

**Memorandum**

Date . NOV 9 1995

From June Gibbs Brown
Inspector General *June G. Brown*

Subject Monitoring the Health Care Financing Administration's Medicare Transaction System --
Status Report (A-14-93-02543)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report on the status of the Health Care Financing Administration's (HCFA) Medicare Transaction System (MTS) initiative as of the end of December 1994. The MTS is intended to be a single, integrated claims processing system which is anticipated to be phased in, at a small number of sites, beginning in 1997 with full implementation before the end of 1999.

The results of our review indicate that HCFA has taken a number of steps to include a broad range of functions related to Medicare benefits administration within the scope of the new system. We also found that HCFA is making a concerted effort under MTS to improve internal and financial management controls over Medicare benefit payments. Some additional steps could be taken, however, to (1) assure flexibility and adaptability of the MTS design for meeting future program requirements and (2) cover certain weaknesses and limitations in current Medicare claims processing that have not yet been addressed so that these conditions are not carried over into the new system.

We are reporting our findings now to assist HCFA in its analysis of MTS requirements, planning future MTS steps, and formulating regulatory changes and legislative proposals needed for fully effective MTS implementation. It should be noted, however, that our review focused primarily on what areas HCFA is addressing through its analysis of system requirements. Our scope did not extend to evaluating the effectiveness of these requirements in meeting current and anticipated program needs.

Our involvement with MTS arose from our recommendations in an August 1992 report that dealt with long-term issues related to the Common Working File (CWF), HCFA's nationwide system for prepayment authorization of all Medicare claims. In that report, we recommended that HCFA follow a more strategically oriented approach to streamlining, consolidating, and integrating Medicare claims processing. The HCFA indicated agreement with our findings and noted that the implementation of MTS would satisfy our recommendations.

In 1992, HCFA initiated MTS by developing and releasing a Request for Proposals (RFP) for technical assistance in the design, development, and implementation of the new system. Three offerors responded to HCFA's RFP.

Based on HCFA's response to our CWF report, and because HCFA's MTS RFP indicated that the new system would control virtually all Medicare benefit payments, we began monitoring HCFA's MTS initiative in January 1993. During the preaward phase of the MTS project, we worked with HCFA staff to share several issues that we believed needed to be addressed before the award of MTS contracts for the design and independent verification and validation. At that time, we suggested that HCFA (1) more clearly and adequately define its needs and information technology requirements and (2) include claims payment and related Medicare banking functions in the scope of the MTS design. The HCFA addressed these concerns during its negotiations with the MTS offerors by (1) emphasizing the need for flexibility and expandability of the system design to accommodate emerging requirements and (2) requesting a separately priced proposal for addressing Medicare banking and payment functions should the agency choose to include these functions as part of the new system.

In January 1994, HCFA contracted with GTE Government Systems Corporation (GTE) to design, develop, and help implement MTS. The HCFA subsequently contracted with Intermetrics, Inc. for independent verification and validation of the MTS requirements, design, and computer software.

In February 1994, we identified and outlined concerns we had in 14 different areas of Medicare benefits administration involving computer edits, internal controls, and related safeguard issues so that HCFA could address them during the MTS requirements analysis phase. We then continued our monitoring efforts by evaluating the MTS workgroups' emphasis on (1) the need for a flexible and adaptable system design to help HCFA meet emerging and long-term program needs, (2) the full scope of Medicare claims processing functions--including the payment process and allied banking functions, and (3) the concerns we had previously identified.

We found that HCFA has involved a number of its most experienced managers and staff in a rigorous, top-down effort to examine virtually all aspects of day-to-day Medicare operations that will be supported by MTS and to identify ways that the administration of the program can be streamlined. So far, HCFA has identified a number of specific areas where improvements in computer edits and related safeguards are needed and has tasked various workgroups to address needed improvements in the development of MTS requirements.

We also found that HCFA has taken some steps to ensure that the functions involved in controlling electronic claims receipts and payments can be addressed by GTE in its analysis of MTS requirements. In addition, we are especially pleased that HCFA has formulated plans to replace the multiple accounting systems now being used by the

Medicare contractors with a fully integrated accounting system and to convert the accounting process for Medicare benefit payments from the current cash-draw down to an accrual basis. These steps, if carried through into MTS implementation, should significantly improve the internal controls and financial management environment in which the Medicare program operates.

