MEDICARE COVERAGE OF ENDOSCOPIC EXAMINATION OF THE LOWER GASTROINTESTINAL TRACT

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

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MEDICARE COVERAGE OF ENDOSCOPIC EXAMINATION OF THE LOWER GASTROINTESTINAL TRACT

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EXECUTIVE SUMMARY

PURPOSE

To determine the appropriateness of Medicare payments for examinations of the lower gastrointestinal (GI) tract; in particular, the extent to which physicians may be billing for cancer screening, a routine procedure which is not reimbursable under Medicare.

BACKGROUND

Colorectal examinations serve to help physicians detect such conditions as cancer or polyps. Prior to the mid-1970's, the instruments used by physicians for these examinations were of rigid design and did not lend themselves readily to examination of the full length of the colon.

For the past 15 years, fiberoptic technology and endoscopic instrument development has revolutionized examination of the lower gastrointestinal (GI) tract. Fiberoptic endoscopic examination is a technique in which a long, flexible tube-like instrument with special optical properties, is inserted via the rectum, permitting visual inspection of variable lengths of the rectum and colon.

Today, physicians have available different lengths of fiberoptic instruments for colorectal examinations. They include two types of flexible fiberoptic sigmoidoscopy (FFS) instruments which permit examination ranging to 65 centimeters (cm), approximately 26 inches. The FFS, a relatively simple outpatient procedure, is readily mastered by the physician, has high patient acceptance, represents low risk, and requires no sedation. Physicians who need to observe conditions further into the colon use a flexible colonoscope which permits examination of the entire length of the colon (approximately 135 cm). Flexible fiberoptic colonoscopy (FFC), in contrast to FFS, involves more physician training and skill, more patient preparation and discomfort, sedation of the patient, and greater risk and cost.

Endoscopic procedures of the lower GI tract are among the most frequently performed procedures paid for by Medicare. Over 80 percent of these procedures are diagnostic; others are done for therapeutic (removal of polyps) or specimen collection purposes. In 1985, 1.48 million diagnostic colorectal examinations were billed to Medicare with allowed charges of $175 million. Two years later, the number of examinations increased by only 5.2 percent, but allowed charges increased by 44.9 percent to $253 million. This increased cost is primarily attributable to physicians' shifting from less expensive, rigid-instrument exams to the more costly, flexible fiberoptic procedures. During the 3-year span, rigid instrument proctosigmoidoscopies decreased while FFS and FFC procedures increased.

Under Medicare law, items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury are, in general, excluded from coverage. Specifically excluded are expenses incurred for routine physical checkups, i.e., examinations performed

without relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury such as screening examinations for cancer of the colon in the absence of symptoms or laboratory test evidence.

METHODOLOGY

A statistically valid random sample of 294 Medicare reimbursed claims was selected. Copies of medical records containing all pertinent pre- and post-endoscopy notes, related consultation reports, and laboratory test results were requested. The OIG contracted for a medical review of the records.

The 35 carriers responsible for adjudicating the sample claims were asked for information on medical policy and claims processing procedures used by them to make coverage and payment determinations. These documents were analyzed to identify carrier practices designed to assure that payments are made only for services that are covered and are medically necessary.

FINDINGS

Twenty-seven Percent Of Claims For Endoscopic Examinations Of The Lower GI Tract Were Found Not Appropriate For Medicare Reimbursement

- Medical review determinations on 237 patients' medical records found that 65 procedures (27.4 percent) were not appropriate for Medicare reimbursement. These procedures were done for noncovered cancer screening purposes or for other noncovered procedures. Other claims did not contain sufficient medical documentation by treating physicians to make a coverage determination.

Projecting these findings to the 1.5 million claims paid in 1986 indicates Medicare made inappropriate payments of $39,249,000.

