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MEDICARE PART B

Inconsistent Denial Rates for Medical Necessity Across Six Carriers

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Mr. Chairman and Members of the Subcommittee:

It is a pleasure to be here to share with you the results of our ongoing work on the Medicare Part B claims processing system. As you requested, in our testimony today, we will present information on claims processed by six carriers that were denied for lack of medical necessity. To develop this information, we analyzed data provided to us by the Health Care Financing Administration (HCFA).

Before turning to the results of our work, let me briefly discuss the program and the process by which carriers determine medical necessity.

The Medicare program, authorized under title XVIII of the Social Security Act, is a nationwide entitlement program to provide health care benefits to persons 65 years of age or older, certain disabled beneficiaries, and most persons with end-stage renal disease. Once eligible, beneficiaries should not receive different benefits solely because their place of residence differs.

Since its inception, the program has grown considerably: The number of people with coverage increased from 19 million in 1967 to over 35 million. Currently, about 96 percent of those eligible for Medicare are enrolled. HCFA, within the Department of Health and Human Services, administers the Medicare program and establishes the regulations and policies under which the program operates.

The Medicare program consists of two distinct insurance programs. Part A (Hospital Insurance Benefits for the Aged and Disabled) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities. Part B (Supplementary Medical Insurance for the Aged and Disabled) covers a wide range of medical services and supplies--including physician services, outpatient hospital services, and home health services not covered under Part A, as well as diagnostic laboratory tests, x rays, and the purchase or rental of durable medical equipment.

In accordance with title XVIII of the Social Security Act, as amended, HCFA contracts with 34 private insurance carriers to process and issue benefit payments on claims submitted under Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1993, carriers processed about 576 million Part B claims submitted by about 780,000 physicians and 136,000 suppliers.

The Social Security Act mandates that carriers pay only for services that are covered, and reject the claim if they determine that the services were not medically necessary. In fiscal year

1993, carriers denied 112 million Part B claims in whole or part (19 percent of all claims processed) for a total of $17 billion (which represented 18 percent of all billed charges, a figure unchanged from the previous year). The percentage distribution by reason of the dollar amount denied was as follows: duplicate claim (30 percent), service not covered (14 percent), claimant ineligible (8 percent), missing information (10 percent), rebundled (6 percent), filing limit exceeded (1 percent), Medicare secondary payer (6 percent), and other (16 percent). Services deemed not medically necessary constituted about 9 percent of the dollar amount denied by carriers.

With the exception of determination of medical necessity, the above reasons for denial are generally the result of routine administrative checks made during claims processing. Determining the medical necessity of a service, on the other hand, requires that carriers develop a medical policy that reflects local standards of medical practice and apply that policy in making determinations as to whether the billed service was performed in accordance with those standards. Carriers have been given broad latitude in this respect--that is, they have been given primary responsibility for defining the criteria that are used to assess the medical necessity of the services on a claim.

Concerning medical necessity, you asked us to assess whether there are differences among carriers with regard to the rates of claims denied for this reason, and to describe the characteristics of the types of claims denied. In response to your request, we analyzed data on claims processed by six carriers to ascertain rates of claims denied specifically for medical necessity. This testimony presents our results. Our analytical methodology is given in Appendix I. A forthcoming report will examine these issues as they relate to the question of claims appeals.

FINDINGS

Our study addressed the issue of consistency in denial rates for the 71 most utilized and costly services across the six carriers we examined. We have three findings to report.

First, we found sizable differences among the carriers with respect to denial rates for the services screened for medical necessity.[1] The denial rates for the top 71 services are

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[1]For the purpose of our analysis, we assumed that, if a carrier denied at least one service for reason of medical necessity, that carrier must have had a screen in place for that procedure code. It should be noted that, while a medical necessity denial constitutes evidence of the presence of a screen, the absence of denials for a particular procedure code, though strongly

presented in table 1, and show notable variability across carriers. For instance, the first line shows the denial rates for code 99213, billed for an office or outpatient visit (see Appendix II for a glossary of service codes), among the six carriers. For example, the Northern California carrier denied 0.4 services for every 1000 they allowed, while the Southern California carrier denied 3.7 services for every 1000 they allowed.

