GAO

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Report to the Chairman, Committee on
Ways and Means, House of Representatives

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MEDICARE

Greater Investment in Claims Review Would Save Millions

GAO

United States
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Health, Education, and
Human Services Division

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March 2, 1994

The Honorable Martin O. Sabo
Chairman, Committee on the Budget
House of Representatives

Dear Mr. Chairman:

In this era of soaring U.S. health care costs and increased fiscal austerity in government programs, the Congress is concerned that the Medicare program pay only for appropriate medical services without compromising the quality of care provided to Medicare beneficiaries. One of the several ways Medicare ensures appropriate payment is through the medical review function performed by contractors—called carriers—who process and pay claims for physician services, diagnostic tests, and other Medicare part B services.

Medical review encompasses a range of review activities carriers design to prevent spending on inappropriate, medically unnecessary, or excessive services. The key elements of the medical review program are the use of medical policies (e.g., allowing only one payment to a physician for an inpatient hospital visit per beneficiary per day unless medical necessity is documented), computerized prepayment reviews (called "screens"), and trained and knowledgeable review staff.

Medical policies serve as the underpinning of Medicare's efforts to safeguard claims payments. Typically, a medical policy is established when claims payment experience shows the tendency of a service to be overprescribed or misprescribed and medical practice norms exist for this service. The Health Care Financing Administration (HCFA), which administers Medicare for the Department of Health and Human Services (HHS), has given carriers the principal responsibility for developing medical policy; medical necessity decisions therefore reflect local physician practice patterns. One example of a medical policy involves concurrent care, which occurs when two or more physicians treat the same patient on the same day in an inpatient hospital or nursing home. Claims reflecting such situations are flagged for review by carrier medical review staff. For concurrent care to be covered, the medical review staff must ensure that management of an active medical problem is documented in the hospital or nursing home chart on the date of service. Claims for services not covered by a medical policy generally trigger no

medical review and, if they are for covered services, are automatically paid in the amount allowed by Medicare.

In fiscal year 1993, HCFA budgeted about $1.1 billion to administer Medicare's part B program. Of this amount, carriers were expected to spend $94 million to medically review 9 percent of all Medicare claims. In the 3 previous years, the carriers' savings resulting from medical review ranged from $1.0 billion to $1.2 billion annually, nearly the equivalent of the entire carrier administrative budget for each year, or an average of 11 times the amount invested.

In a March 1992 letter, the former Chairman of the House Budget Committee asked us to assess a HCFA demonstration project. This project, referred to as the flexibility demonstration project, involves medical review operations at five carriers: three of these (referred to as demonstration carriers) were given added management flexibility and funding to enhance their medical review function and two served as comparisons. We examined whether (1) the improved medical review activities at the demonstration carriers produced measurable savings or benefits to the claims process, (2) additional medical review funding for other carriers would be cost-effective, and (3) HCFA's medical review oversight needs to be improved.

Results in Brief

Medicare carriers' intensified efforts to identify unusual spending patterns and trends netted increased savings, making the greater funding of medical review activities worthwhile: this is the lesson of HCFA's flexible funding and management demonstration project. Over the life of the project, each of the demonstration carriers saved about twice as much as the comparison carriers, or about $2.84 compared with $1.34 saved per claim. Demonstration carriers achieved these savings by taking some very basic actions, namely,

- employing more medical review staff—over twice the number employed by the comparison carriers,
- using more computerized controls to flag questionable claims for review—four times the number used by the comparison carriers, and
- reviewing a much larger volume of services before payment—nearly four times the number reviewed by the comparison carriers.

With additional resources, the demonstration carriers were able to focus on examining spending data for individual procedures. The Louisiana

carrier, for example, found that between 1988 and 1991 its payment for certain foot care services jumped more than threefold—from about $511,000 to about $1.9 million. Having detected this trend, the carrier tightened medical policies and computerized controls, and by 1992 its payments for these services dropped to about $620,000—about one-third the 1991 level.

Despite these greater achievements, the demonstration carriers received performance ratings similar to those of the comparison carriers. HCFA's criteria for evaluating carrier performance, which entailed meeting minimal review and savings quotas, offered no incentives for carriers to improve their medical review programs for the purpose of saving Medicare benefit dollars.

Background

Between January 1989 and September 1991, HCFA conducted a study to determine whether giving carriers greater management discretion—hence, flexibility—over medical review, as well as additional funding, would result in program improvements. Table 1 identifies the five carriers involved in the study and the role of each.

Table 1: Carriers Involved in the HCFA Demonstration Project

State(s)	Carrier	Purpose in project
Arizona/Nevada	Aetna	Comparison
Georgia	Aetna	Demonstration
Indiana	Associated Insurance Companies, Inc.	Demonstration
Louisiana	Blue Cross Blue Shield of Arkansas	Demonstration
North Carolina	Equicor	Comparison

The demonstration carriers were allowed to modify their medical review operations and were given a minimum 12 percent increase in funds for medical review activities, whereas the comparison carriers were to perform their medical review operations with no modifications to their medical review process and no additional money. (See apps. I through V for more information about the carriers in this study.) For our review, we visited HCFA headquarters; HCFA regional offices in Atlanta, Chicago, and Dallas; and all carriers involved in the demonstration project. We reviewed documents and discussed the project with officials at each of these locations. We performed our work between April 1992 and June 1993 in accordance with generally accepted government auditing standards.

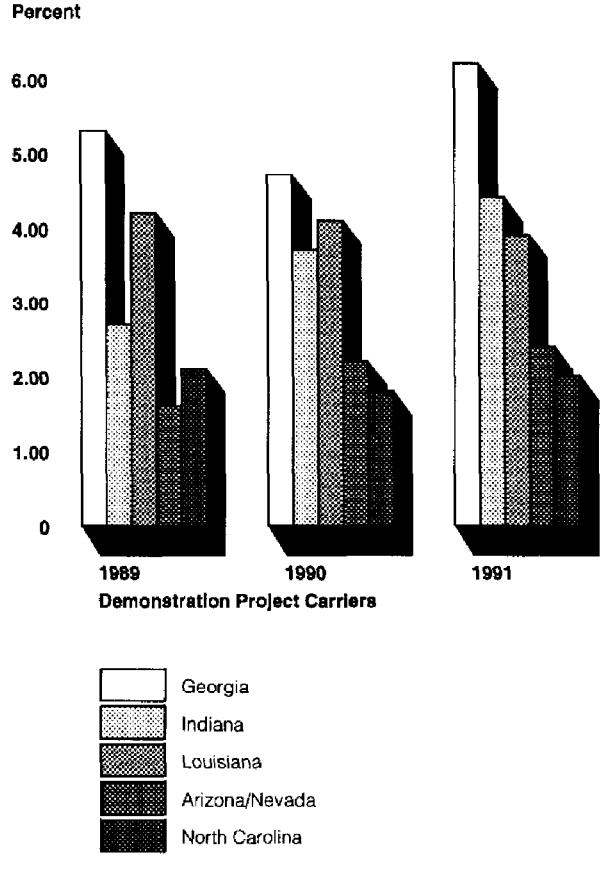
Demonstration Carriers' Efforts Have Been Productive

Demonstration carriers have been far more successful than the comparison carriers in avoiding payments for inappropriate, medically unnecessary, or excessive medical services and in developing more effective ways to detect areas for Medicare savings.

