

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

CODING OF PHYSICIAN SERVICES



**JUNE GIBBS BROWN
Inspector General**

**MAY 1994
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EXECUTIVE SUMMARY

PURPOSE

This report describes vulnerabilities in the maintenance, use, and management of the Current Procedural Terminology Codes, Fourth Edition (CPT-4), as they relate to Medicare reimbursements.

BACKGROUND

The Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) is a three-part procedure labeling system used to identify services in the Medicare Part B program. Current Procedural Terminology (CPT-4) codes identify physician services and comprise the first level of HCPCS. The HCPCS also identifies other services such as ambulance services and durable medical equipment. Since January 1992, HCFA has assigned a relative value unit (RVU) to each CPT-4 code to represent the resources that each service requires. The RVU is now used as the basis to set reimbursements for health care providers. The reimbursement amount for each code is contained in the Medicare Fee Schedule. In Fiscal Year 1991, HCFA paid \$36.2 billion for 867 million services claimed under CPT-4.

The CPT-4 is a systematic listing of descriptive terms and identifying codes used to describe the services of health care providers. It was developed by the American Medical Association (AMA) in 1966. Now in its fourth edition, CPT-4 contains approximately 7,000 codes, each in a five-digit numerical format. In February 1983, HCFA incorporated CPT-4 into HCPCS.

METHODOLOGY

We reviewed both the CPT-4 system itself and HCFA's management of the system as they affect Medicare expenditures. We conducted this inspection in two phases. In the initial phase, we gathered documentation. We first compiled 25 reports on CPT-4 related topics; most were issued by the Office of Inspector General. Other sources included HCFA, the Physician Payment Review Commission, and the General Accounting Office (GAO). We then contacted 41 medical specialty societies, 12 Medicare carriers, the AMA, the American Health Information Management Association, the American Hospital Association, the Blue Cross Blue Shield Association, and the Health Insurance Association of America. We asked each to provide documentation concerning pertinent CPT-4 issues. We also obtained additional material from an on-line search of a data base of medical journals. These articles ranged from descriptions of studies with developed methodologies to discussions of expert opinions. A companion report, *A Compendium of Reports and*

Literature on Coding of Physician Services, OEI-03-91-00921, provides a detailed summary of each document.

In the next phase, we conducted structured interviews to refine the issues we had developed. We interviewed representatives from each group previously contacted except for GAO. In addition, we spoke to 23 coders and coding consultants. Our range of respondents ensured a fair representation of professional opinions and experience.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Incorrect coding affects Medicare reimbursement and causes inequities in payment under the Medicare Fee Schedule.

Flaws in CPT-4 codes, guidelines, and index can lead to improper coding.

- Examples illustrating code flaws occur in most sections of CPT-4.
- Problems in CPT-4 guidelines and index also contribute to incorrect coding.
- Some respondents have criticized the process that AMA uses to consider changes, additions, and deletions in CPT-4.

The AMA and HCFA have both taken some corrective measures to address coding problems.

The methods by which HCFA has incorporated CPT-4 into Medicare's coding system do not ensure appropriate reimbursement to Medicare providers.

- The HCFA has not developed criteria or communicated decision rules to the CPT-4 Editorial Panel for use in changing, adding, or deleting codes in light of the Medicare Fee Schedule's requirements.
- The HCFA has not adequately communicated Medicare coding policy to providers.
- The HCFA has not developed an efficient or effective process for establishing RVUs for new or modified codes.

A proliferation of CPT-4 changes will undermine HCFA's ability to contain expenditures under the Medicare Fee Schedule.

RECOMMENDATIONS

We recommend that HCFA:

- Produce and promulgate to the AMA and medical specialty societies clear coding objectives and criteria for Medicare's resource-based payment system and encourage them to apply the objectives in the development of new or revised codes;
- Apply HCFA coding objectives and criteria when evaluating new or revised codes to assure compliance with the needs of the Medicare Fee Schedule;
- Work with the AMA, Medicare carriers, medical specialty societies and other related parties to develop a mechanism that assures a unified and consistent dissemination of guidelines on how to use and interpret codes.
- Evaluate the current process for implementing changes to the Medicare Fee Schedule. This includes: (1) developing an effective process for establishing work values for new or revised codes, (2) communicating to the AMA the number of annual additions, deletions, and revisions to CPT-4 that HCFA could effectively review, and (3) delaying implementation of new or revised codes, except for new technologies, until reliable data is available to predict service utilization.

We recommend that AMA:

- Consider and encourage medical specialty use of HCFA coding objectives and criteria in the development of new or revised CPT-4 codes;
- Consider a review of the CPT-4 index within the framework of its own commissioned study's recommendations;
- Work with HCFA to develop a mechanism that assures a unified and consistent dissemination of Medicare coding policy;
- Provide HCFA with utilization estimates for new or revised codes; and
- Work with HCFA to arrive at an acceptable number of annual CPT-4 code changes to allow for proper HCFA evaluation.

COMMENTS

The HCFA and AMA commented on the draft reports. The full text of their comments appear in Appendix E. The HCFA concurred with the second and fourth

recommendations and are considering the first and third. Although the AMA expressed concern about the study methodology, they found all but recommendation five to be fair and reasonable. The AMA does not believe that putting a "cap" on the number of CPT-4 changes per year is in the best interest of the Medicare program, its beneficiaries, or medicine.

We recognize the complex nature of the CPT system and commend HCFA and the AMA for their willingness to take the necessary corrective actions to improve the coding process and assure the successful implementation of the Medicare Fee Schedule.

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INTRODUCTION

PURPOSE

This report describes vulnerabilities in the maintenance, use, and management of the Current Procedural Terminology Codes, Fourth Edition (CPT-4), as they relate to Medicare reimbursements.

BACKGROUND

The HCFA Common Procedural Coding System (HCPCS), which includes CPT-4, is used to identify Medicare Part B services.

The Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) is a three-part procedure labeling system used to identify services in the Medicare Part B program. The HCFA developed HCPCS to achieve uniformity in procedure coding (See Appendix A). The Current Procedural Terminology, Fourth Edition (CPT-4) codes comprise the first level of HCPCS codes and were incorporated into HCPCS in 1983. In addition to CPT-4 services, the HCPCS identifies other services such as ambulance services and durable medical equipment.¹ Hospitals² use CPT-4 to report outpatient services.³

The American Medical Association developed and maintains the CPT-4 coding system.

The CPT-4 is a systematic listing of descriptive terms and identifying codes used to describe the services of health care providers.⁴ The American Medical Association (AMA) published the first edition of CPT in 1966. It consisted of 3,634 four-digit numeric codes. The second edition, in 1970, expanded the codes to five digits. The third edition, in 1973, introduced the modifier.⁵ In 1977, the current fourth edition was published. By 1993, CPT-4 consisted of 6,925 codes and 26 two-digit numeric modifiers. It is divided into six sections: Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine.

The CPT Editorial Panel, comprised of 14⁶ physicians, governs the maintenance of CPT-4. In 1977, periodic updates of CPT were introduced. Currently, the Editorial Panel meets quarterly and decides whether to add, delete, or revise codes. Code suggestions, typically, are channeled through national medical specialty societies⁷ that act as intermediaries between the Editorial Panel and health care providers. These societies assist in providing the necessary documentation to support the medical necessity of code changes. Editorial Panel decisions may be appealed to the CPT Executive Committee.⁸ (See Appendix B for an illustration of the code maintenance process).

The HCFA assigns a Relative Value Unit (RVU) to each CPT-4 code to represent the resource that each service requires. The RVU is also the basis for provider reimbursement under the Medicare Fee Schedule.

Since January 1992, HCFA has assigned a relative value unit (RVU) to each CPT-4 code to represent the resources that each service requires. The RVU is divided into three categories: physician work, practice expenses, and the cost of professional malpractice insurance. It is used as the basis to set reimbursements for health care providers. The reimbursement amount for each code is contained in the Medicare Fee Schedule. Prior to the Fee Schedule, HCFA paid provider services on a customary-prevailing-reasonable (CPR) charge basis. The Omnibus Budget Reconciliation Act of 1989 began a process to replace the CPR mechanism and create more equity and consistency in reimbursements.⁹ The HCFA initiated the Fee Schedule in January 1992 and must fully implement it by 1996. Data developed by Harvard University provided HCFA with the framework to develop RVUs in the initial Fee Schedule. The HCFA consulted with the AMA's Relative Value Update Committee (RUC) on the development of subsequent RVUs.¹⁰

In fiscal year (FY) 1991, Medicare reimbursed \$45 billion under HCPCS. The 867 million services paid under CPT-4 account for \$36.2 billion or 80 percent of HCPCS charges. In addition, 325 codes (approximately 5 percent) account for 80 percent of CPT-4 reimbursements.

Three groups within HCFA govern the use of CPT-4.

Three groups within HCFA, the Bureau of Policy Development (BPD), the Bureau of Program Operations (BPO), and the Office of Research and Demonstrations (ORD), govern the use of CPT-4. The BPD establishes coverage and payment policy, including the assignment of RVUs. Currently, a BPD official from the Office of Payment Policy represents HCFA on the CPT Editorial Panel. The BPO implements coverage and payment policy and can issue guidelines to its contractors that differ from CPT-4 if code definitions are unclear or contrary to its payment policy.¹¹ The ORD conducts studies to evaluate Medicare policy alternatives. The ORD contracted with Harvard University to develop RVUs for the Medicare Fee Schedule.

METHODOLOGY

We reviewed both the CPT-4 system itself and HCFA's management of the system as they affect Medicare expenditures. We conducted this inspection in two phases. In the initial phase, we gathered 28 documents on CPT-4-related topics issued by government agencies, most by the OIG. Other sources included HCFA, the Physician Payment Review Commission (PPRC) and the General Accounting Office (GAO).

Next, we gathered other documented material. To do this, we contacted 41 medical

specialty societies, 12 Medicare carriers, the AMA, the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), the Blue Cross Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA) (For a complete list of data sources, see Appendix C). We asked each to provide any reports, newsletters, position statements, or other documented material concerning pertinent CPT-4 issues. We also obtained published articles from the computer files of the National Library of Medicine's Medical Literature Analysis and Retrieval System (MEDLARS).¹² These articles ranged from descriptions of formal studies to discussions of expert opinions. Our research dated to back to 1985, after the establishment of HCPCS. A companion report, *A Compendium of Reports and Literature on Coding of Physician Services, OEI-03-91-00921*, provides a detailed summary of each document.

In the second phase, we conducted structured interviews to refine the issues we had developed. To ensure a fair representation of professional opinions and experience, we interviewed representatives from each group previously contacted.¹³ In addition, we spoke to 23 individuals who currently code using CPT-4 or provide coding advice on the use of CPT-4. We selected data sources in the following manner:

Government Agencies - We chose Federal agencies that regulate or monitor provider activity under Medicare. In the U.S. Department of Health and Human Services, there are HCFA and the OIG. The PPRC and GAO provide input to Congress.

Medicare Carriers - We stratified all Medicare carriers into three groups. Each stratum represented a level of reimbursement activity in FY 1990: high, moderate, or low. From each stratum, we selected five carriers. Since one carrier represented three jurisdictions, the total number of carriers was 12. We chose this method to ensure a fair representation of carrier activity.

Health Care Trade Groups - We included the AMA and the three groups represented on the CPT Editorial Panel: the AHA, BCBSA, and HIAA. The AHIMA¹⁴ also provided information.

Medical Specialty Societies - We chose 41 groups to represent practitioners who use CPT-4 codes. They include 23 members of the Council of Medical Specialty Societies;¹⁵ 13 limited-licensed¹⁶ practitioner groups; and five major groups of internal medicine.

Medical Record Coders - We chose 23 individuals who currently code using CPT-4 or provide coding advice on the use of CPT-4. The AHIMA helped in providing 19. We identified the other four through published articles.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

INCORRECT CODING AFFECTS MEDICARE REIMBURSEMENT AND CAUSES INEQUITIES IN PAYMENT UNDER THE MEDICARE FEE SCHEDULE.

The Medicare program cannot pay providers a fair price for services they render to Medicare beneficiaries without knowing what services were actually provided. The primary mechanism by which physicians inform the program of the services they provide is the CPT-4 system. Flaws in the CPT-4 system, or provider confusion concerning the use of these codes, can lead to improper choices of codes to describe services. Deliberate miscoding also occurs. Improper choice of codes will frequently lead to improper reimbursement.

In previous reports, the OIG has identified improper coding practices which increased annual Medicare expenditures by over \$100 million (See Appendix D). "Upcoding," "unbundling," and "fragmentation" were identified as the most common forms of improper coding. Upcoding or code "creep" occurs when a provider bills for a procedure more extensive or intensive than the one performed. Unbundling involves billing for each component code of a larger, single comprehensive procedure code. Fragmentation, another form of unbundling, allows the billing for incidental procedures done as part of a larger procedure. The larger procedure code would essentially include the definition of the smaller procedure(s).