Incorrect Payments Were Made Because Of Inaccurate Diagnostic Information Provided On Claims

- The reliability of the diagnosis and medical condition information contained on the claim forms is questionable as determined by a review of the sample claims. It was found that if taken at face value, without further medical information, 93 percent would appear to justify payment based on Medicare guidelines. This is in sharp contrast to the medical review results reported earlier which show that 27.4 percent of the actual medical records did not support the decision to pay for these procedures.

- Only 9 of the 35 carriers have specific prepayment claims processing instructions for their claims examiners' use in determining coverage.

- Only 1 of 35 carriers had provided educational materials to physicians regarding coverage of these procedures.

RECOMMENDATIONS

The HCFA should alert its carriers to the national inspection finding of substantial amounts of inappropriate payments being made. In addressing corrective actions, HCFA should consider having its carriers:

- provide information to the medical community through bulletins and other techniques regarding the limits of Medicare coverage for such procedures and the medical record documentation necessary to support payment; and
- give increased attention to these procedures as part of postpayment reviews.

COMMENTS ON DRAFT REPORT

Comments received from the Acting Administrator of HCFA indicate agreement with our recommendations for corrective actions to reduce inappropriate payments identified by this inspection. The HCFA indicates that it will:

- share this report with carrier officials;
- discuss the topic with carrier medical directors at their next scheduled meeting;
- recommend to carriers that they disseminate information on limits of Medicare coverage for these services and medical documentation necessary to support payment; and
- encourage carriers to give attention to these procedures in their postpayment process.

The HCFA also expressed its primary reliance on education of the medical community to reduce these unnecessary payments. The time-consuming nature of postpayment medical review was noted in HCFA's comments. The OIG is supportive of all the planned actions of HCFA but continues to emphasize the value of well-targeted postpayment review as an effective safeguard.

TABLE OF CONTENTS

INTRODUCTION

Nature of Service

Endoscopic examinations of the lower gastrointestinal (GI) tract are uncomfortable but important medical procedures. The purpose of these procedures is to check for such conditions as polyps and cancer of the colon.

Prior to the mid-1970's the available instruments were of rigid design and did not allow for examination of the entire length of the colon. One such item is the rigid proctosigmoidoscope which allows examination up to 25 centimeters (cm) (approximately 10 inches). Fiberoptic technology and endoscopic instrument development has revolutionized examination of the lower gastrointestinal tract. Fiberoptic endoscopic examination is a technique in which a long, flexible tube-like instrument, having special optical properties, is inserted via the rectum, permitting visual inspection of variable lengths of the rectum and colon.

Today, physicians have available different lengths of fiberoptic instruments for colorectal examinations. Two types of flexible fiberoptic sigmoidoscopy (FFS) instruments permit examination ranging to 65 cm (26 inches) in length. The shorter flexible scope permits visualization of slightly more distance than the rigid proctosigmoidoscope and is increasing in use due to better patient and physician acceptance of flexible instruments. The longer FFS is utilized to view the entire descending colon from the rectum to the splenic flexure.
The FFS, a relatively simple outpatient procedure, is readily mastered by the physician, has high patient acceptance, represents low risk and requires no sedation. Usual reasons for performing the procedure include: (a) evaluating patients with symptoms of rectal bleeding, chronic diarrhea, constipation or abdominal pain; and (b) periodically checking asymptomatic patients over age 50 for early detection of colorectal polyps and cancer.

Physicians who need to observe conditions beyond the descending colon use a colonoscope which permits visualization up to 135 cm in length. Flexible fiberoptic colonoscopy (FFC), in

contrast to FFS, involves more physician training and skill, more patient preparation and discomfort, sedation of the patient, and greater risk and cost. Uses for this procedure include: (a) evaluation and treatment of abnormalities found on barium enema; (b) lower GI bleeding; (c) evaluation and treatment of neoplastic polyps (tissue growth) and (d) surveillance of high-risk patients.

Medicare Reimbursement

Endoscopic procedures of the lower GI tract are among the most frequently performed procedures paid for by Medicare. Over 80 percent of these procedures are diagnostic; others are done for therapeutic (removal of polyps) or specimen collection purposes. As shown in figure I, in 1985, 1.48 million diagnostic colorectal examinations were billed to Medicare with allowed charges of $175 million. Two years later, the number of examinations increased by 5.2 percent; however, allowed charges increased by 44.9 percent to $253 million.

