for our estimates are included in appendix II.

Some of the payments that would have been denied by the tested screens would eventually be paid if they were resubmitted with corrected or additional information or successfully appealed. Because contractors' claims processing systems generally do not track claims denied by autoadjudicated screens to determine how many are ultimately paid, we developed our own estimates. Using the 1993 HCFA 5 Percent Sample

[19]We consulted staff at the contractors whose screens we tested to ensure that we applied the screens correctly. Also, we manually reviewed printouts of the claims that were denied by the tested screens to ensure that only nonpayable diagnoses were denied.

Beneficiary Standard Analytic File, we analyzed echocardiography claims processed by one contractor and duplex scan claims processed by another contractor. In each case, the contractors used autoadjudicated screens for these services. For each contractor, we used computer programs to identify claims for the services that were denied for medical necessity in a 3-month period in 1993. We then determined whether another claim was submitted and paid for the same service, provided on the same day, for the same beneficiary, and by the same provider. Our analysis showed that 23 to 25 percent of the echocardiography and duplex scan claims denied for medical necessity were subsequently paid. Based on these results we used 25 percent as our estimate of claims denied that would ultimately be paid. The actual percentage will likely vary by type of medical procedure and the diagnostic criteria used in the screen. However, because of the costs and inefficiencies associated with denying a large percentage of services and then later reprocessing and paying those services, we believe that contractors would not be likely to continue using a prepayment screen that inappropriately denies more than 25 percent of the services.

Estimated Payments for Various Procedures Denied by Selected Prepayment Screens (1993)

Table II.1: Estimated Payments for Echocardiography

Prepayment screens[a] and tested contractors[b]	Paid services	Denied services	Payments for denied services[c]	Error range for payments[d]
Screen 1				
Contractor A	388,200	40,600	$3,608,000	±$146,300
Contractor B	363,900	271,900	18,949,700	±163,600
Contractor D	104,800	14,600	900,400	±57,700
Contractor F	161,200	114,700	9,883,000	±139,700
Contractor G	213,500	149,600	11,836,200	±153,000
Total	**1,231,600**	**591,400**	**$45,177,300**	**±$660,300**
Screen 2				
Contractor A	749,900	34,400	$5,885,600	±$268,600
Contractor B	619,800	153,200	17,218,700	±362,600
Contractor D	269,900	31,200	2,976,900	±134,500
Contractor F	296,000	67,000	8,583,400	±275,500
Contractor G	392,600	72,600	8,097,500	±244,200
Total	**2,328,200**	**358,400**	**$42,762,100**	**±$1,285,400**
Screen 3				
Contractor A	749,900	3,800	$511,900	±$70,800
Contractor B	619,800	73,200	8,051,300	±265,700
Contractor D	269,900	3,300	271,900	±40,000
Contractor F	296,000	2,600	321,600	±53,500
Contractor G	392,600	11,800	1,317,900	±107,100
Total	**2,328,200**	**94,700**	**$10,474,600**	**±$537,100**

Notes: All numbers are rounded to hundreds.

The estimated number of and payments for denied services were derived from a 5-percent beneficiary sample of 1993 claims for each contractor.

[a]The prepayment screens presented in the table apply to different echocardiography codes. Screen 1 was used for echocardiography codes 93320 and 93325. Screens 2 and 3 were used for echocardiography codes 93307, 93320, 93325, and 93350. Therefore, screen 1 was applied to a smaller number of paid services than the other screens.

[b]Two of the seven contractors in our study had medical necessity screens to identify unnecessary echocardiography tests, therefore, those two contractors were not included in this analysis.

[c]Estimated payments for denied services were calculated by multiplying the estimated number of denied services by the average Medicare allowance for the procedure at the contractor.

[d]The error range for estimated payments was based on a 95-percent confidence level.

Table II.2: Estimated Payments for Eye Examinations

Prepayment screens[a] and tested contractor[b]	Paid services	Denied services	Payments for denied services[c]	Error range for payments[d]
Screen 1				
Contractor A	1,271,600	1,100	$51,000	±$13,400
Contractor D	499,400	3,700	164,500	±22,900
Contractor E	527,300	5,500	305,800	±35,000
Contractor G	838,700	8,300	409,700	±38,700
Total	**3,137,000**	**18,600**	**$931,000**	**±$110,000**
Screen 2				
Contractor A	1,271,600	600	$28,800	±$10,100
Contractor D	499,400	300	15,000	±6,900
Contractor E	527,300	3,800	212,400	±29,300
Contractor G	838,700	7,200	355,100	±35,700
Total	**3,137,000**	**11,900**	**$611,300**	**±$82,000**

Notes: All numbers are rounded to hundreds.