Projections of the total scope and impact of improper coding vary. Based on prior experience, software companies who specialize in identifying improper coding practices for private insurance companies estimate between 3 and 17 percent¹⁷ of all claims are improperly coded. If we assume the coding practices are the same for both Medicare and private claims, the impact could be significant. Based on FY 1991 expenditures of \$36.2 billion, between \$1 billion and \$6 billion in Medicare claims may have been affected. Another expert noted that health insurers overpaid \$5.8 billion in unnecessary claims in 1989 because of inaccurate coding.¹⁸ In a 1991 report, Blue Shield of California projected a 15 percent error rate in claims coding.¹⁹

In addition to improperly inflating Medicare costs, improper coding can contribute to inequities in payment across provider specialties, possibly undermining the intent of physician payment reform. As the PPRC stated in its 1992 Annual Report to Congress:

Under the Medicare Fee Schedule, coding issues are extremely important because it is not possible to assure equitable payment under a national fee schedule unless each code represents a similar amount of work to all physicians who use it. In fact, coding is more important than previously because there are fewer variations in payment and no specialty differentials.²⁰

FLAWS IN CPT-4 CODES, GUIDELINES, AND INDEX CAN LEAD TO IMPROPER CODING.

We identified several examples of flaws in the CPT-4 codes, guidelines, and index that we believe cause improper coding practices. Code problems include ambiguous code definitions, multiple codes that define essentially the same procedure, and individual codes that cover an array of significantly different levels of work effort. Specific coding guidelines that appear at the beginning of each section are sometimes ambiguous, particularly in addressing hospital outpatient services. These guidelines define items that are necessary to appropriately interpret and report the procedures contained in that section. The index, which serves as the starting point for code selection, is poorly organized and often difficult to use.

These weaknesses within CPT-4 can impact users in several ways. Flawed CPT-4 codes give knowledgeable users the opportunity to wilfully miscode and cause confusion for those with legitimate intentions. Providers can submit claims that misrepresent services, higher or lower, when codes do not accurately represent the services performed. The problems with coding guidelines and the index compound any already existing weaknesses in the codes.

Examples illustrating code flaws occur in most sections of CPT-4

The following examples illustrate problems with specific CPT-4 codes. While no single study contains a thorough analysis of the CPT-4 system, the following examples identify problems in most sections of CPT-4.

Ambiguous code definitions

Examples in medical visit and consultation services, "arthroplasty" procedures, and laboratory and radiology services illustrate this problem.

In the past, providers did not uniformly or accurately code the levels of service for medical visits and consultations.²¹ Variations in reporting these services were due to coding practices, not patient characteristics or treatment practices. These coding practices result from the ambiguity in definitions such as "brief" or "limited." One report²² on consultation codes noted that 71 percent of respondents believed that code definitions overlapped. This lack of clarity resulted in overpayments of an estimated \$73 million per year nationwide. An article on the coding practices of urologists in Connecticut found, on average, that urologists used one code 82 percent of the time to record visit services. This concentration on one code did not represent the normal distribution of actual practice patterns. The article attributed this coding bias to the imprecise definitions of CPT-4 codes.²³

Another article also noted that podiatrists and orthopaedic surgeons disagree on the correct code to use for the "arthroplasty" procedure²⁴ of the toe. Due to the "non-specific CPT definitions,"²⁵ three codes, 28153, 28160, and 28285,²⁶ are all used.

Code 28285 has the highest RVU of the three codes and accounted for more expenditures, \$21.6 million in FY 1991, than the other two.

The OIG found that billers of laboratory services cannot bill individual tests under one profile code because profile codes often do not adequately describe what they encompass.²⁷ A profile is a package of individual tests commonly performed together. As a result, profiles are subject to interpretation. Providers can increase their reimbursement by billing the individual tests instead of the profile.

In 1987, only 2 million laboratory services billed to Medicare were identified as profiles. However, the OIG had projected that more than 55 million laboratory services should have been billed as profiles. At one carrier, providers who coded multichannel laboratory tests²⁸ individually and not part of the lower profile caused overpayments of \$2.6 million over a 3 year period.

Radiology services (70010-79999) were also unbundled. Tests were coded individually rather than as lower profile tests. An OIG report found this practice resulted in overpayments of \$1.3 million at one carrier.²⁹

Multiple codes that define essentially the same procedure

Examples in the Pathology and Laboratory and Surgery sections of CPT-4 illustrate this phenomenon. Within the surgery section, we specifically target coronary artery bypass graft (CABG) and arthroscopic procedures.

In the Pathology and Laboratory section (80002-83999), multiple procedure codes defined essentially the same lab procedure. As new methods were introduced, more procedure codes were added. Often these new codes were not significantly different from current codes. Providers could increase reimbursement by choosing the code with the highest payment.³⁰

Currently, six codes (33510-33514, 33516) describe venous grafting in CABG surgery. Each code represents the number of venous grafts performed. Before HCFA mandated the use of CPT-4, many carriers listed only three codes for venous grafting. One code identified grafting for a single artery, another for two grafts, and the third for three or more grafts. An OIG study found that over 60 percent of surgeons interviewed agree that the same payment for three or more grafts is appropriate since the work effort for the additional grafts is relatively unchanged. In addition, 50 percent of surgeons did not object to the same payment regardless of the number of grafts involved. Some surgeons believed that higher payments for additional grafts encourage abuse. The OIG had suggested that AMA reduce the number of CABG surgery codes from six to three. This would have saved an estimated \$5 million annually.³¹

Arthroscopic codes such as "meniscectomy," "synovectomy," "chondroplasty," "debridement," "patellar shaving," "patellar plasty," and "lateral release" are closely

related procedures. However, as one article noted, each has different reimbursement implications and could lead to upcoding.³²

Codes that cover an array of significantly different levels of services

The CPT-4 codes that describe diagnostic vascular testing, "open needle" biopsy, and "craniotomy" procedures identify different levels of services.

Diagnostic vascular testing codes failed to distinguish between test types. As a result, providers billed brief tests conducted with inexpensive, hand-held devices, with a code (93910) valued for extensive tests with expensive equipment. The OIG believed the brief tests should not have been billed separately but included in the office visit fee. One report on "pocket dopplers"³³ projected annual overpayments of \$6 million.³⁴ Another, on "zero crossers,"³⁵ estimated annual Medicare savings of \$16.7 million.³⁶

The OIG also found that open needle biopsy procedures present coding challenges. Until recently, there was no clear way to describe an "open needle" biopsy when performed as part of a larger procedure. This procedure was miscoded under 47000 - "percutaneous needle," or 47100 - "open wedge biopsy"³⁷ along with the larger procedure code. Open needle biopsies not part of a larger procedure are included in the "laparotomy" procedure code (49000).

Four codes (61510, 61512, 61514, 61516)³⁸ describe supratentorial craniotomy, a procedure that can take from one to 12 hours.³⁹ The codes differentiate the types of lesion, but not the extent of work. A surgeon who performs the 12-hour craniotomy fares worse financially than the one who takes one hour since there are no codes which differentiate the levels of service.

Problems in CPT-4 guidelines and index also contribute to incorrect coding.

Most respondents said that CPT-4 is well organized (primarily by organ groups) since each section contains like services. However, some CPT-4 guidelines do not provide sufficient detail to properly direct the coder. For example, confusion exists in coding multiple procedures in terms of which procedure takes precedence. Terms such as "simple," "superficial," and "deep or complicated" are also confusing. Without further explanation, application of these terms may not be uniform.

The guidelines on hospital outpatient services appear to be a particular problem. In November 1988, HCFA informed the CPT Editorial panel of its concerns in applying CPT-4 to outpatient services. In a December 1992 position statement, AHIMA states, "attempts to effectively use this (CPT-4) coding system for the hospital setting have resulted in the inconsistent application of the CPT conventions and the general guidelines."

Problems with the index were also noted. An AMA-commissioned study⁴⁰ identified several problems with the index. They include: too many reference points, e.g

procedure, organ, condition; coder directed to a wide range of codes, not specific enough; insufficient eponymic⁴¹ entries; codes in the index which have been deleted from text; procedures in text which were omitted from the index; procedures not clearly differentiated; limited cross referencing; poor use of common abbreviations; and typographical errors. There are still concerns that AMA has not adequately addressed the recommendations of its own study. According to a HCFA official and some coders, the CPT-4 index is poorly organized and the descriptors are "short, inconsistent, and incomplete." Coders perceptions of the CPT-4 index may be influenced by the level of training and experience they have acquired using CPT-4 or other coding systems.

Some respondents have criticized the process that AMA uses to consider changes, additions, and deletions in CPT-4.

Opinions on the AMA process of revising CPT-4 vary. While approximately 40 percent of respondents we surveyed expressed satisfaction with the current system of addressing coding issues, an equal number were dissatisfied. Some respondents believe the Editorial Panel does a good job in balancing requests for unnecessary codes against those resulting from valid changes in medicine. Others used the terms "hostile" and "closed-door" to express their sentiments. Most coders believe they should have a voice in the process because they can provide a valuable "user perspective" on the application of codes. Half of carrier respondents also prefer to have input before the AMA implements new codes. Opinions on the timeliness of code changes were less divisive: 56 percent of providers expressed satisfaction while only 24 percent were dissatisfied.

THE AMA AND HCFA HAVE BOTH TAKEN SOME CORRECTIVE MEASURES TO ADDRESS CODING PROBLEMS.

Both HCFA and the AMA have taken corrective actions to address some of the problems noted. The AMA has revised codes which identify medical visit and consultation, pathology and laboratory, diagnostic vascular testing, and open needle biopsy procedures. They have not, however, revised radiology, arthroplasty, arthroscopic, and craniotomy procedure codes. Nor have they revised the CPT-4 guidelines. The HCFA has instituted pre- and postpayment reviews to identify claims affected by improper coding. They have also studied several approaches to reduce unnecessary codes.

The AMA's corrective actions

The AMA has addressed several of the code problems previously identified. In 1991, the AMA revised office visit codes to formulate the Evaluation and Management section.⁴² Diagnostic vascular testing codes were amended to account for the different levels of service. Code 47001 was added to identify an open needle biopsy when performed as part of a larger procedure. In 1992, there were 945 changes in Pathology and Laboratory codes (446 deletions, 233 additions and 266 revisions).

These changes took effect on April 1, 1993. Also, the American College of Cardiology (ACC) has petitioned the AMA to revise the cardiac catheterization codes in the Medicine section to incorporate supervision and interpretation services.⁴³

The AMA also added vignettes or clinical examples in the 1992 CPT-4 to assist in the selection of Evaluation and Management codes. The 1993 CPT-4 contains 348 vignettes covering 29 medical specialties.

The AMA has taken steps to improve the CPT-4 maintenance process. The Editorial Panel has grown from 12 to 14 members and the Advisory Panel has added representatives of nine non-AMA specialty groups. A new standard form for proposed coding changes should help establish uniformity in the application and review processes. In 1990, the AMA introduced both the CPT Clearinghouse and CPT Assistant "to help bring uniformity and clarity" in code application. The CPT Clearinghouse, a phone bank used to field CPT-4 questions, estimates they field 5,000 questions each month. The CPT Assistant is a quarterly newsletter designed to provide "accurate, up-to-date information regarding coding."

Lastly, the AMA recognizes that CPT-4 contains flaws and encourages constructive suggestions by all interested parties to address them. It is their goal to assure the continual improvement of CPT-4.

The HCFA's corrective actions

The HCFA uses pre- and postpayment reviews to detect improper coding.⁴⁴ The prepayment process involves the use of computerized screens to edit claims. These edits are directed towards high-dollar, high-frequency services. In February 1991, HCFA began Phase I of the "Correct Coding Initiative" (CCI). The CCI required carriers to install edit screens. These screens detect secondary codes that are components of larger primary procedure codes. When the edit identifies the primary code, Medicare denies payment for the associated secondary codes. Phase I identified 68 primary codes. Phase II, introduced in 1992, identified 251.⁴⁵ The edits span all six sections of the CPT-4 codes. Prior to the CCI, only a limited number of edit screens were required for all carriers. In FY 1991, before all the edits were installed, \$4.6 billion was billed under 57 codes which would have been subject to edits.

All 12 carriers contacted have installed the CCI edit screens. Nine respondents believe the screens will reduce unbundling significantly. Two mentioned the need for more screens. Neither the OIG nor HCFA has evaluated the effectiveness of the CCI. We are aware that some insurance companies use a far greater number of edits than HCFA to detect improper coding practices in their non-Medicare claims. The HCFA does permit carriers to use local edits that existed prior to 1992 for Medicare claims. The HCFA believes that edits to detect rebundling are complex but is working with the OIG to improve the prepayment screening process.