FIGURE I

Type Of Service	Frequency (thousands)			Allowed Charges (millions)		
	'85	'86	'87	'85	'86	'87
Rigid	627	528	461	$25	$20	$20
FFS*	615	703	758	$71	$86	$95
FFC	238	273	339	$79	$99	$138
Total	1480	1504	1558	$175	$205	$253

** Combined total of FFS formerly reported as two distinct procedures.*

During this 3-year span, rigid instrument proctosigmoidoscopies decreased while FFS and FFC procedures increased. These trends together with higher reimbursement allowances for flexible procedures primarily account for the significant increase in allowed charges. Reasonable charge reimbursement for rigid, FFS, and FFC is related to the visual distance of the colorectal examination. Four procedure codes were used through 1987 to report the distance of colorectal diagnostic examinations, two of which applied to flexible fiberoptic sigmoidoscopies. At the request of the American Society for Gastrointestinal Endoscopy (ASGE), the American Medical Association (AMA) revised the 1988 version of the Physicians' Current Procedural Terminology (CPT-4) to establish a single procedure code for FFS. In turn, HCFA instructed its carriers to process and pay for FFS under one code, effective January 1988.

Guidelines of Medical Professions

In July 1987, testimony before the Physician Payment Review Commission, the American Society for Gastrointestinal Endoscopy (ASGE) stated:

> *The primary reason for the numbers of diagnostic colonoscopies relates to the health care problem of colon cancer in the United States Colonoscopy is the primary method for discovery and excision of colonic polyps that are either precancerous or cancerous. As we know, early detection and removal of the polyps can substantially aid in the prevention of future problems for these patients. Routine screening of the colon for people who are indicated for such screenings, such as the President of the United States, can have a significant impact on maintenance of health status and prevention of further and more costly problems.*

While the ASGE statement specifically references "colonoscopies," routine screening by sigmoidoscopy is more prevalent.

The American Cancer Society espouses annual screening examinations via sigmoidoscopies at ages 50 and 51; after two successive negative findings, the procedure should be repeated every 3 to 5 years.

Medicare Coverage Limitations

Under Medicare law, items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury are, in general, excluded from coverage. Specifically excluded are expenses incurred for routine physical checkups, i.e., examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury.

Prior to the passage of the Medicare Catastrophic Coverage Act of 1988, no types of cancer screening exams were covered by Medicare. The catastrophic coverage legislation, however, provided coverage of cancer screening mammography (subject to frequency limitations, quality standards and special payment rules) effective January 1, 1990. This legislation also established a Bipartisan Commission on Comprehensive Health Care to make recommendations to Congress on other preventive health care services, among other items.

Medicare carriers are required to apply safeguards against unnecessary utilization of services furnished by providers. They do this by conducting prepayment and postpayment reviews designed to detect inappropriate, noncovered, or excessive services and potentially fraudulent practices. The review process leads to correcting inappropriate program payments by recovery of overpayments, preventing further abuse by educating the individual provider and, where similar issues of program abuse appear to be widespread among providers reviewed, issuing bulletins to the medical community on acceptable billing practices.

PURPOSE

This inspection was undertaken to determine the appropriateness of Medicare payments for colorectal examinations--in particular the extent to which physicians may be billing for cancer screening examinations not covered by Medicare.

SCOPE AND METHODOLOGY

A statistically valid random sample of 294 Medicare-reimbursed claims from around the country, for the four levels of diagnostic endoscopic procedures, was selected from the 1986 HCFA-BMAD data base. Sixty-two of these records indicated that the procedure was performed at hospitals, with the remaining 232 reported as being done by physicians in their offices. Copies of medical records containing all pertinent pre- and post-endoscopy notes, related consultation reports, and laboratory test results were requested for all patients in the sample. We were able to obtain records from 237 respondents (81 percent). The OIG contracted for a medical review of the records. A board-certified gastroenterologist presently in clinical practice and knowledgeable of current practices and utilization guidelines, made and recorded review determinations. The OIG was then provided with quantitative and narrative findings.