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suggestive, does not preclude the possibility that the carrier may have had a screen in place. However, given that the top 71 services generally have high utilization rates, such screens, if they existed, must have been fairly inefficient.

Table 1: Rates of Denial for Medical Necessity Per 1000 Services by Service Code and Carrier for 1992
(Top 71 Part B Service Codes, Ranked by Allowed Charges)

Code	N. CA	S. CA	NC	SC	IL	WI	*Sig.*
99213	0.4	3.7	0.3	0.0	3.7	9.7	*.01*
66984	0.2	10.8	5.5	0.0	1.1	0.0	*.01*
99232	0.9	13.7	0.4	1.7	11.9	17.1	*.01*
99214	0.2	4.4	0.3	0.3	3.8	8.2	*.01*
99231	0.3	12.4	0.3	2.2	13.4	21.5	*.01*
99212	0.6	7.9	0.5	0.0	5.5	18.4	*.01*
99233	0.8	22.9	0.3	2.1	9.1	20.4	*.01*
A0010	0.3	20.4	1.2	48.6	0.0	42.4	*.01*
93307	4.1	140.0	1.2	0.0	0.0	1.5	*.01*
88305	0.1	19.9	1.5	0.5	0.0	0.7	*.01*
99223	0.3	9.5	2.6	1.2	7.8	6.6	*.01*
99215	0.1	6.3	1.0	0.0	5.6	6.2	*.01*
99254	0.2	2.3	0.4	0.8	0.0	0.5	*.01*
66821	0.0	1.0	1.1	0.0	0.0	0.0	*N.S.*
A0220	0.4	10.8	0.0	47.2	0.0		*.01*
71020	0.4	12.4	0.9	0.2	103.2	0.9	*.01*
90844	0.2	9.9	1.0	0.0	0.0	0.7	*.01*
99222	0.6	11.3	1.5	3.1	9.8	2.5	*.01*
92014	0.1	2.8	1.0	0.0	2.5	83.5	*.01*
27447	0.0	2.9	0.0	0.0	0.0	0.0	*N.S.*
E1400	21.9	63.4	51.6	0.0	10.2	6.9	*.01*
99238	0.5	12.2	0.4	0.3	10.3	13.7	*.01*
93547	0.0	3.0	1.5	0.0	0.0	0.0	*N.S.*
80019	1.1	3.5	0.2	2.8	93.8	0.0	*.01*
99244	0.0	3.0	0.0	0.0	0.0	3.6	*.01*
A2000	77.1	72.2	173.9	116.5	142.8	18.3	*.01*
B4150		66.5		0.0	0.0		*.01*
77430	0.0	1.2	0.0	0.0	0.0	1.6	*N.S.*
B4035		66.8		0.0			*.01*
99255	0.4	2.6	0.0	0.0	0.0	0.0	*.01*
J9217	0.0	1.0	17.1	0.0	0.0	2.7	*.01*
90995	0.6	1.8	9.7	0.0	2.1	0.0	*.01*
93005	1.0	8.5	0.6	0.0	0.1	0.8	*.01*
92982	0.0	182.4	29.2	0.0	0.0	33.3	*.01*