The postpayment process involves a comprehensive medical review that identifies potentially fraudulent or abusive practices. Postpayment reviews are expensive, with one estimate placing the cost at \$50 to review one claim.⁴⁶ However, such reviews have been successful in finding instances of "upcoding," and can lead to the development of prepayment edit screens.

The HCFA has targeted the utilization patterns of Evaluation and Management codes as one postpayment review. Their aim is to assure that coding does not vary significantly from expected norms.⁴⁷ Services under Evaluation and Management codes account for over 70 percent of all Part B claims and represent 35 percent of charges. Therefore, significant cost overruns could occur if providers code at levels higher than expected. The HCFA intends these reviews to be purely "informational and not burdensome."⁴⁸

Despite HCFA's efforts, one recent article reported continued misuse of Evaluation and Management codes. It cited HCFA estimates that doctors are using Evaluation and Management codes correctly 60 percent of the time, while carriers report accuracy rates ranging from 30 to 80 percent.⁴⁹ Providers not providing adequate documentation to support their claims is the most common problem cited. While some providers say they do not know what documentation the carrier requires, others wait for the carrier to reject a claim before submitting the proper documentation. Beyond that, there may also be a continuing ambiguity problem with the codes themselves. For example, the decision-making complexity for code 99282 is low; for 99283 low to moderate.⁵⁰

A PPRC-commissioned study⁵¹ cited the opinions of 1,000 physicians concerning Evaluation and Management codes. Although 67 percent of physicians adequately understood how to use the new codes, only 11 percent believe the codes are *very* accurate; while 54 percent thought they were *somewhat* accurate. The study also noted that coding uniformity for Evaluation and Management services has improved despite the 33 percent of physicians who stated they did not know how to use the codes. Lastly, 14 percent of physicians noted problems with coding Evaluation and Management services when citing their concerns about the Medicare Fee Schedule. For those who had problems, the most common were complexity and difficulty finding a code that described the service provided. An ongoing OIG study is examining HCFA's implementation of the new visit codes.

The HCFA has explored other methods to reduce unnecessary Medicare reimbursements. Two alternatives include "packaging" and "collapsing." Packaging places various service components under a broad procedure code. For example, under the "Laboratory Roll-In" (LRI)⁵² concept, office visits and lab services would be packaged under a broad visit code. The physician, not Medicare, would reimburse the lab for its services. Under the current system, the provider bears no financial risk when ordering diagnostic tests,⁵³ and has no incentive to control unnecessary tests. Collapsing reduces the number of similar CPT-4 codes, thereby limiting opportunities to upcode by reducing the number of coding options.

THE METHODS BY WHICH HCFA HAS INCORPORATED CPT-4 INTO MEDICARE'S CODING SYSTEM DO NOT ENSURE APPROPRIATE REIMBURSEMENT TO MEDICARE PROVIDERS.

We identified three flaws in the way that HCFA has incorporated CPT-4 into Medicare's coding system. We believe these flaws prevent HCFA from ensuring appropriate payments to Medicare providers. First, HCFA has not developed criteria or communicated decision rules for changing, adding or deleting codes in light of the Medicare Fee Schedule's requirements. Second, HCFA has not adequately communicated Medicare policy to providers. Third, HCFA has not assessed the effectiveness of the process for establishing RVUs.

The HCFA has not developed criteria or communicated decision rules for changing, adding, or deleting codes in light of the Medicare Fee Schedule's requirements.

The HCFA does not have criteria to evaluate the effectiveness of CPT-4 codes in meeting the needs and intent of the Medicare Fee Schedule. Criteria would provide HCFA, the AMA, and medical specialty societies a tool to evaluate the adequacy of each code and its descriptor and allow for consistent development of CPT-4. While the AMA has coding guidelines, HCFA has not determined whether they are compatible with the goals of the Fee Schedule.

In addition to AMA guidelines, the PPRC published a set of goals to guide the development of visit codes.⁵⁴ A partial listing of these goals illustrate an example of coding criteria. The PPRC believe that visit codes should be (1) clear and interpreted uniformly by all providers, payers, and beneficiaries, (2) clinically meaningful and describe clearly differentiated services, and (3) facilitate the assignment of accurate and equitable resource-based relative values.

In its 1992 Annual Report to Congress, the PPRC stated:

Adoption of a resource-based payment system places new requirements on the coding system because, to provide a sound basis for equitable payment, each code must represent a similar amount of work to all providers who use it. Although coding decisions remain external to the payment process for the most part, HCFA is in a good position to articulate the needs for coding changes.⁵⁵

In its 1993 Annual Report to Congress, PPRC reiterated its concerns and made more specific recommendations to HCFA. It recommended that:

HCFA should continue to develop small-group processes to update the fee schedule for new codes and to conduct the periodic review of the entire fee schedule. The processes should be developed with public input, and clear guidelines and decision rules should be specified in advance. The processes should include (1) mechanisms to promote

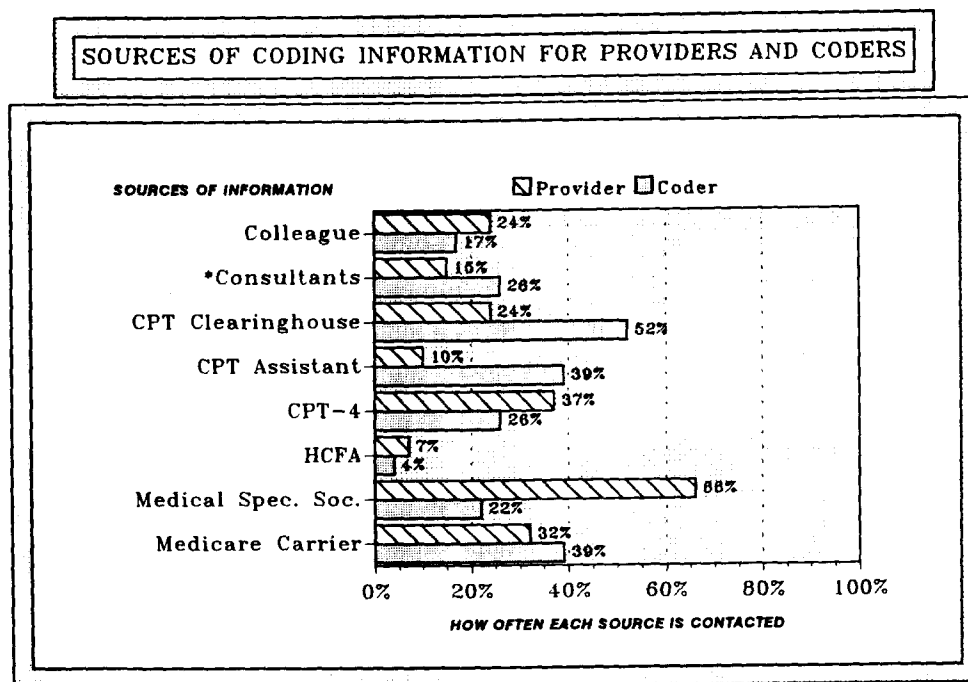
consistent decision making, (2) fair methods and representation of involved parties, (3) a means to identify overvalued as well as undervalued services, ways to ensure public accountability, and (4) feedback to the CPT Editorial Panel when codes need revision to achieve accurate resource-based payment.⁵⁶

- *The HCFA has not adequately communicated Medicare coding policy to providers.*

Continued provider confusion about proper use of CPT-4 codes indicates that HCFA has not adequately communicated Medicare coding policies to providers. In its 1993 Annual Report to Congress, PPRC stated, "many physicians reported they did not understand major aspects of payment reform, such as the newly revised visit codes...and Medicare's global surgical service policies."⁵⁷

Clear and accurate coding advice would ensure uniform application of Medicare's reimbursement policies. We found that the AMA and medical specialty societies, not HCFA or Medicare carriers, are the primary source for coding advice. This would not be a concern if the advice given by the other sources were consistent with Medicare's policies. However, the likelihood of inconsistent advice only increases as the number of sources increase. Coding consultants are another source of coding advice. A new cottage industry of companies which advertise their ability to maximize provider reimbursements, both Medicare and non-Medicare, has also found a market for their services. The following table lists both the source of coding information and the percentage of respondents who cited their use.

Table 1.



*Individuals or organizations that provide coding advice.

Two factors may contribute to limited reliance on HCFA and Medicare carriers for coding advice. First, HCFA lacks a cohesive approach for addressing coding questions. The BPD's Office of Coverage Eligibility Policy, Medical Coding Policy Staff, forward most CPT-4 questions directly to the AMA. The BPO, however, works with HCFA's representative on the CPT Editorial Panel to resolve coding inquiries. Since, HCFA has not assigned staff to specifically address CPT-4 coding questions, these questions are resolved differently depending on to whom they are addressed.

Second, providers and coders have not been satisfied with carrier responses. Approximately 60 percent of providers and 40 percent of coders expressed some frustration in their dealings with Medicare carriers. Problems include: inconsistent coding advice; non-uniform coding policy, especially concerning modifiers and "Not Otherwise Covered" codes; lack of knowledge in some specialties; difficulty in resolving coding conflicts; and lack of timeliness in responding to changes in medicine. All but one carrier respondent estimate that they receive less than 50 calls per month concerning CPT-4 questions. Two carriers, in fact, said they forward CPT-4 questions directly to the AMA. The other ten will resolve the questions themselves. If they cannot, most will also use outside sources.

The HCFA has not developed an efficient or effective process for establishing RVUs for new or modified codes.

Although the process for assigning RVUs is still evolving, both HCFA and the PPRC have questioned the effectiveness of the current process and made suggestions for modifying the process. However, no evaluation of the process has been undertaken, even on an interim basis.

The RVU assignment process has already undergone some changes. In developing the initial set of values for the 1992 Medicare Fee Schedule, HCFA relied primarily on data from Harvard University. For new values in the 1993 Fee Schedule, HCFA considered recommendations from AMA's Relative Value Update Committee (RUC). Recommendations from RUC will also serve as the basis for changes in the 1994 Fee Schedule.

The RUC recommendations are reviewed by HCFA staff and a panel of Carrier Medical Directors (CMD), then published in the Federal Register for comment. Comments on RVUs published in November 1991 and November 1992 were reviewed by a panel of CMDs and medical specialty society representatives. In 1993, HCFA rejected 35 percent of the RUC's recommendations.

Concerns expressed by HCFA and the PPRC indicate that an early assessment of the RVU development process may be warranted.

- The RUC is not following HCFA's methodology for assigning RVUs, and may be incorrectly assigning values to new codes that are split from another code.

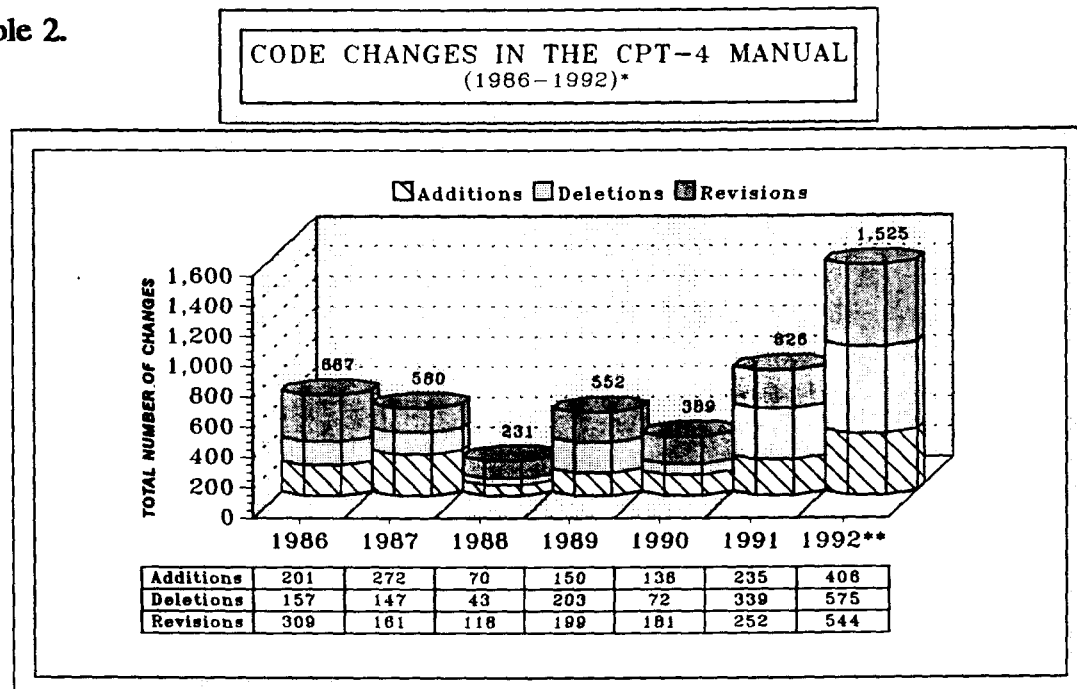
- The current RUC process does not project utilization for new and revised codes. These projections are needed to assure that changes to the Fee Schedule do not adversely affect the requirement for budget neutrality.
- There is no public oversight of the process itself. The PPRC has recommended publishing and allowing public comment on processes and decision rules; soliciting input from all interested parties, particularly non-Medicare payers and consumers; and public review of the process to assure compliance with decision rules.