Demonstration Carriers Saved Millions Through Increased Medical Review

Overall, medical review savings rates for demonstration carriers have been, on average, about twice those of the comparison carriers. For example, in fiscal year 1991, Indiana's medical review savings were 4.4 percent of its total Medicare benefit spending, whereas North Carolina's medical review savings were only 2.0 percent. (See fig. 1.)

Figure 1: Medical Review Savings as a Percent of Medicare Benefit Spending



The common difference between the demonstration and comparison carriers was that HCFA provided the demonstration carriers more money to improve their medical review activities.[1] Indiana and Louisiana carrier officials estimated that over the life of the project they received additional funds of about $1.1 million and $600,000, respectively. When the project began, the Georgia carrier had just replaced the carrier that previously served the state and could not estimate its additional funding. Its overall medical review program, however, was more expensive than the other demonstration carriers, costing about twice as much per claim, in part because the Georgia carrier subcontracted its medical review function to HealthCare Compare, a firm specializing in that service.[2]

The demonstration carriers

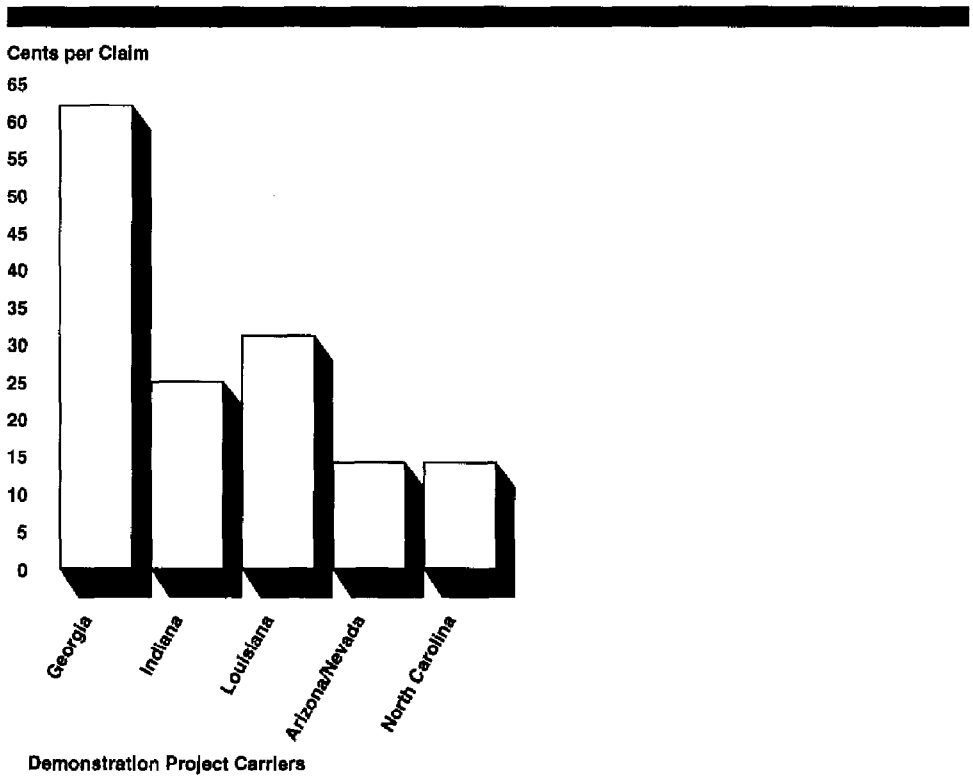
- spent 200 percent more on medical review (relative to their total Medicare expenditures) than did the comparison carriers,
- employed 283 percent more medical review staff—one staff person for every $17.5 million in benefit payments compared with the comparison carriers' one staff person per $54 million in benefit payments,
- had 759 percent more nurses on their medical review staffs than the comparison carriers, and
- reviewed an average of 373 percent more services each year before payment.

The demonstration carriers' medical review costs for fiscal year 1990 ranged from $2.1 million to $5.7 million, or from 25 to 62 cents per claim, while the comparison carriers' costs ranged from $1.1 million to $1.8 million, or 14 cents per claim. (See fig. 2.)

[1]HCFA initially intended the demonstration project to test whether medical review programs would be improved if carriers were given more managerial flexibility as well as more funding. Early in the project, however, HCFA made several major changes nationally, which extended to all carriers the operational flexibility initially extended only to the demonstration carriers. This minimized the differences in operating conditions between the demonstration and the comparison carriers and our findings focus on the funding aspect of the program.

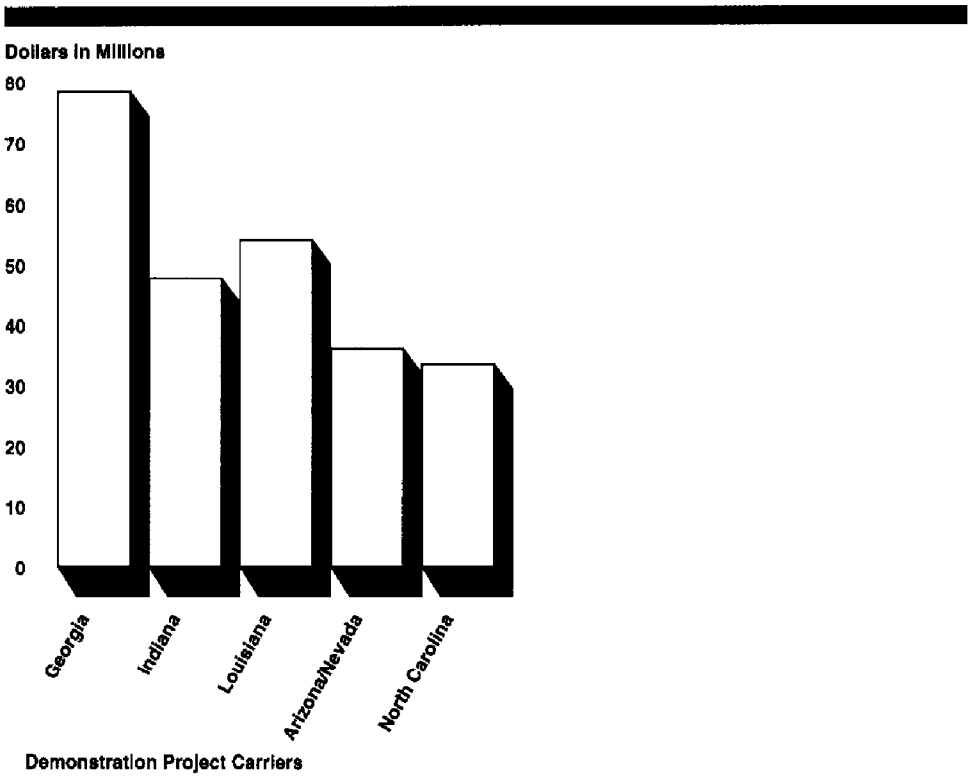
[2]HCFA could not specifically identify the total funds committed to this demonstration carrier.