Code	N. CA	S. CA	NC	SC	IL	WI	*Sig.*
99284	0.2	8.5	1.7	0.0	0.0	4.8	*.01*
99285	0.0	30.7	2.9	0.9	0.0	8.3	*.01*
45385	0.0	3.7	0.0	0.0	0.0	0.0	*N.S.*
92012	0.0	1.8	0.5	0.0	1.6	51.5	*.01*
45378	0.0	0.9	0.0	0.0	0.8	0.0	*N.S.*
99311	0.0	2.6	0.8	0.0	4.1	5.0	*.01*
71010	0.5	16.0	4.4	1.0	80.6	1.0	*.01*
00142	0.0	1.3	5.7	0.0	0.0	17.8	*.01*
E1401	22.4	35.5	17.7	0.0	19.6	14.0	*.01*
E1403	18.1	37.3	18.9	0.0	19.3	18.9	*.01*
33512	14.6	0.0	0.0	0.0	0.0	0.0	*N.S.*
99291	0.3	6.9	1.8	4.2	13.8	27.7	*.01*
Q0043	9.5	32.7	0.0	0.0	10.8	19.2	*.01*
93320	0.4	88.8	8.1	0.0	0.0	4.8	*.01*
99253	0.5	2.6	2.2	0.0	0.0	1.1	*.01*
52601	9.0	3.2	0.0	0.0	0.0	0.0	*N.S.*
99312	0.2	4.3	0.3	0.0	3.6	3.1	*.01*
99204	0.0	8.6	0.0	0.0	4.1	0.0	*.01*
93549	0.0	0.0	198.6	0.0	0.0	0.0	*.01*
99203	0.7	10.4	0.2	0.0	3.6	1.3	*.01*
43235	0.0	0.9	1.1	0.0	1.8	0.0	*N.S.*
43239	0.0	1.6	3.7	0.0	2.2	0.0	*N.S.*
A0020	6.2	74.3	1.4	18.4	0.1	49.5	*.01*
33513	3.9	0.0	0.0	0.0	0.0	0.0	*N.S.*
99283	0.1	12.5	1.0	0.8	0.0	14.7	*.01*
90843	0.2	14.7	1.6	0.0	0.0	1.0	*.01*
27130	0.0	4.7	0.0	0.0	0.0	0.0	*N.S.*
85025	0.9	5.2	0.2	0.0	0.0	0.3	*.01*
A0150	302.5	83.2	1.9	13.0			*.01*
84443	0.6	3.4	0.3	4.4	0.0	0.0	*.01*
93880	0.0	124.9	13.6	0.0	0.0	0.0	*.01*
36415	0.2	3.2	0.9	0.2	0.0	0.1	*.01*
99205	0.3	6.9	0.7	0.0	9.3	0.0	*.01*
00562	0.0	0.0	0.0	0.0	0.0	0.0	*N.S.*
76091	0.3	54.0	0.3	0.0	0.0	0.4	*.01*
83720	1.8	11.2	0.1	2.1	0.0	0.0	*.01*
99245	0.0	2.4	0.0	0.0	0.0	12.8	*.01*

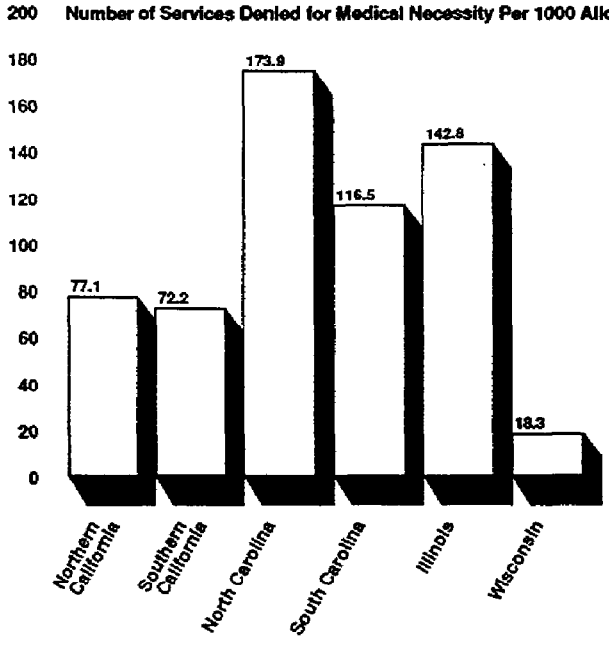
We found that for 58 of the 71 services shown in table 1, significant variations existed among carriers in the denial rates for medical necessity.

The following figures graphically illustrate this overall pattern by showing, across carriers, denial rates for three services: chiropractic (service code A2000); percutaneous transluminal coronary angioplasty, also known as PTCA (service code 92982); and critical care (service code 99291).

Looking at chiropractic services, we see that the rates of denial for medical necessity (per 1,000 services allowed) ranged from 18 to 174 among these six carriers. (See figure 1.) For PTCA, one carrier had a denial rate of 182, two had denial rates of about 30, while three carriers did not deny any services for medical necessity. (See figure 2.) Lastly, for critical care, while the overall range was smaller (0.3 to 27.7), there again was significant variation among carriers. (See figure 3.)