Our own analysis indicates that these concerns raise questions about the effectiveness of the process as it currently operates. An early assessment could result in modifications designed to improve the overall effectiveness of the process.

A proliferation of CPT-4 changes will undermine HCFA's ability to contain expenditures under the Medicare Fee Schedule.

We believe that significant increases in code changes will severely stretch HCFA's already limited resources to the point where they will be unable to effectively implement and manage the Medicare Fee Schedule. As shown in the following table, there has been a dramatic increase in the volume of annual changes to CPT-4. This increase has coincided with the advent of the Medicare Fee Schedule in January 1992. Until the Fee Schedule is fully implemented in 1996, we believe the volume of code changes will be at or above 1991/1992 levels. Entire sections of CPT-4 are now being revised and proposals are pending to split a large number of individual codes into two or more codes.

Table 2.



* Annual changes are published in that year's following CPT-4 manual.
 ** Sixty percent are due to changes in Pathology and Laboratory codes. These services are reimbursed under a clinical diagnostic laboratory fee schedule but still require an evaluation by HCFA staff.

For each CPT-4 code, HCFA must assign an accurate work value and estimate service utilization to project future expenditures. Section 1848(c)(2)(B) of the Social Security Act also requires that changes to the Medicare Fee Schedule have a budget neutral effect on these expenditures.⁵⁸ This evaluation process has already had a significant impact. According to HCFA, its adjustments in 1992 of RVUs for new and revised codes avoided an increase in expenditures of \$30 million in 1993. However, an increased workload for HCFA staff reduces their effectiveness in performing this necessary evaluation.

Lastly, we are also concerned about the nature of recent code changes. The HCFA has expressed a concern that many of the CPT-4 code changes "appear to be an opportunity to revalue work RVUs through a process outside of our usual notice and comment rulemaking process." We believe that any effort to circumvent the intent of the Medicare Fee Schedule could undermine physician payment reform and should be addressed.

RECOMMENDATIONS

Our findings indicate that additional improvements could be made with the CPT-4 codes and in HCFA's management and articulation of Medicare policy. To this end, we make recommendations to HCFA, which develops and implements Medicare policy, and the AMA, who has developed and maintains CPT-4.

We recommend that HCFA:

- Produce and promulgate to the AMA and medical specialty societies clear coding objectives and criteria for Medicare's resource-based payment system and encourage them to apply the objectives in the development of new or revised codes;
- Apply HCFA coding objectives and criteria when evaluating new or revised codes to assure compliance with the needs of the Medicare Fee Schedule;
- Work with the AMA, Medicare carriers, medical specialty societies and other related parties to develop a mechanism that assures a unified and consistent dissemination of guidelines on how to use and interpret codes.
- Evaluate the current process for implementing changes to the Medicare Fee Schedule. This includes: (1) developing an effective process for establishing work values for new or revised codes, (2) communicating to the AMA the number of annual additions, deletions, and revisions to CPT-4 that HCFA could effectively review, and (3) delaying implementation of new or revised codes, except for new technologies, until reliable data is available to predict service utilization.

We recommend that AMA, to the extent that they do not conflict with Federal antitrust guidelines:

- Consider and encourage medical specialty use of HCFA coding objectives and criteria in the development of new or revised CPT-4 codes;
- Consider a review of the CPT-4 index within the framework of its own commissioned study's recommendations;
- Work with HCFA to develop a mechanism that assures a unified and consistent dissemination of Medicare coding policy;
- Provide HCFA with utilization estimates for new or revised codes; and
- Work with HCFA to arrive at an acceptable number of annual CPT-4 code changes to allow for proper HCFA evaluation.

COMMENTS

Both HCFA and the AMA generally agreed with our recommendations. Their comments and our responses are summarized below. A complete version of the comments appears in Appendix E. Changes were made to the draft report to incorporate some of the HCFA and AMA remarks.

HCFA Comments

The HCFA comments focused on the report recommendations. They generally concurred with our recommendations and have begun to take action. With respect to our first recommendation, HCFA is considering developing a policy statement to delineate clear coding and objectives and criteria to the AMA for Medicare's resource-based payment system. They plan to evaluate whether such a policy statement would improve coding accuracy.

The HCFA concurred with our second recommendation to apply its coding objectives when evaluating new or revised codes and recognize that improvements can be made in the coding process. They believe, however, that the OIG should balance its report by citing HCFA's major role in the development of the new evaluation and management codes and clinical examples. The HCFA feels that these new codes "have led to greater uniformity" in coding practices.

The HCFA agreed in principle with our third recommendation that greater guidance to physicians on the use and interpretation of codes is needed. However, they were reluctant to commit to a specific set of actions, and would like to study this issue further. The HCFA feels their work in communicating the changes in evaluation and management codes to the medical community was highly successful and should be recognized. Additionally, HCFA believes the OIG should also highlight their continued cooperation with Medicare carriers and the AMA in identifying and addressing coding issues.

The HCFA concurred with our fourth recommendation to evaluate the current process for implementing changes to the Medicare Fee Schedule and has taken significant action. These changes should allow HCFA to set values that ensure that the integrity of Medicare Fee Schedule is maintained. These changes were detailed in HCFA's Notice of Proposed Rule Making, "Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule," that appeared on pages 37996 and 37997 of the July 14, 1993 *Federal Register*.

OIG Response

We commend HCFA for strengthening its process for implementing new codes and their associated values. We believe these actions are significant and facilitates an orderly implementation of the Medicare Fee Schedule.

We continue to believe that HCFA needs clear coding objectives to support the intent of the Medicare Fee Schedule and urge HCFA to share those objectives with the AMA. We also hope that HCFA will continue to work with the AMA, Medicare carriers, medical specialty societies, and other related parties to develop a policy for improving coordination of coding policy.

The AMA Comments

The AMA, with one exception, agreed with the recommendations. They stressed the importance of working with HCFA and all affected parties to strengthen the CPT system. They strongly disagreed that HCFA should delay implementation of new codes pending the availability of reliable utilization data. They feel the best approach is to work with HCFA to "proactively manage" code changes. They also note that a recently revised process for submitting code changes should provide the best possible utilization estimates.

The AMA believes, however, that our methodology has limitations. They feel the literature was scarce, not found in publications with high standards of peer review, and not suited to generalization. The AMA also believe too much emphasis was placed on the comments from the structured interview process which may be flawed due to the bias of some respondents.

The AMA did not dispute the primary finding that "incorrect coding affects Medicare reimbursements" but questioned several others. However, they believe the reports wrongly suggests that incorrect coding is inherently the fault of the CPT system and only leads to Medicare overpayments, not underpayments. They feel it is possible that "flaws in the CPT codes, guidelines, and index can lead to improper coding" and are seeking improvements to address these concerns. Nevertheless, they did not agree that the examples provided are "necessarily indicative...and, in most cases, no longer apply." Lastly, the AMA questioned our assessment of process of developing codes, their values and the ultimate impact on Medicare reimbursements. They believe these issues are "quite complex...and are continuing to explore."

OIG Response

We recognize the complex nature of the CPT system and commend the AMA for their work to make the necessary improvements when needed. We did not intend this study to be the final word, but the opening of a dialogue that will lead to improvements in code development and assignment of their associated work values.

1. Section 4501 of the Medicare Carrier Manual states that Level II contains alphanumeric (A-V) codes which cover physician and non-physician services not included in CPT-4. They are maintained jointly by HCFA, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. Level III contains local alphanumeric (W-Z) codes needed by HCFA contractors for services not previously covered.
2. Section 3627.8 of the Medicare Intermediary Manual states this term applies to acute care hospitals, long-term care hospitals, rehabilitation hospitals, psychiatric hospitals and hospital based Rural Health Clinics (RHCs). It does not apply to independent RHCs, hospital based or independent End Stage Renal Disease facilities, Skilled Nursing Facilities, Home Health Agencies, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physician Therapy facilities, hospices or Christian Science Sanitoria.
3. Section 3626.4 of the Medicare Intermediary Manual requires hospitals to use the CPT-4 portion of HCPCS to report significant outpatient surgical procedures (clinical diagnostic lab services had been and continue to be coded using HCPCS. Significant surgery is defined as incision, excision, amputation, introduction, repair, destruction, endoscopy, suture or manipulation).
4. "Provider" in this report represents both physicians and non-physicians. Section 1861(r) of the Social Security Act states the term "physician",...means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State...(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State, (3) a doctor of podiatric medicine...but only with respect to functions which he is legally authorized to perform as such by the State...(4) a doctor of optometry, but only with respect to...items or services...which he is legally authorized to perform...by the State (5) a chiropractor is licensed as such by the State.
5. A modifier indicates that the service or procedure has been altered by some specific circumstance. It does not change, but enhances, the code and its definition. Modifiers can be used in two-digit or five-digit forms. A modified procedure can be reported by either adding the two-digit modifier to the original five-digit code or using the five-digit modifier in addition to the original code. For example, under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. This can be reported by adding the two-digit modifier -52 or using the five-digit code 09952 in addition to the original procedure code.
6. The AMA nominates 10 members to the Editorial Panel. The Blue Cross and Blue Shield Association, the Health Insurance Association of America, the American Hospital Association, and the Health Care Financing Administration nominate the remaining four members from their own ranks.
7. There are 85 national medical specialty societies involved in maintenance of CPT-4. The CPT Advisory Committee (CAC) represent 76 groups from the AMA's House of

Delegates. The Health Care Professionals Advisory Committee for CPT (HCPAC) represents nine non-AMA groups who use CPT-4.

8. The Executive Committee of the CPT Editorial Panel includes the chairman, vice chairman and three other members selected by the entire Editorial Panel. One member must be a third-party payor representative. Currently, HCFA's representative to the Editorial Panel serves on its Executive Committee.

9. Commerce Clearing House, Inc., Commerce Clearing House Medicare and Medicaid Guide Extra Edition with an explanation by Gail R. Wilensky, Ph.D. (Chicago: Commerce Clearing House, 1991).

10. The AMA's Relative Value Update Committee (RUC) provides HCFA with recommendations for RVUs to accompany new or revised CPT-4 codes. The RUC is composed of one representative each from 22 medical specialty societies, the American Medical Association, the American Osteopathic Association and the CPT Editorial Panel. There is also a non-voting HCFA representative on the RUC. However, HCFA does have veto power over RUC recommendations.

11. In its comments to the Office of Inspector General's report Liver Biopsies (OEI-12-88-00900), HCFA states ". . . as of January 1, 1992, HCFA has the authority to establish uniform national definitions of services, codes to represent services, and payment modifiers to the codes. Therefore, HCFA can issue guidelines that are different from those in the CPT-4 manual. To the extent that instructions in the CPT-4 manual are unclear or are contrary to payment policy associated with physician payment reform rules, HCFA will issue guidelines that will supersede any CPT-4 manual instructions. In order to ensure uniform payment policy, HCFA will annually issue a Medicare Fee Schedule data base tape which will include payment policy indicators for each code to the carriers."

12. The MEDLARS allows access to a data base of medical journals in its MEDLINE subfile. The MEDLINE contains more than 20 years of data from over 3,000 major medical journals.

13. We did not interview a representative from the General Accounting Office since they do not use CPT-4.

14. The American Health Information Management Association is the professional health care organization of nearly 34,000 credentialed specialists in the field of health information management. Primarily, they collect, analyze, and manage beneficiary health care records. They were formerly known as the American Medical Records Association.

15. The Council of Medical Specialty Societies is an educational and scientific organization. Each of its members have examining boards recognized by voting membership in the American Board of Medical Specialties.

16. Section 1861(r) of the Social Security Act defines "physician" as it is used in the Medicare program. A "physician" includes both full and limited-licensed practitioners. A limited-licensed practitioner may only practice on specific portions of the body. Examples include podiatrists or optometrists.

