

**Memorandum**

Date **SEP 18 1990**
From Richard P. Kusserow *Bryan Mitchell*
Inspector General *FOR*
Subject **OIG Management Advisory Report: "Medicare Prepayment Review - Prepayment Utilization Savings," OEI-07-89-01681**
To **Gail R. Wilensky, Ph.D.**
Administrator
Health Care Financing Administration

The Office of Inspector General (OIG) recently conducted a program inspection of the prepayment review process for Medicare Part B claims. One area of focus during the review was the verification of savings claimed to have been achieved by the carriers as a result of conducting medical reviews. The inspection was to determine if an audit trail existed for those claims resulting in prepayment medical review savings and whether the savings were correctly reported in the carriers' quarterly Medical Review Reports for Fiscal Year (FY) 1989. This management advisory report conveys the finding identified during the inspection.

BACKGROUND

In December 1989, the Health Care Financing Administration (HCFA) required carriers to establish an audit trail for all services denied or reduced as a result of medical review. This requirement followed a study of prepayment medical review screens by HCFA in November 1988. Carrier savings due to prepayment controls for front end medical necessity denials (Category I) and HCFA mandated and carrier initiated screens (Category II) are maintained and reported to HCFA on the quarterly Medical Review Report as provided for in the Medicare Carriers Manual, Section 7529. The HCFA uses the savings data from the quarterly Medical Review Report and the cost benefit ratios resulting from review activities to identify effective prepayment screens and as a source for contractor evaluations.

METHODOLOGY

We conducted on-site reviews at seven carriers in early 1990. We asked carriers to provide a listing of all the Category I and Category II claims used to prepare the Medical Review Report for the fourth quarter FY 1989. One carrier provided a claims listing for the first quarter FY 1990 instead, because data for the FY 1989 period was not available at the time of our review. A random sample of 30 claims were selected for review from each carrier's listing. The savings resulting from the sampled claims were then tracked to the Medical Review Report.

FINDING

Carriers have established reliable systems for reporting medical review savings.

Based on the carriers' control sheets, the review team was able to verify the accuracy of the carriers' reported savings for 192 of 195 claims. We limited our sample to 15 claims, instead of 30 claims at one carrier, because the carrier could not provide a universe of claims. Twenty-nine of the 195 sampled claims had insufficient information in the control sheets to readily establish the validity of the savings. However, upon further investigation, these claims proved to be valid.

Should there be any questions, please have your staff contact Barry Steeley at FTS 646-3138.