Figure 2: Comparison of 1990 Medical Review Costs per Claim Processed



The value to Medicare of the demonstration carriers' added investment in medical review programs is apparent from the resulting program savings. The demonstration carriers saved from $2.19 to $3.18 per claim, whereas the comparison carriers saved between $0.93 and $1.78 per claim in fiscal year 1990. After deducting medical review costs, the demonstration carriers' savings were still 1.7 times those of the comparison carriers for the period. (See fig. 3.)

Figure 3: Comparison of Net Medical Review Savings, 1989-91



Demonstration Carriers Have Developed Analytic Capacity and Medical Policies

The demonstration carriers have achieved higher medical review savings by committing more resources to improving their analytic tools, medical policies, and other payment controls to identify claims for inappropriate or unnecessary services. Moreover, the demonstration carriers had the staffing needed to review the larger number of questionable claims being flagged as a result of their enhanced medical review efforts.

With the resources to redesign their medical review programs, the demonstration carriers substantially increased their ability to avoid making inappropriate payments. Specifically,

- Indiana hired a computer programmer for the medical review area, installed new computer software to generate improved medical review reports, and developed reporting systems to highlight questionable spending patterns;

- Louisiana produced reports showing 5-year expenditure trends for individual services and supplies and used test screens to identify the extent of problems; and
- Georgia subcontracted with an independent medical review firm that already had the capability to analyze patterns of health care services to detect providers who tend to use more services than average, or services that appear to be overused.

Using their new capabilities, the demonstration carriers identified payments that could be lowered by implementing new medical policies and prepayment screens. For example, the Indiana carrier found an unexpected increase in billings for a specialized glaucoma test. By developing a medical policy that clearly defined when the carrier would pay for such a test, reimbursements dropped from $229,772 in 1988 to $10,497 in 1992. In Louisiana, trend analysis indicated that spending on noninvasive vascular testing by podiatrists increased by about one-third—from $1.27 million to $1.7 million between 1988 and 1989. After the carrier implemented a new medical policy defining the medical circumstances under which the carrier would allow the claim, spending dropped by 35 percent from the 1989 level—nearly $600,000. (App. VI provides more examples of medical review savings.)

Unlike the demonstration carriers, the comparison carriers did not modify their medical review activities significantly during the study period. In particular, they did not develop new data analysis methods that could enable them to identify such payment problems as the inappropriately rapid growth of claims for certain medical services or supplies. With little means to evaluate the medical policies and claims review activities, comparison carriers developed or revised significantly fewer medical policies than did the demonstration carriers. Furthermore, they made fewer changes to their computer screens and other medical review activities.

The following section shows the differences between the demonstration and comparison carriers in their activities to identify ways to avoid inappropriate payments during the 1989-91 period.

The demonstration carriers

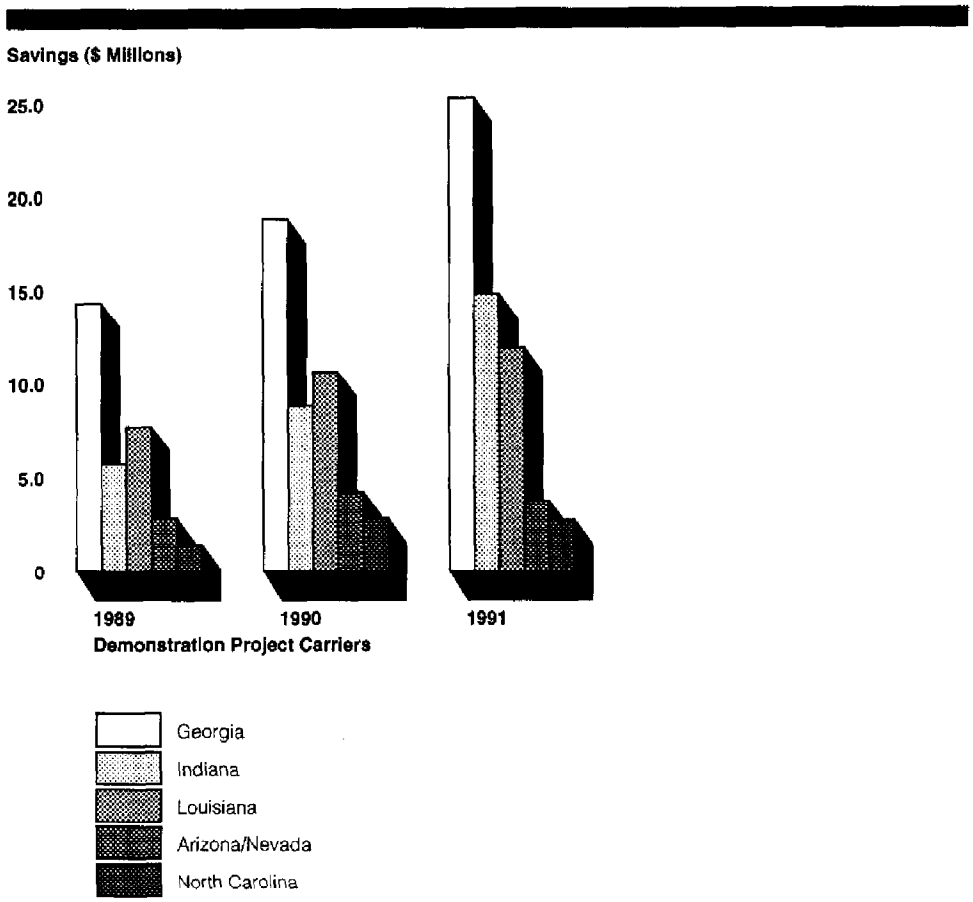
- spent more on medical policy development: The carriers with the highest savings (Indiana and Georgia) in the final year of the project spent about 10 percent of their medical review budgets on medical policy development

in 1989, the first year of the demonstration. The other carriers spent about 3 percent on policy development that year.

- developed more medical policies: The demonstration carriers developed more new policies than the comparison carriers. The Indiana carrier, for example, developed 42 new medical policies in fiscal year 1990, whereas the Arizona carrier developed only 5 new screens throughout the entire project period.
- implemented more prepayment screens: At project end, the demonstration carriers were on average employing 66 carrier-specific computer screens, over 2.5 times the number of the comparison carriers. (Specifically, Indiana had 60 screens; Georgia, 89; and Louisiana, 50, by the end of fiscal year 1991.)
- reviewed a much larger percentage of claims dollars: The demonstration carriers reviewed nearly 4.6 times the dollar volume of claims resulting from carrier-specific prepayment screens than those reviewed by the comparison carriers.