The estimated number of and payments for denied services were derived from a 5-percent beneficiary sample of 1993 claims for each contractor.

[a]The prepayment screens presented in the table were used for eye examination codes 92002, 92004, 92012, and 92014.

[b]Three of the seven contractors in our study had medical necessity screens to identify unnecessary eye examinations, therefore, those three contractors were not included in this analysis.

[c]Estimated payments for denied services were calculated by multiplying the estimated number of denied services by the average Medicare allowance for the procedure at the contractor.

[d]The error range for the estimated payments was based on a 95-percent confidence level.

Table II.3: Estimated Payments for Chest X Rays

Prepayment screens[a] and tested contractors[b]	Paid services	Denied services	Payments for denied services[c]	Error range for payments[d]
Screen 1				
Contractor B	2,146,000	597,400	$7,708,300	±$73,100
Contractor C	2,147,200	530,100	7,914,000	±83,000
Contractor D	1,734,500	693,400	9,288,100	±75,300
Contractor G	1,436,100	617,100	10,701,400	±91,900
Total	**7,463,800**	**2,438,000**	**$35,611,800**	**±$323,300**
Screen 2				
Contractor B	2,146,000	654,900	$8,449,700	±$75,100
Contractor C	2,147,200	521,400	7,743,600	±82,200
Contractor D	1,734,500	441,900	6,017,500	±67,400
Contractor G	1,436,100	669,500	11,514,200	±92,600
Total	**7,463,800**	**2,287,700**	**$33,725,000**	**±$317,300**
Screen 3				
Contractor B	2,146,000	10,200	$136,400	±$11,600
Contractor C	2,147,200	8,900	132,000	±11,900
Contractor D	1,734,500	4,200	55,900	±7,400
Contractor G	1,436,100	23,300	494,300	±27,500
Total	**7,463,800**	**46,600**	**$818,600**	**±$58,400**

Notes: All numbers are rounded to hundreds.

The estimated number of and payments for denied services were derived from a 5-percent beneficiary sample of 1993 claims for each contractor.

[a]The prepayment screens presented in the table were used for chest X ray codes 71010 and 71020.

[b]Three of the seven contractors in our study had medical necessity screens for chest X rays, therefore, those three contractors were not included in this analysis.

[c]Estimated payments for denied services were calculated by multiplying the estimated number of denied services by the average Medicare allowance for the procedure at the contractor.

[d]The error range for estimated payments was based on a 95-percent confidence level.

Table II.4: Estimated Payments for Colonoscopy

Prepayment screens[a] and tested contractors	Paid services	Denied services	Payments for denied services[b]	Error range for payments[c]
Screen 1				
Contractor A	119,700	46,100	$13,291,700	±$418,100
Contractor B	83,600	37,600	11,172,800	±368,600
Contractor C	70,400	28,300	7,613,500	±298,900
Contractor D	59,200	24,900	7,812,400	±325,100
Contractor E	46,500	21,400	7,488,400	±353,800
Contractor F	47,400	17,800	5,913,900	±313,800
Contractor G	64,800	24,100	8,593,700	±375,100
Total	**491,600**	**200,200**	**$61,886,400**	**±$2,453,400**
Screen 2				
Contractor A	119,700	25,600	$7,878,400	±$396,300
Contractor B	83,600	23,100	7,050,400	±348,000
Contractor C	70,400	17,500	4,875,700	±282,100
Contractor D	59,200	15,000	4,829,200	±298,500
Contractor E	46,500	14,500	5,231,800	±336,600
Contractor F	47,400	12,300	4,218,300	±294,100
Contractor G	64,800	15,300	5,658,500	±353,200
Total	**491,600**	**123,300**	**$39,742,300**	**±$2,308,800**
Screen 3				
Contractor A	119,700	3,700	$1,332,200	±$184,100
Contractor B	83,600	3,700	1,227,600	±167,900
Contractor C	70,400	4,700	1,344,100	±167,200
Contractor D	59,200	800	283,300	±84,000
Contractor E	46,500	1,600	647,000	±137,100
Contractor F	47,400	900	333,500	±94,100
Contractor G	64,800	1,600	630,500	±134,800
Total	**491,600**	**17,000**	**$5,798,200**	**±$969,300**

Notes: All numbers are rounded to hundreds.

The estimated number of and payments for denied services were derived from a 5-percent beneficiary sample of 1993 claims for each contractor.

[a]The prepayment screens presented in the table were used for colonoscopy codes 45378, 45380, and 45385.

[b]Estimated payments for denied services were calculated by multiplying the estimated number of denied services by the average Medicare allowance for the procedure at the contractor.

[c]The error range for estimated payments was based on a 95-percent confidence level.