17. National Medical Audit, a San Francisco-based division of benefits consultants Mercer Meidinger Hansen, Inc. estimate that 12 to 15 percent of all physician billing involves gaming or overcharging; Robert D. Hertenstein, M.D., a surgeon and medical director for Caterpillar Inc., worked with Health Payment Review, Inc. to develop the "CodeReview" software. He estimates nine to 17 percent in savings. Gabrieli Medical Information Systems, Inc., a Malvern, PA software firm claims it can save 3 percent to 5 percent on the total benefit dollars paid out or one to five dollars per claim.

18. Nancy Coe Bailey, "How to Control Overcharging by Physicians," Business and Health (August 1990): 13-14.

19. Sophia W. Chang and Harold S. Luft, "Reimbursements and the Dynamics of Surgical Procedure Innovation," Medical Innovation at the Crossroads--Volume II: The Changing Economics of Medical Technology Edited by Annetine C. Gelijns and Ethan A. Halm. (Washington, D.C.: National Academy Press, 1991), 108.

20. Physician Payment Review Commission, Annual Report to Congress (Washington, D.C.: GPO, 1992), 46.

21. Health Care Financing Administration, Medical Visits to Medicare Patients: Physician Coding Practices by Sally Trude ([Washington, D.C.]: U.S. Department of Health and Human Services, Health Care Financing Administration, Contract Number 99-C-98489/0-08, 1992), 41, and Office of Inspector General, Problems with Coding of Physician Services: Medicare Part B (OAI-04-88-00700) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1989), 4-6.

22. Office of Inspector General, Medicare Physician Consultation Services (OAI-02-88-00650) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1988), 9.

23. Peter Albertson, M.D. and Edward A. Kamens, M.D., "Variations in Coding Practices Among Connecticut Urologists for the Medicare Population," Connecticut Medicine (September 1990): 508-511.

24. An example of an "arthroplasty" procedure would be the removal of the head of the proximal phalanx in the second toe to straighten the toe and relieve a painful dorsal hyperkeratosis.

25. The Podiatric Medicare Monthly (Winter 1993): 2-4.

26. 28153 - Resection, head of phalanx,. 28160 - Hemiphalangetomy or

interphalangeal joint excision, toe, single, each. 28285 - Hammertoe operation; one toe (e.g., interphalangeal fusion, fellating, phalangectomy).

27. Office of Inspector General, Ensuring Appropriate Use of Laboratory Services: A Monograph (OEI-05-89-89150) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1987), 8.

28. Office of Inspector General, Review of Multichannel Laboratory Claims Processed by Empire Blue Cross Blue Shield Under Title XVII of the Social Security Act (A-02-85-02030, A-02-86-02013, A-02-87-01026, A-02-88-01001) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1985, 1986, 1987, 1988).

29. Office of Inspector General, Review of Radiology Services Paid by Empire Blue Cross Blue Shield Under Title XVIII of the Social Security Act (A-02-86-62022) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1987), 2-4.

30. Office of Inspector General, Ensuring Appropriate Use of Laboratory Services: A Monograph (OEI-05-89-89150), 8-9.

31. Office of Inspector General, Coronary Artery Bypass Graft Surgery (OAI-09-86-00070) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1987), 20.

32. Chang and Luft, "Reimbursements and the Dynamics of Surgical Procedure Innovation," 108.

33. A "pocket doppler" is an inexpensive screening device used for in-office ultrasound tests of arteries and veins.

34. Office of Inspector General, Pocket Dopplers: A Management Advisory Report (OEI-03-91-00401) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1991), 3.

35. "Zero crossers are ultrasonic testing devices used for in-office diagnostic tests of arteries and veins. They are a technological step above "pocket dopplers."

36. Office of Inspector General, Zero-Crossers (OEI-03-91-00460) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1991), 7.

37. Office of Inspector General, Liver Biopsies (OEI-12-88-00901) ([Washington, D.C.]: U.S. Department of Health and Human Services, Office of Inspector General, 1992), 4.

38. 61510 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma.
 61512 . . . ; for excision of meningioma, supratentorial.
 61514 . . . ; for excision of brain abscess, supratentorial.
 61516 . . . ; for excision or fenestration of cyst, supratentorial.
39. Chang and Luft, "Reimbursements and the Dynamics of Surgical Procedure Innovation," 107.
40. Coopers and Lybrand, Cost-Benefit Analysis of a Uniform Procedural Coding System for Physician Services (American Medical Association: Privately commissioned and published, 1989), 36-40.
41. An eponym identifies the name of an individual who is most closely associated with a procedure, e.g, "McBride procedure" (28292).
42. Evaluation and Management (E/M) codes are used to identify office services; hospital observation services; hospital inpatient services; consultations; emergency department services; critical care services; neonatal intensive care; nursing facility services; domiciliary, rest home, or custodial care services; home services; case management services; and preventative medicine services. Each group contains several levels, usually three or five, which describe the nature of the patient and the level of service. There are 99 E/M codes in the 1993 CPT-4.
43. Cardiologists have traditionally used 90000 series codes to prevent the codes from labeling them as radiologists. Currently, HCFA states that radiology codes (75000 series) should be used along with cardiology codes to ensure complete reimbursement for cardiac catheterization services.
44. Section 1842(a)(2)(B) of the Social Security Act requires HCFA to apply "safeguards against unnecessary utilization of services furnished by providers." These safeguards come in the form of both pre- and postpayment reviews.
45. Billing a total abdominal hysterectomy (51840) along with its component parts was cited an example of a gaming practice. One of the edits under the CCI address this problem.
46. Coe Bailey, "How to Control Overcharging by Physicians," 14.
47. Dennis L. Olmstead, "Medicare Monitoring of Payment Reform," Pennsylvania Medicine (March 1992), 16-17.
48. "RBRVS Briefs," Texas Medicine (March 1992), 58.
49. Carol Stevens, "Coping with Payment Reform: Avoiding the Most Common Mistakes," Medical Economics, 19 October 1992, 102.

50. Marleeta Jones, ART, "RBRVS IS Still Evolving: Seven Issues of Interest to Physicians and Health Information Professionals," Journal of AHIMA 63 (September 1992) 44-45.
51. Physician Payment Review Commission, Annual Report to Congress (Washington, D.C.: GPO, 1993), 110-115.
52. Office of Inspector General, Ensuring Appropriate Use of Laboratory Services: A Monograph (OEI-05-89-89150), 14.
53. Health Care Financing Administration, Packaging Physician Services: Alternative Approaches to Medicare Part B Reimbursement by Janet B. Mitchell Ph.D. (HCFA Contract number 500-81-0054) ([Washington, D.C.]: U.S. Department of Health and Human Services, Health Care Financing Administration, 1987).
54. Physician Payment Review Commission, Survey of Visits and Consultations: 1991-1, 78
55. Physician Payment Review Commission, Annual Report to Congress: 1992, 47.
56. Physician Payment Review Commission, Annual Report to Congress: 1993, 195-199.
57. Physician Payment Review Commission, Annual Report to Congress: 1993, 110.
58. Under Section 1848(c)(2)(B) of the Social Security Act, HCFA is allowed a \$20 million tolerance in physician reimbursements to meet its goal of budget neutrality.

APPENDIX A

HCPCS DEVELOPED AROUND CPT-4

The HCFA developed HCPCS to achieve uniformity in procedure coding. In the mid-1970s, the Medicare and Medicaid programs were using multiple procedure coding systems. After HCFA was formed in 1977, they established project teams to integrate Medicare and Medicaid operations. At that time, there were a wide variety of medical procedural terminology and coding systems (MPTCS) in use by Medicare Carriers, State Medicaid agencies and their fiscal agents. The goal of one project team was to develop one coding system to reimburse both hospital (Part A) and physician (Part B) services. This effort was abandoned since Part A services were reimbursed on a cost basis and Part B on a fee-for-service. The HCFA then shifted its focus to developing separate systems.

The HCFA established the Medicare/Medicaid Integration Project, Number Two Team (MMIP-2) to develop a common system to reimburse physician services. The MMIP-2 determined that the lack of a common system made it difficult and costly for Medicare/Medicaid payment and utilization data to be exchanged, merged, or compared; complicated application of the Medicare Physician Economic Index as procedural terminology systems change; presented severe problems to HCFA in preparing timely, comparable data for Congressional testimony and inquiries; and (4) impeded the development of integrated claims processing systems.

The MMIP-2 noted that implementation of uniform system would provide several benefits. The benefits would permit the development of more effective fraud and systems; lead to improve cost and utilization analysis; and facilitate greater uniformity in Medicare and Medicaid program administration, quality standards, coverage and reimbursement determinations.

The MMIP-2 established three goals for the new system. The codes should: (1) identify physician actions clearly, (2) fulfill the needs of both physicians and third-party payers, and (3) allow for continual maintenance and update.

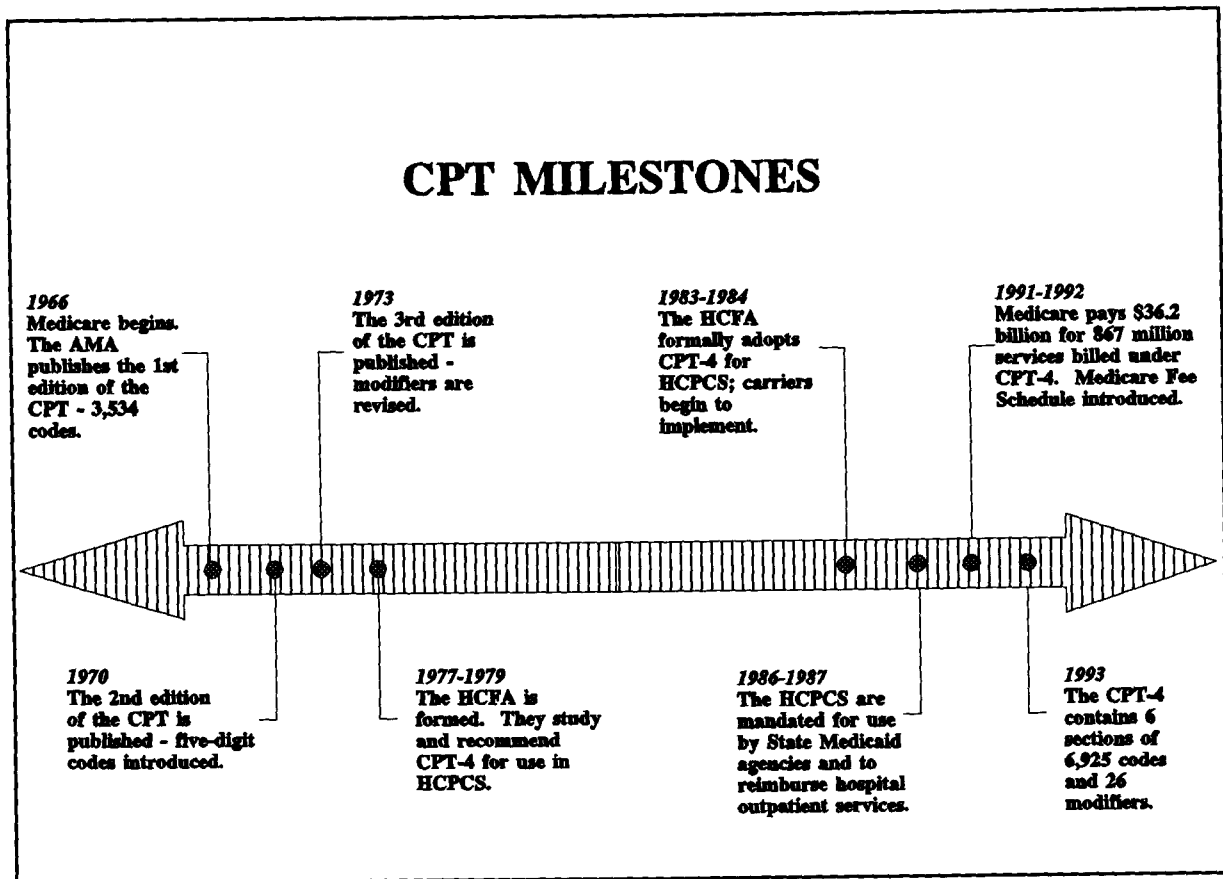
The MMIP-2 studied three options. They could select CPT-4, another procedural coding system, or develop a distinctive HCFA system. These other procedural coding systems included the California Relative Value Studies (CRVS); the International Classification of Diseases, Ninth Revision, Clinical Modification, Volume 3 (ICD-9-CM); the Systemized Nomenclature of Medicine (SNOMED); and the Blue Shield Association's Coding and Nomenclature Manual.