(Filename: C:OPCMEDFIG2)

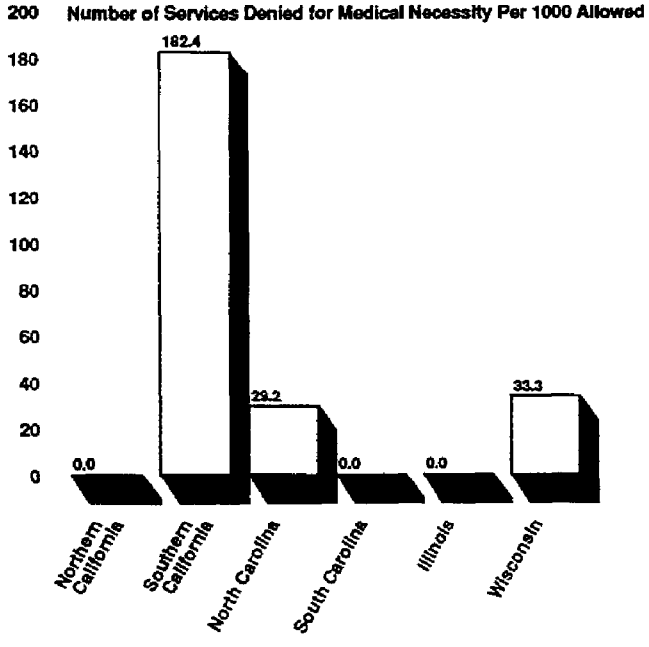
Figure 1: Variation in Denial Rates for Medical Necessity—Chiropractic Visits.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B Claims.

(Filename: C:OPCMEDFIG3)

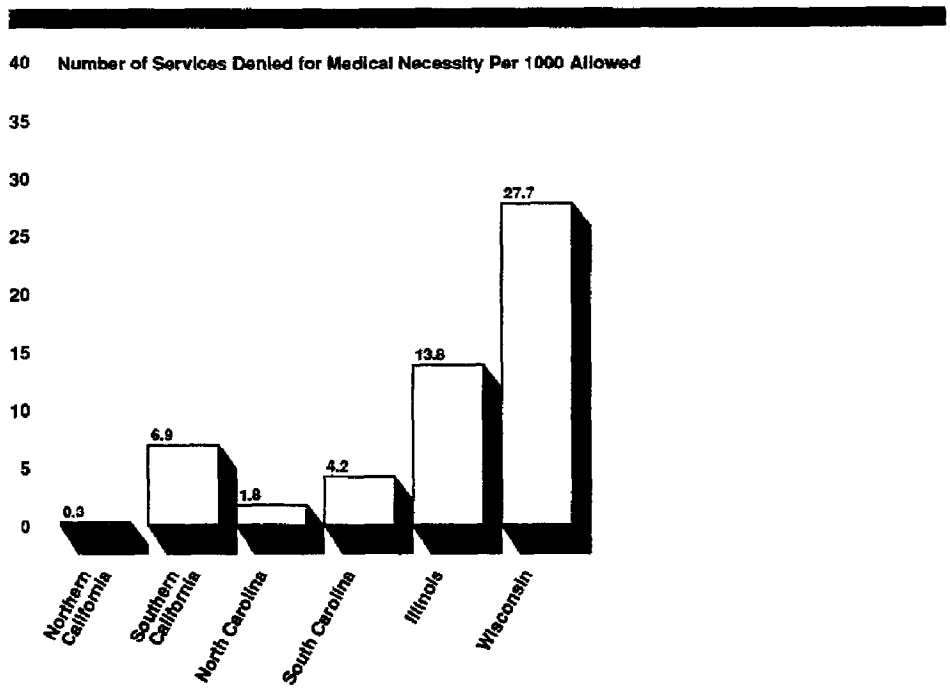
Figure 2: Variation in Denial Rates for Medical Necessity—Percutaneous Transluminal Coronary Angioplasty.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B Claims.

(Filename: C:OPCMEDFIG4)

Figure 3: Variation in Denial Rates for Medical Necessity—Critical Care.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B claims.