The prescribed review areas included patient status (referral, new or established), evidence to support endoscopy performance (clinical, laboratory and history), compatibility of reason for the exam as noted in clinical records with the reason on the billing form, and medical necessity determination for Medicare purposes.

The 35 carriers responsible for adjudicating the sample claims were asked for information on medical policy and claims processing procedures used by them to make coverage and payment determinations. These documents were analyzed to identify carrier practices designed to assure that payments are made only for services that are covered and are medically necessary. Hard copy and electronic media claims were evaluated to determine whether the carriers had received adequate information on them regarding the nature of the patient's medical condition.

FINDINGS

Twenty-seven Percent Of Claims For Endoscopic Examinations Of The Lower GI Tract Were Found Not Appropriate For Medicare Reimbursement

Medical review determinations on 237 patients' medical records found that 65 procedures (27.4 percent) were not appropriate for Medicare reimbursement. These procedures were done for noncovered cancer screening purposes or for other noncovered procedures. Other claims did not contain sufficient medical record documentation by treating physicians to make a coverage determination. The breakdown of the 65 cases is as follows:

Cancer screening examinations - Thirty procedures (12.7 percent) were determined to be noncovered for Medicare reimbursement due to clear indications in the medical record that the procedure was performed for cancer screening purposes.

Other noncovered procedures - Fourteen procedures (5.9 percent) were determined to be noncovered for other reasons:

- Six procedures were not justified since results of previous procedures and/or tests were conclusive in the diagnosis and/or treatment of the patients' condition. These included instances where the source of the medical problem had been identified or recent procedures produced negative findings.
- Procedures were performed on five patients who did not have any recent history, laboratory evidence or clinical symptoms indicating the necessity for the procedure.
- Three procedures were performed without medical justification 6 to 12 months prior to the time which current practices and general guidelines call for in follow-up surveillance.

Insufficient documentation - Twenty-one records (8.9 percent) did not contain sufficient medical documentation to enable the reviewer to make a determination that the procedure performed was covered. In these cases there were no medical record notes of clinical symptoms, laboratory test results or medical history to indicate the necessity for performing the examination.

Projecting these findings to the 1.5 million claims paid in 1986 indicates Medicare made inappropriate payments of $39,249,000.

Incorrect Payments Were Made Because Of Inaccurate Diagnostic Information Provided On Claims

In attempting to understand the carriers' role in reimbursing the sample cases, a review was made of the diagnoses and/or medical condition information contained on the claims forms themselves or an attachment. The intention was to determine whether this information alone, in the absence of the actual medical records, would have justified considering the services covered under Medicare's guidelines.

The results indicate that the great majority contained what would seem to be sufficient documentation. Of the 237 sample claims:

- 221 claims (93 percent) contained diagnoses or medical conditions for which carriers could presume that the endoscopic procedures were covered;
- 16 claims (7 percent) should have been denied coverage or developed for additional information by carriers to determine whether the procedures were covered. Of these, five claims clearly indicated that the procedure was for cancer screening purposes, three claims did not contain any diagnostic or medical condition information and eight claims contained medical conditions which, in and of themselves, did not indicate that the procedure could be presumed to be covered.

In another attempt to understand why the latter 16 claims were not questioned by the carrier, an analysis was made of the documents describing internal claims processing procedures and policies of carriers. Only 9 of the 35 carriers were found to have specific prepayment claims processing instructions for their claims examiners' use in determining coverage. Such carrier instructions typically cite specific diagnoses and medical conditions to allow a presumption of coverage; lacking these, examiners are instructed to deny payment.