During 1978, assessments of the alternatives were performed by HCFA and a HCFA contractor. They used CPT-4 as the focal point for examining other systems. Those studies, particularly the one done at South Carolina Blue Shield, determined that

conversion to CPT-4 would not adversely affect reimbursements. Therefore, in January 1979, MMIP-2 recommended that CPT-4 be chosen as the basis for developing the HCPCS system.

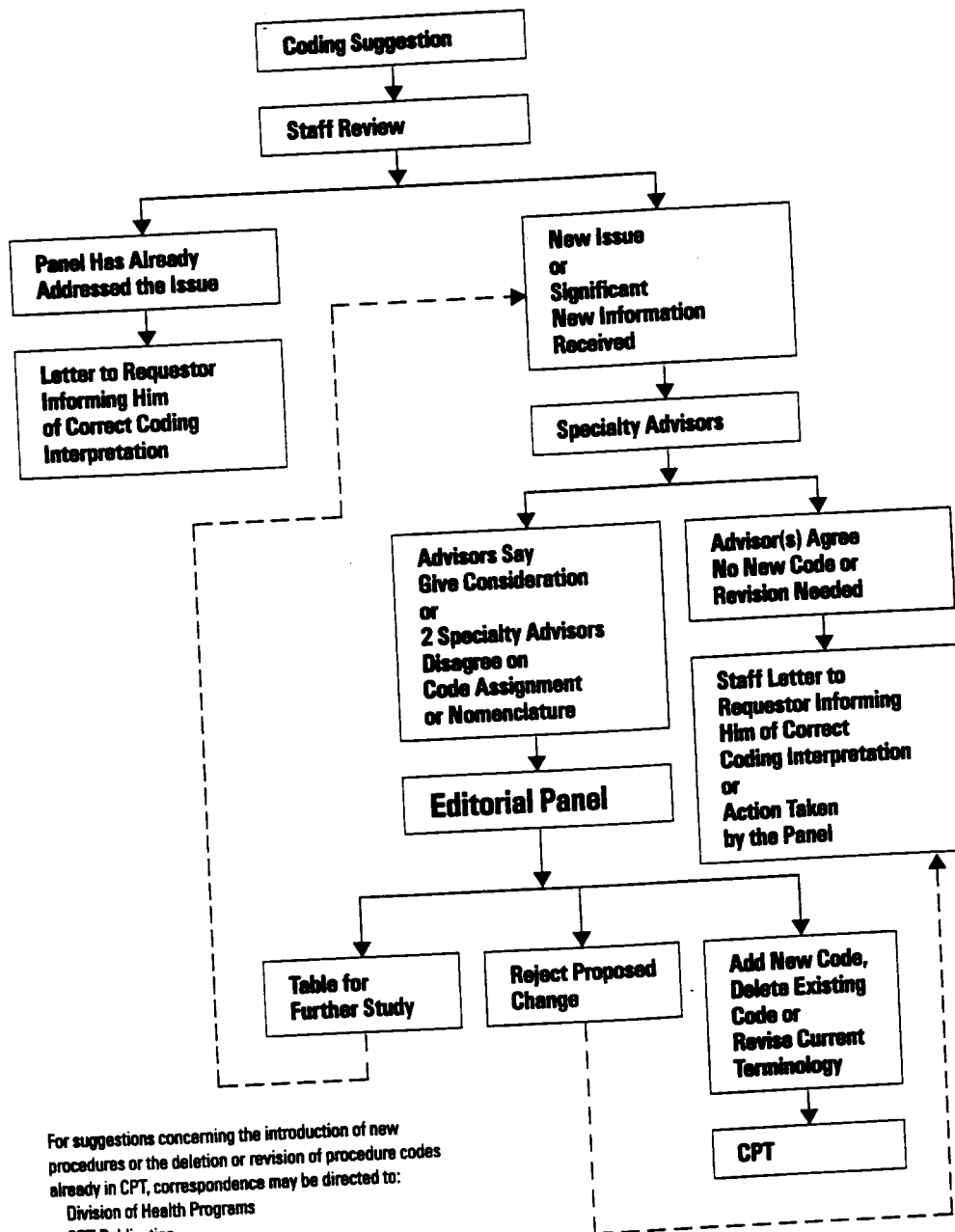
In February 1983, the AMA agreed to let HCFA use its CPT-4 system as part of HCPCS. After signing the agreement with the AMA, HCFA mandated the use of HCPCS. By October 1986, HCFA required State Medicaid agencies to use HCPCS. Beginning July 1, 1987, section 9343(g) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 required hospitals to use HCPCS to reimburse outpatient services. The OBRA 1986 mandated the use of HCPCS in hospital outpatient settings for the following services: July 1, 1987 - surgery; October 1988 - radiology services; October 1989 - other non-radiology diagnostic services; October 16, 1991 - all other services not previously specified except for supplies, drugs (other than drugs used for cancer chemotherapy, ambulance services, and end-stage renal disease (ESRD) services.

Figure 1. CPT-4 Milestones



APPENDIX B

THE CPT PROCESS *



For suggestions concerning the introduction of new procedures or the deletion or revision of procedure codes already in CPT, correspondence may be directed to:
 Division of Health Programs
 CPT Publication
 American Medical Association
 515 North State Street
 Chicago, Illinois 60610

* Reprinted from the American Medical Association's CPT Assistant

APPENDIX C

DATA SOURCES

Government Agencies

U.S. Department of Health and Human Services, Office of the Secretary,
Office of Inspector General
U.S. Department of Health and Human Services, Health Care Financing
Administration
U.S. Congress, General Accounting Office, Human Resources Division
U.S. Congress, Physician Payment Review Commission

Medicare Carriers

Aetna Life Insurance Company - Arizona
Aetna Life Insurance Company - Hawaii
Aetna Life Insurance Company - Oregon
Blue Cross and Blue Shield of Iowa - Iowa
Blue Cross and Blue Shield of Kansas, Inc. - Kansas
Blue Cross and Blue Shield of Maryland - Maryland
Blue Cross and Blue Shield of North Dakota - Wyoming
Blue Cross and Blue Shield of Rhode Island - Rhode Island
Blue Cross and Blue Shield of South Carolina - South Carolina
Empire Blue Cross and Blue Shield - New York
Blue Shield of California - California
Pennsylvania Blue Shield - District of Columbia/Delaware/New Jersey

Health Care Trade Groups

The American Hospital Association
The American Medical Association
The Blue Cross and Blue Shield Association
The Health Insurance Association of America
The Health Information Management Association

Medical Specialty Societies

American Academy of Allergy and Immunology (#) (ACAC)
American Academy of Dermatology (#) (ACAC)
American Academy of Family Physicians (#) (ACAC)
American Academy of Neurology (#) (ACAC)
American Academy of Ophthalmology (#) (ACAC)
American Academy of Orthopaedic Surgeons (#) (ACAC)
American Academy of Otolaryngology - Head and Neck Surgery (#) (ACAC)

American Academy of Pediatrics (#) (ACAC)
 American Academy of Periodontology (&)
 American Academy of Physical Medicine and Rehabilitation (#) (ACAC)
 American Academy of Physician Assistants (&) (HCPAC)
 American Association of Neurological Surgeons (#) (ACAC)
 American Association of Oral and Maxillofacial Surgery (&)
 American Chiropractic Association (&)
 American College of Cardiology (*) (ACAC)
 American College of Chest Physicians (*) (ACAC)
 American College of Clinical Pathologists (#) (ACAC)
 American College of Emergency Physicians (#) (ACAC)
 American College of Gastroenterology (*) (ACAC)
 American College of Obstetricians and Gynecologists (#) (ACAC)
 American College of Physicians (#) (ACAC)
 American College of Preventative Medicine (#) (ACAC)
 American College of Radiology (#) (ACAC)
 American College of Surgeons (#) (ACAC)
 American Nurses Association (&) (HCPAC)
 American Occupational Therapy Association (&) (HCPAC)
 American Optometric Association (&) (HCPAC)
 American Osteopathic Association (&) (ACAC)
 American Physical Therapy Association (&) (HCPAC)
 American Podiatric Medical Association (&) (HCPAC)
 American Psychiatric Association (#) (ACAC)
 American Psychological Association (&) (HCPAC)
 American Society of Anesthesiologists (#) (ACAC)
 American Society of Clinical Oncology (*) (ACAC)
 American Society of Colon and Rectal Surgeons (#) (ACAC)
 American Society of Internal Medicine (*) (ACAC)
 American Speech-Language-Hearing Association (&) (HCPAC)
 American Urological Association (#) (ACAC)
 National Association of Social Workers (&) (HCPAC)
 Society of Thoracic Surgeons (#) (ACAC)
 The Society of Nuclear Medicine (#) (ACAC)

Key

Members of the Council of Medical Specialty Societies (23)
 & Limited-Licensed Physicians (13)
 * Internal Medicine and Its Major Subspecialties (5)

ACAC AMA CPT Advisory Committee Members
 HCPAC Health Care Professionals Advisory Committee for CPT

APPENDIX D

SUMMARY OF OIG REPORTS ON CPT-4

Report Title	CPT-4 Section	Annual Effect
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"Upcoding"

<i>Medicare Physician Consultation Services OAI-02-88-00650, June 1988</i>	Evaluation and Management	\$73.0M
<i>Coronary Artery Bypass Graft Surgery OAI-09-86-00070, August 1987</i>	Surgery	\$5.0M
<i>Pocket Dopplers OEI-03-91-00461, June 1991</i>	Medicine	\$6.0M
<i>Zero Crossers OEI-03-91-00460, August 1991</i>	Medicine	\$16.7M

"Unbundling"

<i>Review of Multichannel Laboratory Claims Processed by Empire Blue Cross/Blue Shield Under Title XVII of the Social Security Act A-02-85-02030, March 1985 A-02-86-02013, June 1986 A-02-87-01026, September 1987 A-02-88-01001, October 1988</i>	Pathology and Laboratory	\$0.9M (\$2.6M/ 3 years)
<i>Review of Radiology Services Paid by Empire Blue Cross/Blue Shield Under Title XVII of the Social Security Act A-02-86-02022, April 1987</i>	Radiology	\$1.3M
<i>Manipulation of Procedure Codes by Physicians to Maximize Medicare and Medicaid Reimbursements: A Management Advisory Report A-03-91-00019, August 1991</i>	All Sections	\$12.2M

Total	\$115.1M
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APPENDIX E

COMMENTS ON DRAFT REPORT



Memorandum

Date MAR 8 1994

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Reports: "Coding of Physician Services,"
(OEI-03-91-00920), and "A Compendium of Reports and Literature on Coding of
To Physician Services," (OEI-03-91-00921)

June Gibbs Brown
Inspector General

We reviewed the above-referenced draft reports which raise concerns about coding practices and their impact on Medicare policy objectives.

We concur with the second and fourth recommendations contained in the report and are considering the first and third. Our detailed comments on the report findings and recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on these draft reports. Please advise us if you would like to discuss our position on the recommendations at your earliest convenience.

Attachments

IG	_____
SAIG	_____ ✓
PDIG	_____
DIG-AS	_____
DIG-EI	_____ ✓
DIG-OI	_____
AIG-MP	_____
OGC/IG	_____
EXSEC	_____ ✓
DATE SENT	3-10

1994 MAR 10 11 29 53

RECEIVED
OFFICE OF INSPECTOR
GENERAL

Comments on Office of Inspector General (OIG) Draft Reports:
"Coding of Physician Services," (OEI-03-91-00920), and "A
Compendium of Reports and Literature on Coding of Physician
Services,"
(OEI-03-91-00921)

Recommendation 1

The Health Care Financing Administration (HCFA) should produce and promulgate to the American Medical Association (AMA) and medical specialty societies clear coding objectives and criteria for Medicare's resource-based payment system and encourage them to apply the objectives in the development of new or revised codes.

HCFA Response

We are considering developing a policy statement delineating clear coding objectives and criteria for Medicare's resource-based payment system and informing the AMA Current Procedural Terminology (CPT) committee of our priorities. We plan to evaluate whether the issuance of a general set of coding objectives would improve coding accuracy.

Recommendation 2

HCFA should apply its coding objectives and criteria when evaluating new or revised codes to assure compliance with the needs of the Medicare Fee Schedule.

HCFA Response

We concur. We agree that improvements can be made in the coding process. However, to give the report greater balance, we suggest that OIG include in the final report a description of the improvements in the coding system in which HCFA has had a major role, and the policies that HCFA has installed to guard against coding changes leading to greater expenditures. In particular, OIG should cite HCFA's role in the major improvements made in evaluation and management physician visit codes in 1992, such as the creation of additional, more precise and descriptive codes to distinguish among various levels of physician visits. HCFA developed several clinical examples for each specialty to explain the use of the new codes. Despite some continuing elements of confusion among physicians about the codes, these changes have led to greater uniformity in the use of visit codes.

