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Testimony

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U.S. Senate

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**MEDICARE CLAIMS
BILLING ABUSE**

**Commercial Software Could
Save Hundreds of Millions
Annually**

Statement of Frank W. Reilly
Director, Information Resources Management/
Health, Education, and Human Services
Accounting and Information Management Division



063513/154200

Mr. Chairman and Members of the Committee:

We are pleased to be here today to assist the Committee's inquiry into the use of commercially available technology to reduce Medicare losses associated with billing abuse. Specifically, you asked that we assess the feasibility and cost-effectiveness of acquiring commercial systems designed to detect miscoding of Medicare claims submitted for payment, a practice called code manipulation. These systems are designed to prevent overpayments rather than attempting to identify and recover them after they have been made. You also asked that we evaluate efforts by the Health Care Financing Administration, or HCFA--which administers Medicare--to develop its own capability to detect such coding abuse.

GAO invited four commercial firms that market systems to detect miscoded claims to reprocess--without compensation--statistically selected claims that Medicare paid in 1993. Each firm reprocessed over 200,000 claims. As shown in exhibit 1, our analysis focused on the \$36-billion portion of the program that pays for physician services and supplies, which represents 23 percent of annual Medicare outlays. While billing abuse costs Medicare hundreds of millions of dollars every year,¹ the good news, Mr. Chairman, is that many of these losses can be prevented.

As my testimony this morning will explain, and as the report we are releasing at this hearing will detail,² we compared what these companies would have paid to providers, against what Medicare actually did pay. We estimate that if such commercial technology had been in place, it could have saved the government, on average, \$640 million in fiscal year 1994 (1.8 percent of program outlays), largely through enhanced detection of two specific types of billing abuse--*unbundling* and *global service period violations*--which I will describe shortly. Similarly, we estimate that Medicare beneficiaries would have saved, on average, about \$142 million during that year.

I want to emphasize, as indicated by exhibit 2, that the vast majority of Medicare providers--92 percent in our sample--bill appropriately. Only 8 percent had one or more claims adjusted by the commercial systems. What we are talking about, then, is avoiding significant losses due to miscoding by a very small segment of the provider community. The great majority of physicians and other providers would not, then, be affected by better controls to combat these losses.

¹1995 High-Risk Series: Medicare Claims (GAO/HR-95-8, February 1995).

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

Last fall HCFA initiated internal action to improve its ability to detect incorrectly coded claims. While this was a positive effort, HCFA's approach will not match the capabilities and savings attainable with a commercial system. This is primarily because its ability to detect unbundling is significantly limited when compared with the capabilities of a commercial system.

BACKGROUND

As the nation's largest health insurer, Medicare serves one in every seven Americans. Program costs totaled \$158 billion last year; this is expected to rise to \$286 billion by 2000. Medicare provides health insurance for some 33 million elderly and about 4 million disabled Americans. About two-thirds of 1994 program costs were for inpatient hospital expenses. Of the remaining third, which covers noninstitutional care, physician and supplier services--from which our sample was drawn--is the largest component.

New computer technology, developed by commercial firms, addresses a problem--code manipulation--faced by all health insurers. And while incorrectly coded claims do not necessarily indicate deliberate abuse, the monetary loss to the government is real. The predominant coding system used in this country to bill for medical services was developed by the American Medical Association and is, by its nature, complicated. Called the Physicians' Current Procedural Terminology, or CPT, it is a system in which every medical procedure a provider can perform--however minor--has its own code.

It is difficult for providers and insurers to stay proficient in proper coding practices, not only because of the complex nature of the system but also because a substantial number of the codes change each year. One complicating factor in billing based on CPT codes--and one that creates a window for errors and abuse--is that more complex or comprehensive procedures often have codes that may include several individual component codes.

Medicare's 32 contract insurance carriers together processed about 500 million physician-supplier claims in 1993. Detecting code manipulation manually with this volume is obviously impossible. HCFA has, therefore, directed its carriers to implement computer controls to detect combinations of specific codes that should not be billed together.

Several independent vendors have developed and now market systems that use the latest in computer technology to automatically detect such billing abuse. Computer programs allow these commercial firms to provide complex analysis of millions of code combinations, quickly and accurately pinpointing those that would result in overpayment.