Table II.5: Estimated Payments for YAG Laser Surgery

Tested contractors[a]	Paid services	Denied services	Payments for denied services[b]	Error range for payments[c]
Contractor A	57,700	9,000	$2,813,200	±$239,700
Contractor B	31,100	2,900	1,054,900	±159,000
Contractor C	67,100	23,600	4,355,000	±200,900
Contractor D	25,300	2,400	1,094,700	±183,400
Contractor E	26,100	3,300	2,134,300	±304,700
Contractor F	23,900	2,900	1,314,500	±200,000
Contractor G	19,100	3,200	2,167,800	±302,200
Total	**250,300**	**47,300**	**$14,934,400**	**±$1,589,900**

Notes: All numbers are rounded to hundreds.

The estimated number of and payments for denied services were derived from a 5-percent beneficiary sample of 1993 claims for each contractor.

[a]Only one prepayment screen was used.

[b]Estimated payments for denied services were calculated by multiplying the estimated number of denied services by the average Medicare allowance for the procedure at the contractor.

[c]The error range for estimated payments was based on a 95-percent confidence level.

Table II.6: Estimated Payments for Duplex Scans of Extracranial Arteries

Prepayment screens[a] and tested contractors[b]	Paid services	Denied services	Payments for denied services[c]	Error range for payments[d]
Screen 1				
Contractor B	101,200	53,000	$7,536,700	±$193,700
Contractor F	55,800	25,400	3,173,000	±126,700
Total	**157,000**	**78,400**	**$10,709,700**	**±$320,400**
Screen 2				
Contractor B	101,200	28,300	$4,021,600	±$173,700
Contractor F	55,800	15,600	1,949,300	±113,700
Total	**157,000**	**43,900**	**$5,970,900**	**±$287,400**

Notes: All numbers are rounded to hundreds.

The estimated number of and payments for denied services were derived from a 5-percent beneficiary sample of 1993 claims for each contractor.

[a]The prepayment screens in the table were used for duplex scan code 93880.

[b]Five of the seven contractors in our study had medical necessity screens to identify unnecessary duplex scans, therefore, those five contractors were not included in this analysis.

[c]Estimated payments for denied services were calculated by multiplying the estimated number of denied services by the average Medicare allowance for the procedure at the contractor.

[d]The error range for estimated payments was based on a 95-percent confidence level.

Comments From the Contractor Medical Director Steering Committee

BLUE SHIELD of California

MEDICARE

Mail Address: Medicare, P.O. Box 7013, San Francisco, CA 94120

TO: Bureau Program Operation Administration Steering Committee

DATE: November 27, 1995

FROM: Glenn Molyneaux, M.D.

RE: GAO Study Draft

At the November 21, 1995 Steering Committee telephone conference, I took the responsibility to correlate Steering Committee members responses to the GAO's draft to "Congressional Committees", regarding HCFA. The GAO draft had been faxed to Steering Committee members the day before the telephone conference but all of the members of the Steering Committee had either not received or had opportunity to review the GAO draft before the Steering Committee telephone conference.

The GAO study took HCFA to task for lack of leadership regarding the use of pre-payment screens to reduce "over use" of Medicare services.

The GAOs review involved six procedures or procedure groups and whether seven large volume Medicare Part B Carriers used screens to control "over use." GAO concluded that "HCFA lacks an effective national strategy" and "has not exercised its statutory authority." The draft report did acknowledge that decreasing administrative budgets restricted carriers ability to adequately review claims and did discuss the role of focus medical review in identifying over use.

Three Steering Committee Carrier Medical Directors responded to the GAO draft report. In summary, those responses suggested that CMDs develop six small Work Groups to rapidly compose Model Medical Policy for the six procedures and procedure groups identified by the GAO. The CMD comments and the GAO study further addressed the delay between development and distribution of model medical policy caused by the time required by HCFA to research possible statutory conflict in Model Medical Policy developed by CMD Work Groups. One suggestion was that the Model Medical Policies be distributed to Carriers as soon as they are finalized by the Work Groups and have the 45 day HCFA statutory conflict review run concurrent with the comment periods required after individual Carriers proposed Local Medical Review Policy to their respective Carrier Advisory Committees.

The GAO study can serve as an incentive to HCFA and CMDs to facilitate the more rapid development of Model Medical Policy and the more rapid conversion of those policies to Local Medical Review policy.

These comments only address the possible responses of Carrier Medical Directors and Carriers to the GAO study, not the possible HCFA response.

Addendum: Comments came through from a fourth CMD after development of the above summary.

The additional comments felt that "autoadjucated screens" would tend to be "too tight" and result in a significant increase in claims for review. Such review is expensive and the commentor wondered if the GAO considered such review costs in estimating the program savings.

Autoadjudcated screens would add "hassle", counter to our charge to reduce same.

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