In addition, HCFA has established several methods to guard against coding changes leading to the circumvention of the relative value scale and escalation of expenditures. Some of the steps that OIG urges HCFA to take to establish more effective methods of assigning relative value units (RVUs) for new and revised codes were announced by HCFA in a notice of proposed rulemaking (NPRM) published on July 14, 1993, a copy of which is attached. We would like OIG to mention these efforts in order to provide a context and accurate representation of HCFA's efforts in improving coding of medical services.

The NPRM describes our concerns about the escalation of new and revised codes as well as our intentions regarding assignment of RVUs to these cases if we could not readily ensure budget neutrality. We have held extensive discussions with the AMA on other changes that would be desirable in the CPT process. For example, the AMA is going to close the CPT process 2 months earlier beginning with the 1995 CPT, which will allow HCFA to review the coding changes and the proposed RVU values in a more deliberative manner. Also, the AMA is going to require all specialty societies to identify the coding changes that are planned and their relative priority for the next 4 or 5 years. This would allow the AMA to put more discipline in the CPT process and would allow HCFA, through its representative on the CPT editorial board, to influence the scheduling of coding changes.

Recommendation 3

HCFA should work with the AMA, Medicare carriers, medical specialty societies and other related parties to develop a mechanism that assures a unified and consistent dissemination of guidelines on how to use and interpret codes.

HCFA Response

We agree there is a need for greater HCFA guidance to physicians on how to use and interpret new codes, particularly for codes expected to be high volume and where the definition is not precise. However, we are not prepared at this time to commit to a specific set of actions, and would like to consider this issue further.

We note that our effort to communicate the interpretation of the new evaluation and management codes mentioned above, which was the most significant set of changes in several years, was highly successful. HCFA participated in and led several educational efforts, such as having the carriers send out special publications on the use of the new codes, special seminars, and information in the carrier newsletters that are distributed to every physician in the country. In addition, we have worked extensively with carrier medical directors to identify areas of continued confusion and developed recommendations for clarification and guidance on documentation to be used by the AMA/CPT and ultimately to be used to distribute

to physicians and carriers to improve the consistency in the use of these codes. We have worked closely with AMA who has distributed our recommendations to specialty societies on two occasions. We (HCFA and AMA) are currently in the process of preparing recommendations for the CPT panel to consider for revisions of the CPT definitions. We will consider these types of efforts for communicating the correct use and interpretation of new codes.

Recommendation 4

HCFA should evaluate the current process for implementing changes to the Medicare Fee Schedule. This includes (1) developing an effective process for establishing work values for new or revised codes, (2) communicating to the AMA the number of annual additions, deletions, and revisions to CPT-4 that HCFA could effectively review, and (3) delaying implementation of new or revised codes, except for new technologies, until reliable data are available to predict service utilization.

HCFA Response

We concur, and have made the recommended changes:

1. We developed an effective process for establishing work values for new and revised codes that preserves budget neutrality, protects primary care, and is fair and equitable to all concerned.

2. With the tighter deadline for making CPT changes and the establishment of a long-term coding workplan, HCFA's ability to review established RVUs for new and revised codes will be greatly enhanced.

3. If reliable data are not available to predict service utilization needed to preserve budget neutrality, we will delay implementation of new or revised codes, except for new technologies, until reliable data are available to predict service utilization. See page 37997 of the July 13 NPRM.

Technical Comments

OIG attributes the entire \$450 million in expenditures resulting from the 1992 RVU refinement process to new and revised codes. Actually, only a small fraction of these dollars was attributable to coding changes. The bulk was due to changes made to values of existing codes. The year 1993 was atypical since the values assigned to all codes in 1992 were considered "interim" and subject to comments. Numerous changes were made in response to comments requiring the \$450 million adjustments. For 1994, only a 0.1 percent adjustment to all RVUs (about \$30 million) was needed to maintain budget neutrality due to the establishment of new or revised codes.

The next to last paragraph on page 9 of the report states:

"Neither the OIG nor HCFA has evaluated the effectiveness of the [Correct Coding Initiative]. However, we are aware that some insurance companies use a far greater number of edits than HCFA to detect improper coding practices in their non-Medicare claims."

While it is true that HCFA has fewer edits than some private companies, HCFA also allows its carriers to use local edits, which existed prior to 1992, thus increasing the overall number of edits. In addition, while HCFA currently uses edits only for high dollar, high frequency services, we are working with OIG to develop a Request for Proposal to develop edits on an ongoing basis for use by carrier systems. We would like these points to be added to the paragraph to provide an accurate context for describing the number of edits HCFA uses.

In addition, the report does not recognize the complexity of developing rebundling edits in the context of the fee schedule. We need to ensure that the proposed rebundling edits reflect the interpretation of codes by different physicians, including physicians in different specialties. Also, with the advent of a fee schedule which links a definition of the work for each code, Medicare must carefully examine the combinations of codes being proposed for rebundling. HCFA must take into consideration the services being provided under this CPT code and determine what services were included in the code when the relative work value was assigned. If the services considered part of the code changed through rebundling, the work value of the individual code, and codes within the family, must be reassessed for consistency.

In the exit conference on this inspection, OIG indicated it would discuss in its report the fact that HCFA does not blindly accept recommendations from the AMA's Relative Value Update Committee (RVUC). HCFA attendees pointed out in the exit conference that HCFA rejected 35 percent of the RVUC's recommendations last year. We believe this fact should be inserted on page 13 of the report to represent what actually occurred.

Statements citing findings of previous OIG studies should indicate that dollar amounts of overpayments are estimates. Findings that Medicare overpaid specific dollar amounts due to coding problems are based on sample data, and are estimates whose correspondence with the actual overpayment will depend on the quality of sample selection, sampling variability, and other technical factors. To accurately convey the uncertainty that accompanies such statements, we suggest using the term "estimated" liberally for citations of previous OIG findings. On page 5 of the

report, for example, the fifth sentence from the bottom would read, this lack of clarity resulted in *estimated* overpayments of \$73 million per year nationwide." Several other instances occur in the report and in the companion report.

The reference to survey responses from "providers" on pages 7 and 8 is unclear because in the methodology description (pages 2-3), no providers are mentioned as respondents. The methodology section describes the respondents as medical specialty societies, Medicare carriers, the AMA, and other organizations. In common usage, such entities are not providers per se; rather, providers refer to individual deliverers of medical care. It is unclear, for example, which entities on OIG's list of respondents "expressed satisfaction with the current system addressing coding issues . . ." (page 8).

American Medical Association

Physicians dedicated to the health of America



James S. Todd, MD
Executive Vice President

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312 464-5000
312 464-4184 Fax

October 8, 1993

Bryan B. Mitchell
Principal Deputy Inspector General
Department of Health & Human Services
Office of Inspector General
Washington, DC 20201

IG	_____
PDIG	_____
DIG-AS	_____
DIG-EI	_____
DIG-GI	_____
AIG-MP	_____
OGG/IG	_____
EX SEC	_____
DATE SENT	10/8

Dear Mr. Mitchell:

Thank you for allowing the American Medical Association (AMA) the opportunity to comment on your draft report "Coding of Physicians' Services". I appreciate your kind comments on the cooperation you have received from the AMA staff in development of this draft. Throughout the research and analysis process we have, in turn, been impressed by the objectiveness of the project staff and their obvious dedication to providing the best report possible.

While the stated objective of your report is to describe the "vulnerabilities in the maintenance, use and management of CPT as they relate to Medicare reimbursement", it seems that we share the same ultimate goal—that of making certain that the Physicians' Current Procedural Terminology (CPT) is at a sufficient level of clarity, accuracy, and professional acceptance to allow the Health Care Financing Administration (HCFA) to effectively and efficiently administer the Medicare program.

The CPT system is of extreme importance to physicians. It allows physicians to report the services they provide in terms that are clinically meaningful to them. Accordingly, the AMA is dedicated to supporting and improving CPT and welcomes constructive criticism from any source including, of course, that of the Office of the Inspector General (OIG). It is in that spirit that we have reviewed your draft report and in which our comments on your report are offered. To the degree that there are, in fact, "vulnerabilities" in the CPT maintenance system, the AMA appreciates learning of those, and you may be assured that we plan to take every step possible to address them.

Few would dispute the notion that the adoption of CPT by Medicare in 1983 has provided a tool to allow HCFA to bring unprecedented uniformity and control to the Medicare Part B program. And for the first time since the program's inception in 1965, CPT has provided the federal government with the ability to implement, monitor and evaluate national payment policies. We agree with your observation that, with the implementation of the Physician Payment Reform on January 1, 1992, the CPT system has taken on increased importance. We believe that, while continuing improvements are needed, the relationship that AMA has established with HCFA concerning the CPT system, its modifications and relative value updating, was critical in enabling that new system to be implemented with a very high level of operational efficiency. This relationship is, in our view, an excellent example of the type of public/private partnerships that will be so critical as we move toward a reformed health care system.

With one exception that will be discussed, we find your recommendations to AMA to be fair and reasonable. Several of the activities you suggest are, in fact, already underway. Our major concern relates to the sections of your draft report which cite numerous alleged flaws in the CPT system. While we would be the first to point out that CPT is not perfect, we are concerned that your listing of these examples (most of which have been identified and corrected through the existing CPT maintenance process) may create a distorted perception of the usefulness of CPT to Medicare.

Based on the organization of your report, our comments are grouped into four sections:

- background;
- methodology;
- findings; and
- recommendations.

BACKGROUND

We offer a few minor suggestions for your background section that we believe would strengthen your report overall. First, we would recommend that your report include a more precise definition of CPT. As noted in the CPT publication, as copyrighted by the AMA, "CPT is a systematic listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians." The descriptor is the key to each code, not the code number itself.

Next, the statement concerning hospital use of HCPCS is somewhat misleading. Actually, hospitals use only Level 1 of HCPCS (CPT). This Medicare program limitation has frustrated hospitals in coding outpatient services, as hospitals frequently provide services that might be more accurately reported using Level 2 of HCPCS (e.g., dental services) yet they are currently prohibited from doing so by HCFA.

Third, there is an inaccuracy in the statement on modifiers, as referred to in endnote 5. Strictly speaking, "QI" is not a CPT modifier, but one that has been established by HCFA on a temporary basis. And lastly, there is a typographical error on page 2, "The RVU is divided into three categories: physician (not physical) work, practice expense...".

METHODOLOGY

The OIG's methods rely primarily on two sources of information: literature review (and other published documents); and personal interview. We understand that these methods were relied on due to resource constraints within the OIG. While both these sources have merits and are an important part of any investigation, we have concerns about the degree to which they can be

relied upon exclusively to produce definitive results. We strongly believe that the methodology used has serious limitations.

First, we note that the literature that was uncovered during your exhaustive computerized searches was scarce and, in general, not found in publications that have the high standards of peer review. Accordingly, we believe that information garnered from the literature must be viewed somewhat skeptically and is not well suited, in our view, to generalization.

Second, in light of the scarcity of reliable literature, a great deal of emphasis was placed on the structured interview process. While an effort was clearly made to interview a wide spectrum of physicians, coding experts and claims processors, we question the degree to which it is possible to conduct such interviews without injecting important selection, pre-existing opinion, and timing biases into the process. For example:

- It is widely recognized that many so-called coding experts (e.g., consultants, software companies) profit by perpetuating a perception that CPT is over-complicated and vague. Similarly it is to their advantage to overstate the degree of unbundling and upcoding that exists so that they might be engaged to correct the situation. Accordingly, we believe "findings" such as those listed on page 4 cannot safely be concluded to be valid.
- You solicited the views of medical record coders, 23 individuals, 19 of whom were recommended by the American Health Information Management Association (AHIMA). As I am sure you are aware, AHIMA has formal policy positions in opposition to the continued usage of CPT in, at least, some patient settings. We seriously question the degree to which such a group of interviewees, even with the best intentions, could present a truly balanced view of the merits of CPT.
- Most of the work was done during the fall of 1992, a period in which there existed tremendous frustration and resentment among some physicians (and the national medical specialty societies) for policy decisions made by HCFA in implementing the RBRVS system, most notably the unjustifiably low conversion factor and some components of the GPCIs. Because of this, some physicians and organizations were unhappy with everything dealing with Medicare payments, coding included. Some, in fact, blamed the CPT codes for the payments that were far lower than believed appropriate. Thus any study conducted during this period, particularly one based so heavily on interviews, would certainly develop a much more negative view of CPT, than would the same study if it were being conducted today.

In sum, we believe there are important limitations in the methodology of your study. While we recognize that practicalities may have dictated your approach, we also believe those limitations should be acknowledged and taken into account when making drawing conclusions or in making recommendations.