While each of the four commercial firms participating in our test processed a different sample of over 200,000 paid Medicare claims, we verified the test results by independently reviewing a random sample of claims each firm identified as having been overpaid.

COMMERCIAL SYSTEMS CAN SAVE BILLIONS OVER SEVERAL YEARS

Estimates resulting from the four firms' billing abuse-detection systems show clear savings, averaging \$603 million for 1993 and \$640 million for 1994. At this rate, savings over a 5-year period would exceed \$3 billion. In addition, Medicare beneficiaries--who are responsible for about 22 percent of billed charges in copayments and noncovered services--would have realized an annual estimated savings of about \$134 million in 1993 and \$142 million in 1994.

Two particular types of billing abuse accounted for 93 percent of the savings in our claims sample: unbundling and global service period violations, as indicated in exhibit 3. In its most basic form, *unbundling* means that a provider charges for a comprehensive procedure code as well as for one or more component codes. For example, the fee for removing a ruptured appendix includes making the incision to reach the appendix and closing the wound. An overpayment due to unbundling would occur if the physician submitted, and HCFA paid, a claim that included all three codes--for making the incision, closing the wound, and the comprehensive code covering removal of the appendix. A variant of this type of abuse--*fragmentation*--means charging for separate component parts instead of the less expensive comprehensive procedure.

Global service periods, with regard to surgery, denote the period of time both before and after a procedure during which fees for related services--such as examinations--are included in the surgical fee and are therefore not separately billable. For example, if the global service fee for a type of knee surgery included related procedures provided up to 1 day before and up to 90 days after surgery, a physician would not be entitled to bill separately for visits related to the surgery within that 91-day window. Detecting violations of this kind is made more difficult when services are rendered by several different providers within the global service period.

The benefits to be gained from the use of commercial systems are confirmed by both private and public insurers who already use such technology. Almost 200 private insurers now use commercial systems to detect code manipulation, including 13 of the 20 largest. In the public sector, state Medicaid agencies and Medicare contractors for managed health-care plans also use commercial systems. CHAMPUS, the Defense Department's Civilian Health and Medical Program of the Uniformed Services, is implementing a commercial system. In our discussions with representatives of 11 of these

organizations, all attested to the systems' benefits. In the case of CHAMPUS, a test similar to ours also identified savings averaging about 2 percent of outlays. Another important point is that such systems can be customized in a variety of ways to fit the needs of the individual client.

COMMERCIAL SYSTEMS OFFER BENEFITS UNAVAILABLE THROUGH HCFA APPROACH

The narrow scope of HCFA's effort to strengthen its detection of billing abuse seriously limits its effectiveness. First, in the area of unbundling, HCFA's contractor has identified about 40,000 component codes to be denied when submitted with a comprehensive code. In contrast, commercial systems can analyze millions of potential code combinations. Second, HCFA's contract does not address global service period violations, which alone accounted for almost a quarter of the losses to billing abuse identified in our sample. Third, using a commercial system also provides another advantage, since the firms need to update their systems quickly to stay competitive when code changes take place--something that HCFA's resources may prevent it from doing on a consistently prompt and efficient basis.

COMMERCIAL SYSTEMS ARE COST-EFFECTIVE

The cost to acquire a commercial system of the type we have been discussing is modest relative to program costs and savings opportunities. While estimates range from \$10 million to \$20 million to equip all 32 Medicare carriers with such systems, anticipated returns of over \$600 million per year show without question that such technology is cost-effective. And, Mr. Chairman, our savings figures are conservative because we did not test all of the systems' capabilities.

We have been sharing these results with HCFA officials in recent weeks. They have expressed interest in exploring the use of commercial technology but cited several issues that they feel they must fully explore before mandating that carriers use commercial systems. These include (1) whether system customization can mirror HCFA payment policies, (2) the extent to which HCFA can disclose information about the system in order to obtain provider feedback on matters that affect their reimbursement, and (3) the cost and technical feasibility of implementing commercial technology with existing carrier processing systems. HCFA officials have scheduled briefings with each firm currently marketing this technology to gain a more complete understanding of what such systems can offer the Medicare program.