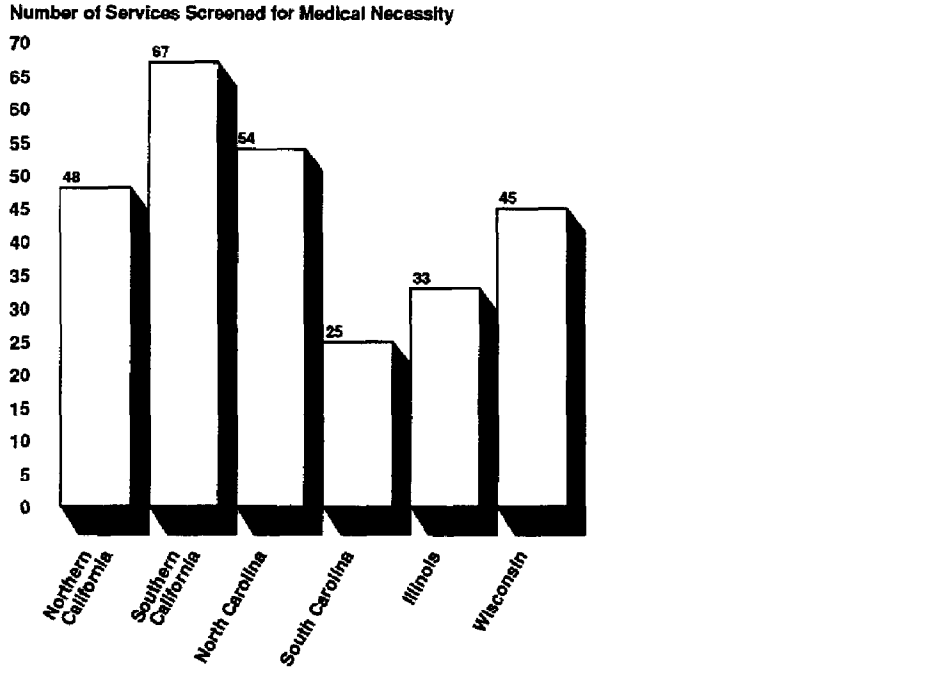
Second, we found that the number of services that carriers screened for medical necessity varied markedly. As shown in figure 4, some carriers had screens in place for almost all of the top 71 services, while others screened for little more than one third of these codes.[2]

Finally, our third finding is that the overall denial rate for medical necessity also differed among these six carriers. As shown in figure 5, at one extreme, one carrier denied as few as 1 service per 1,000 allowed, while at the other extreme, another carrier denied 23 services per 1,000 allowed.

[2]Service codes are also referred to as procedure codes.

(Filename: MEDFIG1)

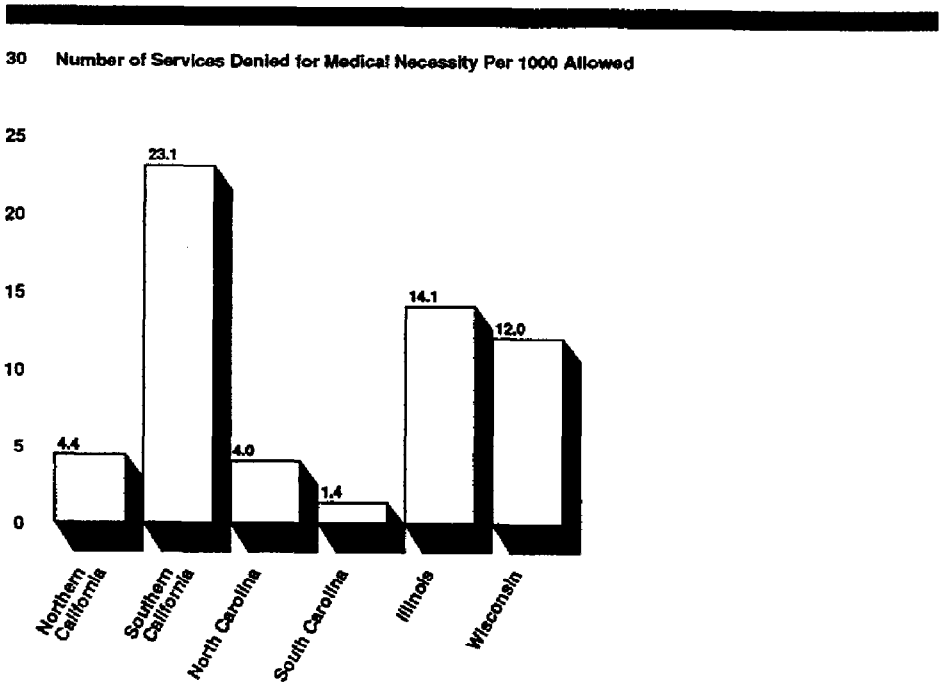
Figure 4: Number of Top 71 Services Screened for Medical Necessity by Carrier.