Because of their heightened efforts to identify payment problems and implement carrier-specific prepayment edits, the demonstration carriers saved Medicare nearly 350 percent more than the amounts saved by the comparison carriers on their carrier-specific edits. Specifically, during the project period, the demonstration carriers averaged Medicare savings of $39.3 million per carrier for their carrier-specific prepayment edits, while the comparison carriers averaged $8.8 million per carrier for their edits. The carriers' savings from their carrier-specific prepayment edits are shown in figure 4.

Figure 4: Comparison of Savings From Locally Developed Prepayment Screens



The comparison carriers' more limited medical review budget was a significant factor discouraging them from developing more medical policies and prepayment edits. Arizona carrier officials told us, for example, that the workload created by existing medical policies and screens overwhelmed the carrier's staff. Adding new medical policies and prepayment edits would only generate an increased workload and was therefore not a significant consideration during the project period.

The demonstration carriers' higher medical review budgets allowed them to employ more staff, which greatly increased their ability to undertake medical review initiatives. During the project period, on average, the demonstration carriers had 2.8 times more medical review staff than the comparison carriers. The demonstration carriers also had over 7.5 times

the number of nurses as the comparison carriers. With more nurses, they could implement many more prepayment screens; such screens can add significantly to medical reviewers' workloads by identifying more claims that are questionable and require medical review. This provided them greater ability to develop new medical policies and to undertake other more complicated medical review functions. The demonstration carriers' more substantial investment in medical review staffing was cost effective for Medicare, returning (after expenses) an average $672,000 dollars per medical review staff member each year.[3]

Increased Funding Has Yielded Substantial Program Savings

The demonstration project illustrates that spending more money on medical review activities can yield substantial Medicare program savings. Yet, nationally, HCFA has decreased funding for medical review. Decreased funding translates directly into fewer medical review staff and fewer claims reviewed before payment. Although this is likely to result in increased Medicare spending for unnecessary services, funding was decreased to save administrative dollars during a period of severe budgetary constraints.

Declining Funding for Medical Review

Nationally, funding for medical review declined on a per claim basis from 1989 to 1992. In 1989, Medicare spent 23.1 cents per claim for medical review compared with 17.5 cents per claim in 1992, about a 25-percent decrease. To help carriers cope with the declining medical review budget, HCFA decreased the carriers' medical review workload. In 1989, HCFA set targets for carriers to suspend and review 20 percent of all claims. Because of continuing declines in per claim funding, HCFA reduced this target to 15 percent in 1991, 9 percent in 1992-93, and 5 percent for 1994. To place the 1994 suspension rate target in perspective, the demonstration carriers as a group achieved their significant savings by suspending over 10 percent of their fiscal year 1991 claims for medical review—twice the number of suspensions expected by HCFA for fiscal year 1994.

Since the project ended, even the demonstration carriers are beginning to feel the pinch of decreasing money for medical review. With less money to spend on medical review activities than they had during the last year of the project, officials in two demonstration carriers stated that new medical

[3]The comparison carriers saved on average nearly $1 million each year per medical review staff member after expenses. The higher comparison carrier savings are an indication that the demonstration carriers may have been experiencing some diminishing returns as they nearly tripled their staffing relative to the comparison carriers. The demonstration carriers' overall savings, however, provide an indication that they did not approach the point where adding staff would become nonproductive.

policies and screens implemented during the project were already generating sufficient work for their available staffing. Consequently, they were not planning to maintain their prior level of effort to develop new medical policies and companion prepayment edits. Officials at the Indiana carrier pointed out that implementing new policies and edits causes increased provider inquiries and more suspended claims to review. Such additional workload cannot be accommodated because the carriers' medical review budgets are declining.

Budget Process Makes Carrier Funding Increases Unlikely

Increasing funding for medical review could save Medicare substantially more than it costs. Nevertheless, in the current budget environment doing so appears unlikely. Medical review and other activities funded out of Medicare's administrative appropriations come under discretionary spending and must compete for scarce dollars against programmatic funding.

In the past we have recommended that the Congress consider amending the Budget Enforcement Act of 1990 to treat Medicare safeguard activities in the same manner that the act treats Internal Revenue Service compliance activities.[4] This would allow increased funding of Medicare program safeguard activities without decreasing funding to other programs. We continue to believe this recommendation warrants consideration because it would allow the Congress more flexibility to consider funding increases for Medicare program safeguards solely on their merit—that is, their potential to reduce overall Medicare costs.

Current HCFA Evaluations of Carrier Performance Do Not Provide Incentives to Carriers to Increase Medical Review

Lacking additional funds, carriers have few incentives to improve medical review activities on their own. Carriers target their resources according to the functions on which HCFA will base their performance evaluation. HCFA's carrier performance evaluation criteria for medical reviews, however, do not use measures that would encourage or reward carriers for improving medical review programs.

Although HCFA evaluates whether carriers apply existing medical policies accurately in calculating claims payment, it does not assess (1) the appropriateness of carriers' existing medical policies, (2) the adequacy of

[4]Under the Budget Enforcement Act, if additional appropriations are made for Internal Revenue Service compliance activities, federal discretionary spending limits are automatically increased. This permits additional funding for these activities without necessitating spending cuts elsewhere. Our recommendation to amend the Budget Enforcement Act is included in a May 1991 report, Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67).

carriers' medical policies to safeguard Medicare payments, or (3) the scope and effectiveness of carriers' prepayment edits. Additionally, HCFA does not collect or evaluate carriers' medical policies or sufficient information on the effectiveness of computerized screens to permit comparison among carriers.

Carrier performance evaluation criteria can be met by carriers whether they improve their medical review programs or not. For example, throughout the demonstration project period, both comparison carriers exceeded HCFA's overall medical review standards although HCFA reported that medical review activities at these carriers remained basically unchanged. In fact, in 1991 HCFA awarded a higher medical review score to one comparison carrier than it did to a demonstration carrier with 2.5 times the reported savings. The cost-effectiveness of the demonstration carrier was not considered to be high enough to receive maximum points on this standard. After expenses, however, this demonstration carrier's medical review efforts saved Medicare $3.41 per processed claim, while the comparison carrier saved Medicare $1.79 per claim.

During the project, HCFA used cost-benefit ratios as one of its performance standards for medical review programs. In all 3 years, the comparison carriers exceeded the ratios. In fiscal year 1992, the year after the demonstration project ended, HCFA shifted from a cost-benefit ratio to an absolute savings goal. However, the savings goals were not meaningful. Because they were set so low, almost every carrier met its goal before the year was half over, according to HCFA officials.

One comparison carrier's proposal to trim certain medical review edits illustrates the problem that results from low savings goals and the absence of alternative measures of performance to give carriers the right incentives. Specifically, the North Carolina carrier's Medicare director, in a staff memorandum, suggested eliminating all carrier-initiated screens in fiscal year 1992 because ". . . the medical review savings goal for '92 [was] significantly less than what [they were achieving] in '91." The carrier had no incentive to review additional claims or save Medicare additional money once targets had been reached. In fiscal year 1991, these screens had saved Medicare over $2.6 million.