In summary, Mr. Chairman, commercial technology offers the Medicare program an opportunity to save over \$600 million annually, at relatively modest cost. Current best practices in information

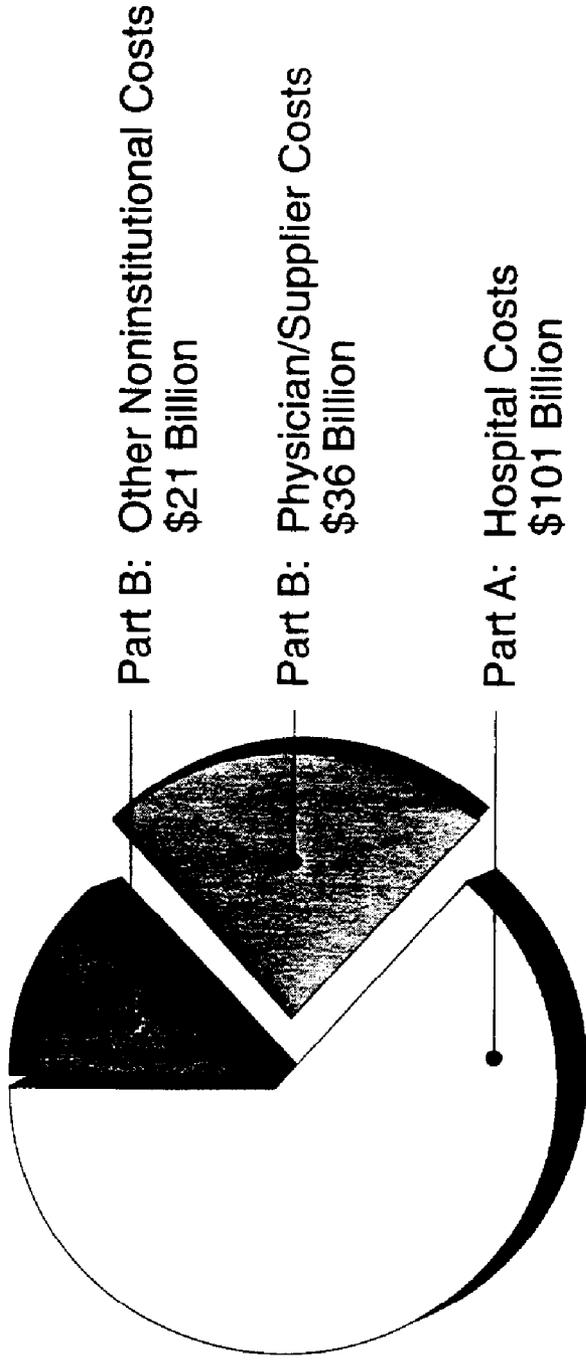
systems development recommend taking a hard look at commercially available technology, and in fact favor its acquisition over specific in-house development efforts. Taking advantage of readily available private-sector development and the experiences of organizations both private and public that use such systems today with substantial benefit is an opportunity the federal government cannot afford to miss.

That concludes my statement, Mr. Chairman. As I mentioned, copies of our detailed report are available at this hearing. I would be happy to answer any questions you or other members of the Committee may have at this time.