Note. Percentages based on a 5 percent sample of Medicare Part B claims processed in 1992. Top 71 services based on allowed charges.

(Filename: C:OPCMEDFIG5)

Figure 5: Variation in Denial Rates Among Carriers.



Note. Rates based on a 5 percent sample of 1992 Medicare Part B claims.

CONCLUSIONS

Significant variations exist among six Medicare Part B carriers in the ratio of medical necessity denials for 58 of the top 71 services. What do such differences in denial rates among carriers mean? The answer to this question depends on how these variations arise. Two plausible explanations have been advanced--with each having a different policy implication. One explanation focuses on differences in the medical policies used by carriers, while the other focuses on the billing practices of providers.

Variation Due to Differences in Medical Policy

The Social Security Act mandates that carriers pay only those Medicare Part B claims that are reasonable and medically necessary. Medicare law recognizes regional and local differences in medical practice and thus gives carriers broad latitude in defining the criteria for determining medical necessity. However, this latitude, in and of itself, produces some degree of variability in how similar claims are treated across carriers representing different geographic areas. That is, a policy cannot, at the same time, both allow for local variation in what is or is not viewed as medically necessary and also produce uniform results.

As our results show, carriers have in fact exercised this latitude. We found significant differences in both the number and types of services that are screened for medical necessity. Moreover, even when screening the same type of service, carriers used different working definitions of what is medically necessary.

For example, the first 12 visits to a chiropractor for spinal manipulation to correct a subluxation (code: A2000) must meet certain basic HCFA coverage criteria such as the following: An x ray must be available, if requested; signs and symptoms must be stated; and the precise level of subluxation must be reported. The carriers we spoke to had all incorporated these criteria into their medical policy for chiropractic spinal manipulation. HCFA requires that carriers assess the necessity of visits in excess of 12 per year, but carriers diverged in how they assessed such treatments. One carrier stated that, after 12 visits, additional documentation on medical necessity would be required. Another carrier set the number of additional visits allowed based on the injured area of the spine. When that number of additional visits was reached, this carrier required additional documentation from the provider. Still another carrier stated that, while they reviewed additional visits beyond the 12th, they usually did not require additional documentation until the 30th visit.

Given the broad variations found in denial rates across the

six carriers we examined, it would seem reasonable to conclude that some portion of that variance is due to differences in medical policies. Thus, one unintended consequence of setting medical policy locally is that, while it attempts to promote congruence between local medical policy and practice, viewed from a national perspective, it has also produced inconsistent treatment of Medicare providers and beneficiaries from one region to another, and one carrier to another.

Variations in Billing Practices

In our discussions with HCFA officials and representatives of the six carriers, it was asserted that difference in medical policy is but one possible explanation for variation in denial rates. Both the carriers and HCFA pointed to a second potential source for the observed variation in denial rates, one that focuses on differences in the billing practices of providers. Their explanation has several variants, which we summarize below:

- the various regions of the country have different levels of fraud and abuse, which in turn produce different denial rates;
- differences in denial rates could be due to aberrant billing practices by as few as two or three providers;
- in certain regions of the country, providers disregard the feedback they receive from denied claims--that is, they continue to bill for services they know are not medically necessary in the hope that some will be approved; and
- certain carriers do a better job of educating providers in how to submit Medicare claims correctly.

In sum, although at least two hypotheses can thus be advanced to explain the wide variation we found in the denial rates of our six carriers, it is important to note that (1) these findings are new: the size of this variation had not been previously examined by HCFA; and (2) HCFA is only now beginning to conduct evaluations to determine which, if either, of the above major explanations (that is, medical policy or billing practice) best accounts for the inconsistency we observed in denial rates. Given this lack of information, it has been difficult for HCFA to take a position on the question of whether a high or a low denial rate represents better public policy. HCFA officials told us that, although low denial rates are desirable from the standpoint that they imply less trouble for providers and beneficiaries, they are only desirable insofar as providers appropriately bill only for what is medically necessary. If providers are inappropriately billing Medicare, high denial rates are desirable.