In 1993, HCFA dropped all savings goals and instituted new evaluation criteria to encourage carriers to enhance their data analysis capabilities. Based in part on lessons learned from the demonstration study, HCFA developed a new performance standard—focused medical review—which

emphasizes carrier data analysis capabilities. Specifically, HCFA's fiscal year 1993 medical review standards require each carrier to identify and take corrective action on 40 services or procedures, for which utilization rates are unusually high compared with all other carriers. Under its focused medical review requirements, HCFA is beginning to require that carriers improve their capabilities for identifying and correcting problems that result in unnecessary Medicare expenditures. HCFA's efforts are still in a very early stage, however, and carrier performance requirements regarding development of medical policies and prepayment screens remain minimal. Moreover, continuing problems with funding will also constrain HCFA's efforts to achieve more from its carrier medical review activities.

Conclusions

The achievements of the demonstration carriers suggests that other carriers can substantially improve their medical review operations if HCFA provides them with adequate funding and other incentives to do so. Successfully transferring the results of the demonstration program to the general carrier network depends on whether HCFA provides carriers with adequate funding and other incentives to operate competent medical review programs. Without this stimuli, carriers are not likely to undertake initiatives to improve their medical review programs. Despite the large payoff to Medicare, medical review provides no payoff to carriers; in fact, better medical review costs carriers more money and complicates their basic jobs as claims processors.

In recent years, HCFA has been concerned with reducing program administration costs and has significantly reduced per-claim medical review funding, which means fewer claims are subjected to medical review. With or without increased funding, however, HCFA needs to encourage carriers to be more vigilant in safeguarding Medicare program dollars. The absence of key evaluation criteria allows HCFA to characterize a wide range of performance as acceptable, which does not challenge carriers to continue to improve.

Recommendation

We recommend that the Secretary of HHS direct the HCFA Administrator to take better advantage of carrier medical review activities by developing precise measures of carrier performance in such key medical review areas as

- the effectiveness of carrier data analysis capabilities,

- the adequacy of carrier medical policies,
- the scope and effectiveness of prepayment screens, and
- the significance of carrier medical review savings.

This will enable HCFA to assume a larger role in reducing Medicare expenditures by holding carriers more accountable for medical review efforts.

HHS Comments and Our Evaluation

In commenting on our recommendations, HHS focused on recent activities that HCFA has undertaken to improve carriers' medical review programs and the agency's ability to oversee those programs. HHS expressed some concern about developing contractor evaluation standards that would require contractors to meet specific savings goals, such as a minimum cost-benefit ratio. HHS believes that savings standards can give contractors incentives to focus excessively on achieving savings at the expense of performing other carrier medical review functions, such as the development of effective provider education activities. We agree that it would be inappropriate for HCFA to focus exclusively on savings when assessing a carrier's medical review performance. The amounts carriers save provide only one of several performance measures that we believe HCFA needs to develop. HHS noted that HCFA recently let a contract to help the agency develop better performance measures. We believe this initiative and the other initiatives HHS cites in its comments provide HCFA a good start toward developing better Medicare contractor performance measures and, ultimately, more effectively managing the Medicare program.

In its technical comments on the draft report, HHS also explained how carriers develop medical policies and apply them to make medical necessity determinations. HHS, however, did not address our basic concern that HCFA does not assess the appropriateness or adequacy of carrier medical policies. We have considered other HHS comments and incorporated them as appropriate. (HHS comments are included as app. VII.)

We are sending copies of this report to the appropriate Senate and House committees and subcommittees, the Secretary of Health and Human Services, the Administrator of HCFA, and the Director of the Office of Management and Budget. We will make additional copies available to other interested parties upon request.

If you or your staff have any questions about this report, please call me on (202) 512-7123. Other major contributors are listed in appendix VIII.

Sincerely yours,

Leslie G. Aronovitz
Associate Director, Health Financing Issues

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Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

Aetna: Comparison Carrier for Arizona/Nevada

Aetna has been the Medicare carrier for Arizona and Nevada since the program's inception. The Arizona/Nevada Aetna operation, located in Phoenix, Arizona, is part of the national Aetna organization that also services Medicare part B claims in Alaska, Georgia, Hawaii, New Mexico, Oklahoma, Oregon, and Washington. The Health Care Financing Administration selected it as a comparison carrier for the study to provide a contrast with the Aetna carrier for Georgia, which HCFA selected as a demonstration carrier.

Table I.1: Information on Medical Review in Arizona/Nevada, 1989-92

	1989	1990	1991	1992
Beneficiary population (thousands)	**587.9**	**614.8**	**642.0**	707.4
Benefit payments (millions)	**$559.4**	**$634.1**	**$668.4**	$719.4
Claims volume (millions)	**6.8**	**7.8**	**8.5**	9.3
Administrative cost (millions)	**$12.0**	**$13.8**	**$14.4**	$16.0
Medical review cost (millions)	**$1.0**	**$1.1**	**$1.2**	$0.9
Medical review staff				
Prepayment				
Nurses	**0.5**	**0.5**	**0.5**	0.5
Other	**6.0**	**6.0**	**6.0**	6.0
Postpayment				
Nurses	**1.5**	**1.5**	**1.5**	1.5
Other	**3.0**	**3.0**	**3.0**	3.0
Total staff	**11.0**	**11.0**	**11.0**	11.0
Medical review savings (millions)	**$9.0**	**$13.8**	**$16.4**	$16.9
Medical review savings/benefit payments (percent)	**1.6**	**2.2**	**2.5**	2.3
Medical review savings per claim	**$1.33**	**$1.78**	**$1.93**	$1.81

Aetna: Demonstration Carrier for Georgia

Aetna replaced Prudential as the Georgia part B carrier on January 1, 1989 (also the start of the demonstration). The Georgia Aetna operation, located in Savannah, Georgia, is part of the national Aetna organization that also services Medicare part B claims in Alaska, Arizona, Hawaii, Nevada, New Mexico, Oklahoma, Oregon, and Washington.

At the same time Aetna became the Georgia carrier, HCFA awarded HealthCare COMPARE, an independent provider of health care utilization review services, the Medicare part B medical review subcontract for Georgia for the length of the 33-month demonstration. This organizational separation of the medical review function was unique among carriers.

The transition to a new carrier in Georgia was particularly difficult for two reasons. First, Aetna planned to establish a new claims-processing office, but did not provide its clerks enough training to process claims effectively in the time it had prior to becoming operational. Second, HCFA made a last-minute decision to subcontract the medical review function, instead of relying on Aetna staff for this. The subcontractor, HealthCare COMPARE, had little time to set up its operation, determine how its review policies would affect providers, and inform providers of the changes they should expect. As a consequence, claims processing slowed, backlogs grew, processing errors increased, beneficiaries were confused, and providers' finances were strained by payment interruptions. At the demonstration's end, Aetna assumed the Georgia medical review function from HealthCare COMPARE.