Our review of the carriers' response to our request for copies of provider bulletins they had issued with specific coverage information regarding these procedures indicates a paucity of attempts to provide educational material to the medical community regarding coverage issues identified in this inspection. We found that only one of 35 carriers had done so. This carrier had prepared an article on colonoscopy claims.

The main problem appears to be that roughly three-quarters of the questionable claims (49 of 65) which were determined in the first finding to be noncovered (based on a review of the actual medical records) contained seemingly satisfactory information on physicians' claims forms to allow payment.

A review of the sample claims forms and supporting documents indicates that virtually all of the diagnostic information was provided by the physician or his/her authorized representative. As such, responsibility for misrepresenting the reason for the procedure, which occurred in many of these cases, rests with the physicians.

The OIG did not seek to obtain explanations from physicians responsible for the content of the claim information, nor did the sample methodology permit an analysis of whether the 49 physicians responsible for these claims routinely provide "suspect" information. It should be noted that the Medicare Part B claim form (HCFA-1500) instructs physicians that the services shown on the form should be medically indicated and necessary for the health of the patient, and that misrepresentation of essential information to receive payment may be subject to fine and imprisonment.

RECOMMENDATIONS

The HCFA should alert carriers to the substantial amounts of inappropriate payments being made. In addressing corrective action, HCFA should consider having its carriers:

- provide information to the medical community, through bulletins and other techniques, regarding the limits of Medicare coverage for such procedures and the medical record documentation necessary to support payment; and
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APPENDIX I

PAYMENT PROJECTIONS

The data for this inspection consisted of 294 records drawn from the fourth quarter of the 1986 BMAD file. These records represent a 0.08 percent sample of all Medicare Part B bills for that quarter. The results of the review indicate that 65 of the bills represented by these records were inappropriately paid a total of $7,850.00 in allowed charges. The average amount inappropriately paid per record is $26.70 with a standard error of 4.572. This gives a 90 percent confidence interval of $19.18 to $34.22 per record. This sample represents approximately 367,500 records in the universe of the fourth quarter of 1986. The projections would indicate that $9,812,250.00 (standard error of 1,680,477) was inappropriately paid in allowed amounts in this universe. The 90 percent confidence interval runs from a lower cutoff point of $7,047,915 to an upper cutoff point of $12,576,585.

Assuming that the other three quarters of 1986 are identical to the fourth quarter, both in the distribution of bills and in expected findings, then a 1-year estimate of the potential inappropriate payment would be $39,249,000.00 (standard error of 6,721,908). The lower 90 percent confidence interval cutoff point would be $28,191,660.00 and the upper cutoff point would be $50,306,340.00. These figures give an overall precision of approximately 28 percent.

APPENDIX II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date APR 13 1989

From Louis B. Hays
Acting Administrator

Subject OIG Draft Report: Medicare Coverage of Endoscopic Examination of the Lower Gastrointestinal Tract - OAI-02-88-00090

To The Inspector General
Office of the Secretary

We have reviewed the OIG draft report performed to determine the appropriateness of Medicare payments for examinations of the lower gastrointestinal tract, in particular the extent to which physicians may be billing for cancer screening which is not reimbursable under Medicare.

In order to bring this problem to the attention of the carriers, HCFA will share the OIG report with them, and the topic will be placed on the agenda of the May 23, 1989 meeting of the carrier medical directors. In line with the postpayment alert list (Medicare Carriers Manual, section 7514 E), we will recommend that medical directors provide information to the medical community through bulletins and other techniques regarding the limits of Medicare coverage for such procedures and the medical record documentation necessary to support payment.

Although we will encourage the carriers to give their attention to this procedure in their postpayment review process, we believe that the best way to reduce these unnecessary payments is to educate the medical community as set out in the previous paragraph. Post-payment medical review can be an effective tool, but it is a time-consuming and expensive process. Medical records must be obtained from physicians' offices and reviewed by carrier medical staff. Costs for this activity can average $15 per claim and higher. These costs must be considered in relation to the anticipated dollar return and within the context of the finite funding allocated for this activity.

Thank you for giving us the opportunity to comment on this draft report.