The issue here, however, is not the size of denial rates, but rather their consistency. Medicare is not a local initiative. It is a national program under which beneficiaries should not receive different benefits solely because their place of residence differs. Yet we found that beneficiaries and providers have in fact been treated with considerable inconsistency by six carriers making individual determinations concerning what is and is not medically necessary. While it may be essential for Medicare to allow for local determination of medical policy, we found that this allowance, left to itself, leads to inconsistent treatment of beneficiaries and providers.

Carrier representatives told us they believe that inter-carrier variation would be reduced if HCFA established more national medical policies that define specific parameters for what is medically necessary. What is clear from our work to date, however, is that denial rates provide useful insight into how effectively Medicare contractors are managing program dollars and serving beneficiaries and providers. We believe that HCFA needs to play a greater role in using such data to oversee carriers' claims review activities to better assure that beneficiaries and providers are equitably treated.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or members of the Committee may have.

METHODOLOGY

To develop the information in this testimony, we visited six carriers and analyzed claims processed by each of them. In selecting carriers, we considered two factors: geographic location and the number of claims processed.[3] Table I.1 lists the carriers we visited and the number of claims they processed in fiscal year 1992.

Table I.1: Selected Medicare Part B Carriers (Data for 1992)

Carrier	Geographic location	Number of claims processed (in millions)
California B/S	West	24
California-Occidental	West	25
Illinois B/S	Midwest	22
Wisconsin-Physician Srv.	Midwest	10
North Carolina-Conn. Gen.	Southeast	18
South Carolina B/S	Southeast	8

Taken together, these six carriers processed about 19 percent of all Part B claims in fiscal year 1992; however, because of our judgmental selection process, we cannot generalize our findings to the universe of carriers.

[3]Our sample included two carriers from each of the following three regions: the Southeast, the Midwest, and the West. In making this selection, we sought to maximize the geographic distance between regions, while at the same time retaining the potential for examining intraregional variation in medical policies. In terms of the number of claims processed, the frequency distribution of carriers is essentially bimodal--that is, there are two large clusters of carriers, those that annually process between 2 and 13 million claims and those that process between 18 and 29 million claims (2 carriers processed over 46 million claims each). Our sample included two carriers from the former cluster and four from the latter.

Source of Data

To compare medical necessity denial rates among carriers, we obtained from HCFA a 5 percent sample of 1992 Medicare Part B claims for the above six carriers. This information was abstracted from the physician/supplier portion of the Common Working File, which serves as a repository for all Medicare claims.

The Common Working File contains information on many claims-related variables, including the type of billed service and the action that was taken as a result of the claim review process. Medicare claims can contain submitted charges for more than one service; a claim for a simple medical checkup, for example, may include both the doctor's fee as well as the charge for lab tests performed during the visit. On the Medicare claim form, each billed service, or line item, appears as a separate charge with a corresponding five-digit service code that describes the type of service provided (for example, office visit, chiropractic treatment, and so on). Each of these services listed as a separate line item is subject to approval or denial by the carrier. During claims processing, carriers assign an action code to each line item that indicates that it was paid or, if denied, the reason for denial.[4]

In our analysis, we focused on two line item variables--the service and the action code. In calculating denial rates presented in our statement, we contrasted the number of services denied for lack of medical necessity with the total number of services allowed for a given service. Services denied for other reasons were excluded from the analysis.

Because there are more than 10,000 different service codes, we ranked service codes in terms of the total of allowed charges (in 1992), and then restricted our analysis to the top 71 codes.[5] Services that rank high in allowed charges are those that have high utilization rates and/or high cost per service. The top 71 service codes constitute approximately 50 percent of all Medicare Part B allowed charges.

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[4]Reasons for line item denial included in the Common Working File are: benefits exhausted, non-covered care, invalid care, duplicate line item, medically unnecessary, reprocessed adjustment, secondary payer, and other.

[5]The "allowed charge" is set by HCFA. The amount actually paid by HCFA is 80 percent of the allowed charge less deductible and/or co-payment.