Table II.1: Information on Medical Review in Georgia, 1989-92

	1989	1990	1991	1992
Beneficiary population (thousands)	**692.9**	**708.1**	**725.1**	788.1
Benefit payments (millions)	**$440.9**	**$624.7**	**$666.9**	$709.1
Claims volume (millions)	**6.8**	**9.2**	**10.7**	11.5
Administrative cost (millions)	**$19.0**	**$22.5**	**$22.6**	$19.8
Medical review cost (millions)	**$5.4**	**$5.7**	**$4.9**	$2.3
Medical review staff				
Prepayment				
Nurses	**13.0**	**19.0**	**12.0**	9.0
Other	**23.5**	**18.5**	**14.5**	11.0
Postpayment				
Nurses	**3.0**	**8.0**	**10.0**	8.0
Other	**1.0**	**2.0**	**2.0**	1.0
Total staff	**40.5**	**47.5**	**38.5**	29.0
Medical review savings (millions)	**$23.5**	**$29.4**	**$41.5**	$36.4
Medical review savings/benefit payments (percent)	**5.3**	**4.7**	**6.2**	5.1
Medical review savings per claim	**$3.48**	**$3.18**	**$3.87**	$3.16

Associated Insurance Companies, Inc.: Demonstration Carrier for Indiana

Associated Insurance Companies, Inc., located in Indianapolis, Indiana, has been the Medicare contractor for both part A and part B claims for Indiana since Medicare's inception. According to carrier officials, prior to the demonstration the Indiana carrier relied almost exclusively on HCFA-mandated screens for medical review savings.

Indiana carrier officials envisioned Associated's role as a demonstration carrier in this study as a vehicle for improving Associated's medical review program. Associated received about $1.1 million in additional funding over the 3 years of the demonstration. To facilitate improvements, the Indiana carrier reorganized its corporate structure by consolidating the part A and part B medical review functions into a single unit. In conjunction with the consolidation, the carrier (1) developed a database for analyzing payment practices; (2) hired an assistant for the Medical Director, a computer programmer, and additional managers and medical review staff; and (3) purchased new statistical software and computer time to run complicated reports.

On October 1, 1991, Associated reorganized its overall corporate structure. According to carrier officials, the restructuring concentrated operational activities in order to focus accountability, spread costs over several subsidiaries, and improve responsiveness to customers. This reorganization included creating a subsidiary, AdminaStar Federal, to oversee its Medicare operations, and another subsidiary, AdminaStar Solutions, to market its data analysis programs, derived during the demonstration, to other clients, including the part B carriers in the states of Alabama, Minnesota, and South Carolina.

Table III.1: Information on Medical Review in Indiana, 1989-92

	1989	1990	1991	1992
Beneficiary population (thousands)	**725.8**	**737.2**	**748.8**	803.4
Benefit payments (millions)	**$468.4**	**$510.9**	**$527.7**	$572.4
Claims volume (millions)	**7.6**	**8.5**	**9.6**	10.6
Administrative cost (millions)	**$16.8**	**$15.2**	**$17.1**	$18.5
Medical review cost (millions)	**$2.6**	**$2.1**	**$2.3**	$2.3
Medical review staff				
Prepayment				
Nurses	**7.0**	**7.0**	**7.0**	6.0
Other	**4.0**	**5.0**	**5.5**	7.0
Postpayment				
Nurses	**8.0**	**5.0**	**5.5**	7.0
Other	**2.0**	**2.0**	**2.0**	2.0
Total staff	**21.0**	**19.0**	**19.5**	21.0
Medical review savings (millions)	**$12.6**	**$18.7**	**$23.4**	$22.8
Medical review savings/benefit payments (percent)	**2.7**	**3.7**	**4.4**	4.0
Medical review savings per claim	**$1.66**	**$2.19**	**$2.43**	$2.14

Blue Cross Blue Shield of Arkansas: Demonstration Carrier for Louisiana

Blue Cross Blue Shield of Arkansas became the Louisiana carrier for Medicare part B claims on January 1, 1985. The Louisiana carrier has two physical locations: prepayment functions located in Baton Rouge, Louisiana, and postpayment functions located in Little Rock, Arkansas. Gradually, the carrier has been shifting workload from Little Rock to Baton Rouge; however, this has been slowed by the shortage of nurses, used as reviewers, in the Baton Rouge area.

According to carrier officials, Louisiana's medical review program prior to the demonstration relied primarily on manually identified problem areas and referrals. Even so, its medical review program was well-established at the start of the project. For example, in 1987 the carrier's medical review savings were twice as high as Indiana's. At the start of the demonstration, Louisiana employed 64 locally developed medical review computer screens—about four times the number of screens employed by Arizona/Nevada and about one and one-half times the number of screens for North Carolina and Georgia.

The Louisiana carrier estimated it received an additional $600,000 over the life of the study—considerably less than either Georgia or Indiana and limiting the carrier's ability to hire staff. For example, in fiscal year 1991, the carrier requested an additional $329,000 for nursing staff and clerical and system support; however, HCFA provided only $169,300.

At the end of the demonstration, the Louisiana carrier encountered severe difficulties in retaining nurses for medical review and began using specially trained claims analysts instead.

Table IV.1: Information on Medical Review in Louisiana, 1989-92

	1989	1990	1991	1992
Beneficiary population (thousands)	**499.8**	**507.8**	**516.9**	558.6
Benefit payments (millions)	**$436.1**	**$489.9**	**$529.2**	$556.6
Claims volume (millions)	**6.2**	**6.8**	**7.8**	8.4
Administrative cost (millions)	**$12.3**	**$13.6**	**$14.7**	$15.9
Medical review cost (millions)	**$1.5**	**$2.1**	**$1.7**	$1.6
Medical review staff				
Prepayment				
Nurses	**11.0**	**9.0**	**10.0**	5.5
Other	**11.0**	**11.0**	**12.0**	13.0
Postpayment				
Nurses	**3.0**	**4.0**	**5.0**	5.0
Other	**2.0**	**2.0**	**2.0**	2.0
Total staff	**27.0**	**26.0**	**29.0**	25.5
Medical review savings (millions)	**$18.2**	**$20.1**	**$20.9[a]**	$18.8[a]
Medical review savings/benefit payments (percent)	**4.2**	**4.1**	**3.9**	3.4
Medical review savings per claim	**$2.94**	**$2.97**	**$2.68**	$2.24

[a]Figures adjusted to maintain consistency of reported savings over the 3-year period. Other calculations were adjusted accordingly.

Equicor: Comparison Carrier for North Carolina

Equicor replaced Prudential as the North Carolina carrier for Medicare part B claims on December 1, 1988. When Equicor took over the North Carolina Medicare part B contract, it decided to handle the North Carolina operations principally out of its existing Nashville, Tennessee, operations center because Prudential employees stayed with that company. Transition problems, such as deterioration in claims processing, were less severe in North Carolina than in Georgia. This was due to the carrier's decision to use existing facilities and its longer lead time to hire and train staff. The North Carolina carrier began hiring and training staff 6 months prior to "live" claims processing, as opposed to 3 months prior in Georgia. Because of the effort required to manage the transition, Equicor officials were initially reluctant to participate in the demonstration project but ultimately agreed to become a comparison carrier.