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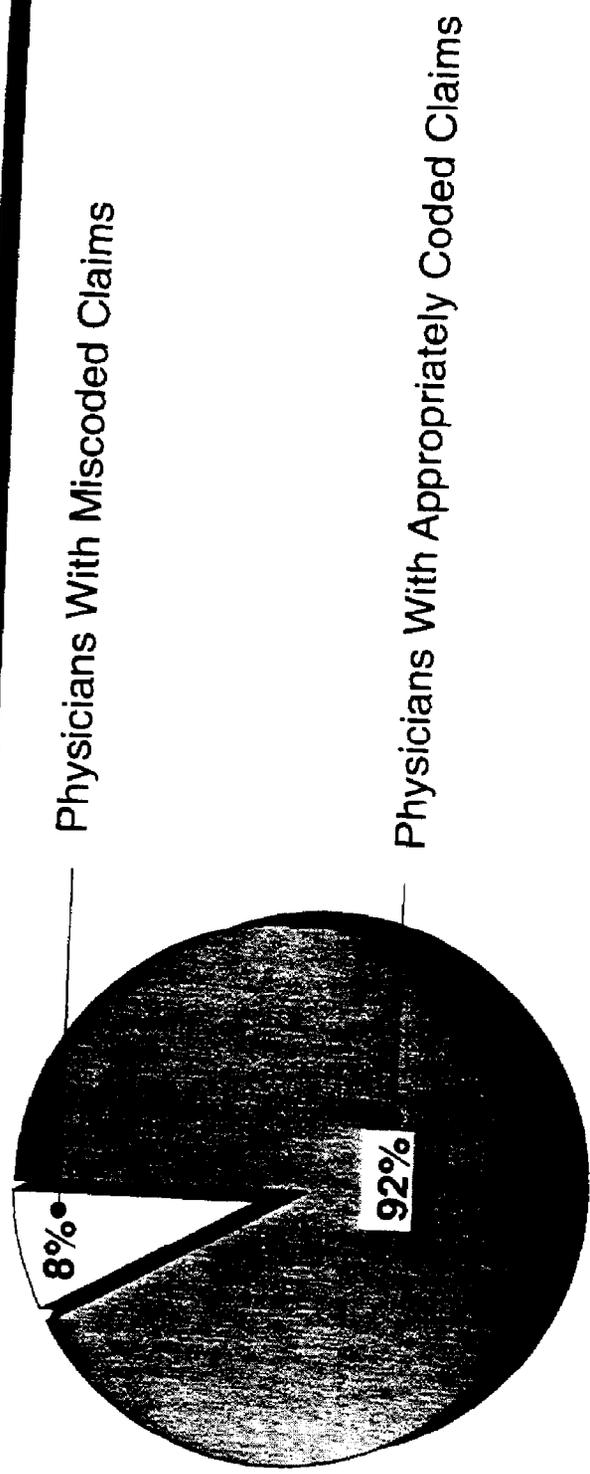
Exhibit 1

GAO 1994 Medicare Budget: \$158 Billion



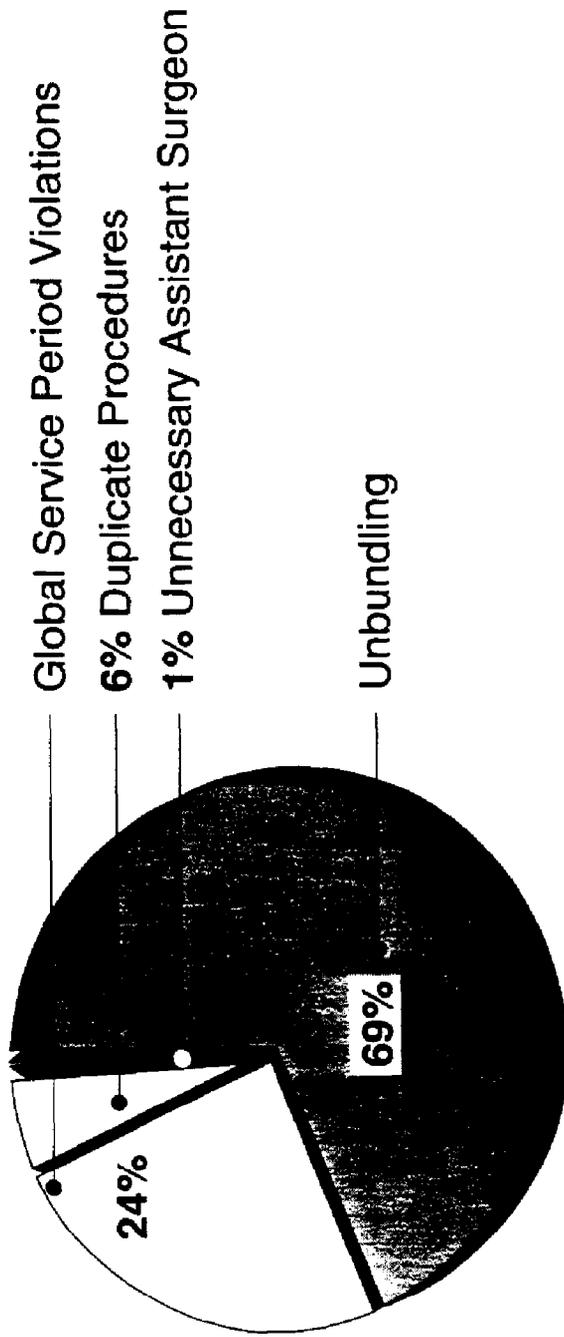
Source: HCFA.

GAO Most Physicians Code Correctly



Source: GAO analysis of test data.

GAO Types of Miscoding



Source: GAO analysis of test data.

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