FINDINGS

First, your study concludes that "incorrect coding affects Medicare reimbursement". We do not dispute this as surely some incorrect coding takes place and this may impact Medicare payments. Your study seems to suggest, however, that incorrect coding is inherently a fault of the CPT system and that when incorrect coding occurs that it only leads to Medicare overpayments. We suspect that where incorrect coding does occur, there may be multiple causes many of which are totally removed from the actual coding system. In addition, we know of no studies that have sought to quantify "undercoding" (although we have significant anecdotal evidence of such) and in the absence of these data, it is not possible to accurately assess the overall impact of coding accuracy on Medicare payments.

On the point of coding accuracy your study also implies that the CPT error rate is high (you cite as much as 15 or 17 percent), but this is not put in appropriate context or compared with other reporting mechanisms. A 1992 article in the Journal of the American Medical Association (JAMA), for example, reports on a study of hospital medical record coding and concludes that hospital reporting error rate (that is, errors that were large enough to cause a change in DRG assignment) "dropped" to 15 percent in 1988 from almost 21 percent in 1985. In-patient hospital coding is generally done by trained medical records professionals using the ICD-9-CM system and the end date of the study (1988) was a full five years after the DRG system went into effect. The study further concluded that, nationally, these hospital reporting errors did not result in significant overreimbursement.

Similarly, your extrapolation that between \$1 and \$6 billion in Medicare claims may have been affected by improper coding is extremely suspect. The literature used to make these assumptions is not current, does not address the issue of potential "undercoding", and the "studies" refer to so many different phenomena (e.g., medically unnecessary services, undocumented services and general coding errors) that it is impossible, with the limited information available, to attribute any precise dollar figure with coding errors. And again, coding errors, in and of themselves, do not directly imply structural problems with a coding system.

A second finding leads you to conclude that "flaws in CPT codes, guidelines and index can lead to improper coding", and provide several illustrations. Here again we do not argue with the possibility that this can occur and are always seeking ways to improve the guidelines, index etc. But we do not believe your illustrations are necessarily indicative of the alleged problems you identify and are, in most cases, no longer applicable. We offer comments on each area you identify.

Ambiguous code definitions

We agree that, prior to 1992, providers did not uniformly code levels of services for office visits, consultations and other evaluation and management services. It is for precisely that reason that the AMA invested over three years of research and study in the revision of the Evaluation and Management codes. These coding revisions were based on empirical data provided by the Harvard University team that developed the RBRVS methodology. Resulting codes were subject to extensive comment by physicians, payors and other groups and were the subject of extensive

pilot testing and training programs by the AMA, HCFA and others. Only now is literature beginning to appear that discusses these new codes. Reliance on outdated information to demonstrate "flaws" in the system can lead to an inaccurate view of CPT as it is used currently. We concur that there may be some confusion concerning the use of "arthroplasty" procedures of the toe. We will pursue the development of this issue and address it either through the CPT Editorial Panel or by publishing clarification in CPT Assistant.

The issue of laboratory "panels" has also already been addressed. In CPT 1993, the Editorial Panel eliminated the majority of disease or organ panels. The ones that remain are specifically defined as to the components that are included. Further, we have published educational materials in the CPT Assistant, pertaining to the correct use of these codes. (Copy attached)

Multiple codes that define essentially the same procedure

Again, the information in this report does not reflect current coding. In CPT 1993, with the extensive assistance of the College of American Pathologists, the Editorial Panel began the task of eliminating outmoded and duplicative codes from the laboratory section. In CPT 1994, which will be available later this month, this task will have largely been completed.

Coronary Artery Bypass grafts have also been addressed by the Editorial Panel. The codes found in the current CPT reflect the techniques being performed. We were surprised to learn that the OIG had previously "suggested that the AMA modify coding for CABG" as we were not provided with a copy of that report, nor had we been made aware that the issue was being pursued. The Editorial Panel adopted the existing codes (not the ones referred to in your draft report) only after empirical demonstration that the procedures involved significantly different amounts of physician work, while the report you cite relies on surgeon interviews prior to RBRVS. Further, it is our understanding that adoption of these new codes by HCFA will not result in any additional HCFA expenditure for CABG. Thus, we see no justification for your conclusion that a reduction in the number of codes would have saved \$5 million annually.

Endoscopic and arthroscopic procedures represent a special challenge to coding. Because of the large number of procedures that can be performed during one operative session using an endoscope, it is particularly difficult to develop an appropriate number of descriptors without compromising data quality. CPT 1994 contains a new section on sinus endoscopy and the Editorial Panel will continue to work on this issue in future years.

Codes that cover an array of significantly different levels of service

The issues listed as "problems" in this section have all been resolved. For example, the codes for diagnostic vascular testing have been significantly revised and "pocket doppler" procedures have specifically been deleted from CPT.

While we concur that the time required to perform a supratentorial craniotomy may vary, the use of the type of lesion being operated on is, in a clinical sense, a better proxy for the amount of physician time and intensity. It is not appropriate for a clinical coding system to categorize operations on the basis of time spent, as time can be impacted by many factors (e.g., training and skill of the physician, availability of assistants, individual case severity, hospital scheduling) that are not directly associated with the typical physician work involved. The code should represent a clinical description of the operation, not the time it takes to perform it.

Problems in CPT-4 guidelines and index also contribute to incorrect coding

The Panel has been working for several years to systematically replace adjectives that may have multiple meanings such as "superficial" and "deep". There are sections of CPT, however, such as the muscle groups, where such terms have specific clinical meaning and should appropriately remain.

Concerning the guidelines on hospital outpatient services, in 1987 the use of CPT was mandated by Congress for hospital outpatient use. While the Editorial Panel was not asked for its views concerning the applicability of CPT to this environment, the Panel has responded positively and quickly to issues that have been presented to it, including the publication of the hospital outpatient version of CPT. In this volume, we include specific HCFA guidelines for CPT use by hospitals. However, our ability to help HCFA transmit this information has been hampered by a lack of cooperation by the hospital coding area within HCFA. Contributing to the difficulties that hospitals experience are the HCFA reporting guidelines themselves. For example, HCFA guidelines do not permit hospitals to report modifiers, yet modifiers are an integral part of the CPT system.

You are also aware that the American Hospital Association (voting member) and American Health Information Management Association (non-voting) have had representation on the Editorial Panel for several years. The purpose of the inclusion of these groups was to specifically serve the needs of the hospital users of CPT.

Some respondents have criticized the process that AMA uses to consider changes, additions, and deletions in CPT

The CPT Editorial Panel process has been significantly revised to allow for a full range of comments from groups seeking, and those that might be affected by, coding changes. A specific appeals process has been instituted to allow for further exchange of information. All participating organizations have the opportunity to present information in writing or in person to the Editorial Panel. We are also aware that HCFA Carrier Medical Directors provide input to their HCFA representative prior to the Editorial Panel meetings. We believe our process is open, deliberate and that it contains sufficient due process safeguards. It is our belief that many groups that express dissatisfaction are those same groups that have had large code-splitting proposals turned down by the Panel in its continuing effort to provide a proper balance to coding modification.

While we cannot speak directly to many of your points concerning HCFA's internal operations, we would strongly disagree with your findings on page 13 that "HCFA has not developed an efficient or effective process for establishing RVU's for new or revised codes". Your observation that the process for assigning RVUs is still evolving is correct, but it is important to also note that many of the improvements made in the evolution of this process have been made in direct response to constructive suggestions or concerns expressed by HCFA and PPRC. AMA and HCFA staff have developed positive and productive working relationships and worked closely together to develop new procedures for gathering and reporting information on new and revised codes. As a result, the Carrier Medical Directors considered the RUC recommendations for the 1994 RVS to be considerably better than the first set, with one reviewer stating they were "a thousand times better." Likewise, HCFA has made substantial efforts to allow for more public oversight of this process. In a Proposed Rule published July 14 in the Federal Register, HCFA outlined its plans for RVS refinements for 1994 and 1995 and provided a 60-day period for public comment.

Lastly, we would disagree with your finding that a "proliferation of CPT changes will undermine HCFA's ability to contain expenditures under the Medicare Fee schedule". No relationship has been established between the number of CPT coding changes and Medicare expenditures. Your statement that RVUs for codes that were new or revised in 1992 would have increased Medicare expenditures by \$450 million is inaccurate. The expenditure increase to which you refer was due to HCFA's 1992 refinement process, which focused on the relative values assigned to existing codes and had nothing to do with changes in CPT. The relationship between CPT coding changes and Medicare expenditures is actually quite complex and is an issue that the AMA, HCFA, and RUC are continuing to explore.

The statements cited in your report regarding the types of changes being made in CPT are from a Proposed Rule that is open to comment and which has been the subject of considerable discussion within the medical community. We strongly disagree with the characterization of changes being made by CPT as simply splitting a large number of individual codes into two or more codes in an effort to circumvent the usual notice and comment process. The changes being made to CPT are generally quite complex. Whole sections may be revised and there may be many new codes added, many revisions, and a number of deletions within a section. In other cases, entire sections of CPT are deleted and a new section with new numbers and descriptors is created. HCFA has itself acknowledged that it is often difficult to predict how the old section will "crosswalk" to the new or revised section and has asked for the CPT Panel's and the RUC's assistance in this regard.

RECOMMENDATIONS

As indicated above, with one relatively minor exception, we find most of your recommendations for AMA to be appropriate and reasonable. We would, however, like to make a few observations about each.

Bryan B. Mitchell

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Recommendation #1

We agree that cooperation is necessary and are most willing to work with HCFA to disseminate information on HCFA program requirements and on coding guidelines that are consistent with those requirements. We would point out, however, that the new CPT submission forms have, inherent in them, an expanded set of coding objectives, several of which were provided by HCFA.

Recommendation #2

We will continue to pursue the issue of index refinement directly. We agree with your previous observation that coders' perceptions of the CPT index may be influenced by the level of training and experience they have acquired using CPT or other coding systems (particularly ICD-9-CM). It is our hope that those organizations or individuals that have found problems with the current index would come forward with specific suggestions for improvement and be willing to be part of the overall index enhancement process.

Recommendation #3

We agree with this recommendation concerning development of better mechanisms for transmission of national uniform Medicare coding policies and are willing to work with HCFA as appropriate. To the degree that HCFA has established national uniform Medicare coding policies, we would be pleased to enter those into our CPT Clearinghouse Data Base and inform Clearinghouse users of those policies as a way of supplementing HCFA's efforts. We would be most willing for HCFA to publish its policies, on a regular basis, in the CPT Assistant. With this being accomplished, HCFA may wish to consider identification of the CPT Assistant as the official source of CPT coding information.

Recommendation #4

We agree with this recommendation concerning the need for relative value recommendations to be accompanied by data on anticipated utilization and have already taken steps to implement it. However, we stress the fact that these utilization figures will only be estimates that may need to be revised based on actual program experience.

Recommendation #5

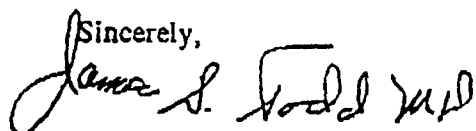
We believe that AMA and HCFA should work together to manage and plan the changes to CPT on an annual and longer term basis. We have taken preliminary steps to accomplish this. We do not believe that putting a "cap" on the number of CPT changes per year is in the best interests of the Medicare program, its beneficiaries, or of medicine. A "cap" artificially constrains improvements in the coding system, many of which in fact, are needed by HCFA to enable them to implement Congressionally mandated changes in the physician payment system.

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It is our strong belief that the relatively large numbers of changes seen in CPT in the past two years represents needed adjustments to better define physicians services and to accomplish the fundamental goals of the OBRA '89 Physician Payment Reform and will not become a permanent feature of the CPT maintenance process.

With respect to your recommendations to HCFA, we would only like to comment on the last element of your recommendation #4 concerning delay in code implementation. AMA would strongly disagree with HCFA if they sought to delay implementation of new codes pending their obtaining "reliable data" on utilization. First, we would argue that such a delay would be inconsistent with HCFA's Congressional mandate to make payment for physicians' services based on (determined) resource costs. Next, as a practical matter it is impossible to collect definitive utilization data unless physicians have the opportunity to report the code on the claim form, and third, such a delay would cause great confusion among physicians who participate in private health insurance programs where such new codes would be accepted and implemented. Here again, we believe that the best approach, with HCFA's input, is to proactively manage the number of annual coding changes and utilize the new CPT submission process to provide the best possible utilization estimates.

Thank you again for the opportunity to provide comments on your draft report. We would be happy to meet with your staff to review our comments if that would be helpful in preparation of your final report. In the event that you choose to move directly to a final report, we would appreciate your consideration of publishing our comments along with that final document.

Sincerely,


James S. Todd, MD

JST:dcl
attachments