Originally, almost all of North Carolina's operations were handled out of Nashville; however, Equicor gradually shifted more of the workload to its Greensboro, North Carolina, office. The prepayment functions are now located in Nashville and postpayment functions are located in Greensboro. In 1991, Equicor was bought by CIGNA. However, Equicor's Medicare staff was retained by CIGNA because CIGNA was not in the Medicare business at the time of the takeover.

Table V.1: Information on Medical Review in North Carolina, 1989-92

	1989	1990	1991	1992
Beneficiary population (thousands)	**841.5**	**864.8**	**889.1**	986.7
Benefit payments (millions)	**$518.6**	**$673.1**	**$726.6**	[a]
Claims volume (millions)	**10.2**	**13.3**	[a]	[a]
Administrative cost (millions)	**$15.1**	**$21.1**	[a]	[a]
Medical review cost (millions)	**$1.3**	**$1.8**	[a]	[a]
Medical review staff				
Prepayment				
Nurses	**1.0**	**2.0**	**2.0**	1.0
Other	**7.0**	**5.0**	**3.0**	6.0
Postpayment				
Nurses	**2.0**	**2.0**	**2.0**	2.0
Other	**3.0**	**4.0**	**4.0**	5.0
Total staff	**13.0**	**13.0**	**11.0**	14.0
Medical review savings (millions)	**$10.9**	**$12.4**	**$14.7**	$11.0
Medical review savings/benefit payments (percent)	**2.1**	**1.8**	**2.0**	[a]
Medical review savings per claim	**$1.06**	**$0.93**	[a]	[a]

[a]Not available.

Examples of Medical Review Savings

Trabeculectomy

Trabeculectomy is the surgical release of fluid in the eye for glaucoma patients. The Louisiana carrier discovered that some surgeons routinely perform a trabeculectomy when doing cataract surgery even if glaucoma had not been diagnosed or previously treated. The carrier's analysis revealed an increase during 1989 and 1990 in ophthalmologists' billing for trabeculectomy. In response, the carrier published a local medical policy in August 1990. The medical policy simply required a diagnosis on the claim when the procedure was done in conjunction with a cataract extraction. Reimbursements dropped 8 percent in 1991 and 4 percent in 1992.

Table VI.1: Change in Medicare Expenditures for Trabeculectomy, 1988-92

Year	Amount allowed	Variance (percent)
1988	$ 479,770	
1989	513,067	+ 6.9
1990	613,989	+ 19.7
1991	562,940	- 8.3
1992	541,031	- 3.9

Nationally, the Medicare program spent about $45 million on this procedure in 1992.

Hospital Beds

The Indiana carrier discovered an increase in billings for hospital bed rentals during fiscal year 1989. As a result, the carrier published a local medical policy in December 1989 addressing the criteria necessary for authorization of hospital bed rentals and also established internal computer screen parameters on March 1, 1990. The medical policy required narrative justification; specified the medical necessity criteria, such as the patient requiring special positioning of the body; and defined medical conditions, such as what constitutes "bedfast." Subsequently, reimbursements dropped 27 percent in 1991 and another 24 percent in 1992.

Table VI.2: Change in Medicare Expenditures for Hospital Beds, 1988-92

Year	Amount allowed	Variance (percent)
1988	$2,593,532	
1989	2,551,306	- 1.6
1990	2,434,753	- 4.6
1991	1,777,882	- 27.0
1992	1,357,376	- 23.7

Nationally the Medicare program spent $212 million for hospital beds in 1992.

Serial Tonometry

Serial tonometry indicates repeated testing over a few hours in a doctor's office, usually to assess variations in pressure in the eye of a patient who is suspected of having glaucoma or to monitor pressure in certain glaucoma patients. The Indiana carrier discovered an increase in provider billing for serial tonometry during fiscal year 1988, which, according to the carrier's medical review director, was much larger than expected. As a result, the carrier published a local medical policy in July 1989 for serial tonometry. The medical policy clarified the expected duration and the uncommon frequency of this test. Subsequently, reimbursements for this procedure have dropped each year, starting with a 4-percent drop in 1989, then 32 percent in 1990, 87 percent in 1991, and another 45 percent in 1992.

Table VI.3: Change in Medicare Expenditures for Serial Tonometry, 1988-92

Year	Amount allowed	Variance (percent)
1988	$ 229,772	
1989	219,845	- 4.3
1990	148,700	- 32.4
1991	19,200	- 87.1
1992	10,497	- 45.3

Nationally, the Medicare program spent $5 million on this procedure in 1992.

Right Heart Catheterization

Right heart catheterization is the placement of a catheter into the right atrium, ventricle, and pulmonary artery to detect various forms of heart disease. The Louisiana carrier discovered an increase in provider billing for right heart catheterizations during fiscal year 1991. As a result, the carrier published a local medical policy in June 1991 for right heart catheterizations. The medical policy defined when this procedure is warranted. Subsequently, reimbursements dropped 83 percent in 1992, with no increases in related procedure codes.

Table VI.4: Change in Medicare Expenditures for Right Heart Catheterization, 1988-92

Year	Amount allowed	Variance (percent)
1988	$ 233,286	
1989	206,573	- 11.5
1990	189,871	- 8.1
1991	168,556	- 11.2
1992	28,064	- 83.3

Nationally, the Medicare program spent $11 million on right heart catheterizations in 1992.

Noninvasive Vascular Testing

Noninvasive vascular testing involves studies of the lower extremities through various forms of pressure, velocity, and wave form analysis. The Louisiana carrier's trend analysis revealed a 35-percent increase during 1989 for podiatrist reimbursements for noninvasive vascular testing. In response, the carrier published a local medical policy in August 1990. The new medical policy limited the procedure to evaluations prior to scheduled surgery no more than once a year, required specific documentation, and identified specific diagnoses and symptoms. Reimbursements dropped 9 percent in 1991 and 38 percent in 1992.

Table VI.5: Change in Medicare Expenditures for Noninvasive Vascular Testing, 1988-92

Year	Amount Allowed	Variance (percent)
1988	$1,266,546	
1989	1,704,002	+ 34.5
1990	1,943,712	+ 14.1
1991	1,773,416	- 8.8
1992	1,105,515	- 37.7

Nationally, the Medicare program spent $56 million on this procedure in 1992.

Routine Foot Care

Routine foot care includes the cutting or removal of corns or calluses, trimming of nails, application of skin creams, and other hygienic and preventive maintenance foot care of both ambulatory and bedfast patients. The Louisiana carrier's analysis revealed an increase in provider billing for five nonroutine foot care-related procedures from 1989 through 1991. The carrier suspected that podiatrists were performing routine foot care but billing for the five nonroutine foot care procedures that were reimbursed at higher rates. In response, the carrier published a local medical policy in

November 1991 for routine foot care. The medical policy delineated the difference between routine foot care and the five nonroutine foot care procedures. Subsequent to the implementation of the medical policy, reimbursements dropped from 57 to 86 percent in all five nonroutine foot care procedure codes, for a total reduction in 1992 of over $1.2 million. The carrier's analysis also revealed, as anticipated, that reimbursements for routine foot care increased by about $47,000 in 1992.