Sampling Considerations

The 5-percent sample used in our analysis was extracted from the Common Working File by keying on the last two digits of the beneficiary identification number. This method is commonly used by HCFA, and while we have no reason to believe that it is biased, it is not, strictly speaking, a random sample, but rather an approximation of a random sample. Consequently, the tests of statistical significance presented in this testimony are included mainly for heuristic purposes: that is, to identify those codes where carriers had especially large differences in denial rates.

To avoid unstable estimates of denial activity for certain service codes with low frequencies, we focused on the top 71 services (based on allowed charges). This group of services generally has high utilization rates and thus sufficiently large frequencies for making inter-carrier comparisons of denial rates.

LIST OF TOP 71 PROCEDURE CODES RANKED BY ALLOWED CHARGES FOR 1992

Procedure Code/ Narrative Description
99213 Office or other outpatient visit
66984 Extracapsular cataract removal
99232 Subsequent hospital care, per day
99214 Office or other outpatient visit
99231 Subsequent hospital care, per day
99212 Office or other outpatient visit
99233 Subsequent hospital care, per day,
A0010 Ambulance service, basic life support
93307 Echocardiography, real-time with image documentation (2D)
88305 Level IV - surgical pathology, gross and microscopic examination
99223 Initial hospital care, per day
99215 Office or other outpatient visit
99254 Initial inpatient consultation for a new or established patient
66821 Discussion of secondary membranous cataract
A0220 Ambulance service, advanced life support
71020 Radiologic examination, chest, two views, frontal and lateral
90844 Individual medical psychotherapy by a physician
99222 Initial hospital care, per day
92014 Ophthalmological services: medical examination and evaluation
27447 Arthroplasty, knee, condyle and plateau
E1400 Oxygen concentrator
99238 Hospital discharge day management
93547 Combined left heart catheterization, selective coronary angiography
80019 Automated multichannel test
99244 Office consultation for a new or established patient
A2000 Manipulation of spine by chiropractor
B4150 Enteral formulae; category I
77430 Weekly radiation therapy management
B4035 Enteral feeding supply kit; pump fed, per day
99255 Initial inpatient consultation for a new or established patient,
J9217 Leuprolide acetate, for depot suspension, 7.5MG
90995 End stage renal disease (ESRD) related services, per full month
93005 Electrocardiogram, routine ECG with a least 12 leads
92982 Percutaneous transluminal coronary angioplasty
99284 Emergency department visit
99285 Emergency department visit
45385 Colonoscopy, fiberoptic, beyond splenic flexure
92012 Ophthalmological services: medical examination and evaluation
45378 Colonoscopy, fiberoptic, beyond splenic flexure
99311 Subsequent nursing facility care, per day
71010 Radiologic examination, chest
00142 Anesthesia for procedures on eye

APPENDIX II

E1401 Oxygen concentrator, manufacturer specified maximum rate greater than 2
E1403 Oxygen concentrator, manufacturer specified maximum rate greater than 4
33512 Coronary artery bypass, autogenous graft
99291 Critical care, including the diagnostic and therapeutic services
Q0043 Stationary liquid oxygen system rental, includes contents (per unit)
93320 Doppler echocardiography, pulsed wave and/or continuous wave
99253 Initial inpatient consultation for a new or established patient,
52601 Transurethral resection of prostate
99312 Subsequent nursing facility care, per day
99204 Office or other outpatient visit
93549 Combined right and left heart catheterization
99203 Office or other outpatient visit
43235 Upper gastrointestinal endoscopy including esophagus
43239 Upper gastrointestinal endoscopy including esophagus
A0020 Ambulance service, (BLS) per mile, transport, one way
33513 Coronary artery bypass, autogenous graft
99283 Emergency department visit
90843 Individual medical psychotherapy by a physician
27130 Arthroplasty, acetabular and proximal femoral
85025 Blood count
A0150 Non-emergency transportation, ambulance, base rate one way
84443 Thyroid stimulating hormone (TSH), RIA or EIA
93880 Duplex scan of extracranial arteries
36415 Routine venipuncture for collection of specimen(s)
99205 Office or other outpatient visit
00562 Anesthesia for procedures on heart, pericardium
76091 Mammography;
83720 Lipoprotein cholesterol fractionation calculation by formula
99245 Office consultation for a new or established patient

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Washington, DC

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