Table VI.6: Change in Medicare Expenditures for Various Foot Care Procedures, 1988-92

Year	Amount allowed	Variance (percent)
Code 11700 - Debridement of nails, manual; five or less		
1988	$ 119,309	
1989	195,090	+ 63.5
1990	300,100	+ 53.8
1991	384,740	+ 28.2
1992	134,603	- 65.0
Code 11701 - Each additional, five or less		
1988	55,230	
1989	134,533	+ 143.6
1990	245,654	+ 82.6
1991	320,837	+ 30.6
1992	43,647	- 86.4
Code 11710 - Debridement of nails, electric grinder; five or less		
1988	127,871	
1989	233,267	+ 82.4
1990	368,090	+ 57.8
1991	434,783	+ 18.1
1992	186,035	- 57.2
Code 11711 - Each additional, five or less		
1988	106,363	
1989	171,660	+ 61.4
1990	307,365	+ 79.0
1991	394,321	+ 28.3
1992	121,970	- 69.1
Code 11730 - Avulsion of nail plate, partial or complete, simple; single		
1988	102,419	
1989	164,882	+ 61.0
1990	315,020	+ 91.1
1991	344,025	+ 9.2
1992	134,767	- 60.8

Nationally, the Medicare program spent $190 million on the five nonroutine foot care-related procedures in 1992.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

NOV 30 [illegible]

Ms. Leslie Aronovitz
Associate Director,
Health Financing Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on your draft report, "Medicare: Greater Investment in Claims Review Would Save Millions." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

June Gibbs Brown

June Gibbs Brown
Inspector General

Enclosure

Comments of the Department of Health and Human Services (HHS) on the General Accounting Office (GAO) Draft Report, "Greater Investment in Claims Review Would Save Millions"

Overview

According to GAO, Medicare carriers' intensified efforts to identify unusual spending patterns and trends netted increased savings, making the greater funding of medical review activities worthwhile. GAO believes that this is the lesson of the Health Care Financing Administration's (HCFA) flexible funding and management demonstration project. Over the life of the project, GAO reports that each of the demonstration carriers saved about twice as much as the comparison carriers.

GAO Recommendation

We recommend that the Secretary of HHS direct the HCFA Administrator to take better advantage of carrier medical review activities by developing precise measures of carrier performance in such key medical review areas as:

-- the effectiveness of carrier data analysis capabilities;

-- the adequacy of carrier medical policies;

-- the scope and effectiveness of prepayment edits; and,

-- the significance of carrier medical review savings.

Department Comment

HCFA evaluates carrier performance in conducting medical review through the annual Contractor Performance Evaluation Program (CPEP). Each year the CPEP is developed with the goal of evaluating the most important elements of carrier operations.

GAO correctly notes that effective with Fiscal Year (FY) 93, HCFA dropped from the CPEP the evaluation standard that measured carrier performance in generating savings from medical review activities. In its place, HCFA established a standard that focused on the success of a carrier's activities in analyzing data to identify and correct aberrant situations in its provider service area.

The elimination of the standard measuring a carrier's achievement in generating savings or in achieving a specific cost-benefit ratio from medical review activities was based on HCFA's concern that it created a perverse incentive for the carriers' medical review activities. Demanding a pre-set and prescribed recovery quota of savings caused the carriers to focus on generating savings, at times at the expense of performing appropriate reviews.

The former standard generated considerable administrative costs and burden in the areas of inquiries, hearings and the appeal of denied services. Therefore, we do not consider the reestablishment of incentives to generate medical review savings to be an effective means to manage carrier medical review activities.

As noted by GAO, HCFA established a new standard to measure the carriers' performance in analyzing HCFA-provided payment data and its own identification of aberrant patterns of practice that result in inappropriate program payments. This new standard, created and included in the FY 93 CPEP, required carriers to identify and correct noted aberrancies by:

- educating providers about the problems identified; and,
- developing prepayment review screens and medical policy, as appropriate, to preclude future incorrect payments.

We believe this new performance standard is a better measure of carrier medical review activities.

Actions Taken by HCFA Following the Flexibility Demonstration Project

We would like to stress that we have learned a great deal from the flexibility project, and, further, that we have incorporated this knowledge into the way HCFA conducts this payment safeguard activity. As a direct result of the flexibility project, HCFA moved to a focused medical review process. This approach to medical review requires contractors to focus their medical review activities on those areas with the highest probability of medically unnecessary services through the utilization of data analysis, policy development, and focused screens. Beginning with FY 93, contractors were given additional funding to develop or purchase software, and to hire the additional capacity needed to implement focused medical review.

We have found that focused medical review yields the highest return for the money invested by targeting those areas that will produce the highest savings. This focus conforms with a reduction in carriers' medical review workload.

Under the 1993 CPEP, carriers were required to use the systems developed for focused medical review to identify 40 aberrancies (e.g. areas where the utilization varied significantly from the nation) and, from these, develop 15 new or revised local medical review policies. Under the CPEP program, HCFA is evaluating carrier performance in both identifying aberrancies and the corrective actions taken.

It should be further noted that the emphasis of carrier medical review has moved to education of the providers. Instead of stressing savings and providing incentives to deny claims, the creation of Carrier Advisory Committees and implementation of focused medical review stress the importance of giving the providers the information needed to bill correctly the first time.

HCFA has let a contract to develop methodologies for better assessing the effectiveness of Medicare Part A and Part B medical review. One method of assessing the effectiveness of medical review is by applying a cost-benefit ratio to the medical review of claims. However, the objective of medical review is to change inappropriate provider behavior through education on national and local medical policies. We hope the contractor will suggest an alternative method to measure effectiveness.

Technical Comments

Now on p. 1.

On Page 2, beginning in the eleventh line, change "suspended from further processing until" to "selected from manual processing so that they can be". GAO should avoid the term "suspended" because it connotes both a delay in processing the claim as well as the making of an adverse action against the physician, neither of which is intended or accurate.

Now on p. 12.

On Page 20, the report states that HCFA does not assess the appropriateness or adequacy of carrier medical policies. In the absence of National Policy, carriers are required to develop local medical review policies which describe when and under what circumstances procedures will be considered medically necessary. Local medical review policies are developed by the carrier medical director in consultation with the Carrier Advisory Committee, with input from the local medical community. Local medical review policy leads to explicit criteria (internal Medical Review guidelines) that are used by review staff to make medical necessity determinations. The carrier medical director is responsible for reviewing these criteria.

Now on p. 13.

Also on Page 20, the report states that HCFA does not assess the scope and effectiveness of medical policies. Carriers are required to evaluate the effectiveness of prepayment screens on a quarterly basis. Moreover, we believe that the focused medical review initiative provides a dynamic environment in which carriers are routinely evaluating postpayment data in order to re-focus their medical review efforts. This process assures that effective and timely local medical review polices are being developed.

Major Contributors to This Report

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