At the end of the period covered by our review, however, HCFA needed to provide GTE with additional guidance on the possible course of changes to the Medicare program so that flexibility and adaptability can be built into the system design. Also, HCFA needed to address concerns in 4 of the 14 areas we had previously identified: Prospective Payment System (PPS) patient transfers, outpatient services performed during the Diagnostic Related Group (DRG) payment window, paneling of certain clinical laboratory tests, and multiple billing for ambulatory surgical center services.

We recommend, therefore, that HCFA (1) provide GTE with program and operations planning scenarios addressing issues that could have a major impact on MTS over its useful life for the contractor's use in evaluating alternative systems design and (2) cover all previously identified weaknesses and limitations in program edits and related safeguards that have not yet been addressed during the requirements analysis phase before detailed specifications are formulated.

In its response to our June 1995 draft report, HCFA concurred with our first recommendation and identified several program and operations planning documents it has already provided to GTE. In commenting on our second recommendation, HCFA reiterated positions taken in March 1995 with respect to the four remaining areas affecting program edits and related safeguards we had identified. The HCFA indicated it has evaluated the four areas and concluded that no cost-effective alternative is available at the present time with respect to two of the areas: PPS patient transfers and outpatient services performed during the DRG payment window. The HCFA indicated, however, that it has already taken action to address paneling of certain laboratory tests and has a corrective action plan to address multiple billing for ambulatory surgical center services. Because these positions were taken after the period included in the scope of our review, however, we were not able to evaluate them. We plan to assess these positions, as well as the overall effectiveness of system requirements with respect to ensuring the appropriateness and accuracy of benefit payments, as we continue our monitoring of HCFA's further planning and implementation of MTS. The full text of HCFA's comments is included as Appendix C to this report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. Copies of this report are being sent to other interested Department officials.

Page 4 - Bruce C. Vladeck

To facilitate identification, please refer to Common Identification Number A-14-93-02543 in all correspondence related to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MONITORING THE
HEALTH CARE FINANCING ADMINISTRATION'S
MEDICARE TRANSACTION SYSTEM -
STATUS REPORT**



JUNE GIBBS BROWN
Inspector General

NOVEMBER 1995
A-14-93-02543

SUMMARY

In the latter part of 1992, to achieve greater economy in, and control over, Medicare operations, the Health Care Financing Administration (HCFA) launched a major initiative called the Medicare Transaction System (MTS). The MTS is intended to be a single, integrated processing system, operated at a limited number of sites, to replace all the presently used claims processing systems and newly established Common Working File (CWF). The CWF is a national, standardized system for prepayment authorization of all Medicare bills and claims.

In January 1994, HCFA contracted with GTE Government Systems Corporation (GTE) to design, develop, and help implement MTS. The HCFA subsequently contracted with Intermetrics, Inc. (Intermetrics) for independent verification and validation of the MTS requirements, design, and computer software.

Our involvement with MTS arose from our recommendations in an August 1992 report that dealt with long-term issues related to CWF. In that report, we recommended that HCFA follow a more strategically oriented approach to streamlining, consolidating, and integrating Medicare claims processing. The HCFA indicated agreement with our findings and noted that the implementation of MTS would satisfy our recommendations. Based on this response, we began monitoring HCFA's MTS initiative in January 1993, while MTS was still in the planning phase.

This *Status Report* presents the results of our monitoring of MTS activities and issues as of the end of December 1994. It recapitulates some of our interim findings, conclusions, and recommendations provided to HCFA staff during the preaward phase of the MTS contracts and before the work of the MTS design contractor had begun. We discussed our findings on a number of occasions with HCFA staff responsible for MTS planning and implementation. We are now reporting the results of our work for HCFA's use in its ongoing analysis of MTS requirements, planning future MTS steps, and formulating new proposals for regulatory and legislative changes needed to maximize the benefits that the new system can provide. It should be noted, however, that our review focused primarily on what areas HCFA is addressing through its analysis of system requirements. Our scope did not extend to evaluating the effectiveness of these requirements in meeting current and anticipated program needs.

During the preaward phase of the MTS project, we worked with HCFA staff to share several issues that we believed needed to be addressed before the award of MTS contracts for design and independent verification and validation. At that time, we suggested that HCFA: (1) more clearly and adequately define its needs and information technology requirements and (2) include claims payment and related Medicare banking functions in the scope of the MTS design. Our preaward suggestions were based on concerns that (1) sufficient data be made available to offerors on new or emerging requirements in the Medicare program and (2) HCFA not limit the ultimate effectiveness of its streamlining, consolidation, and integration efforts by leaving an essential part of

the Medicare claims process outside the scope of MTS. The HCFA addressed these concerns during its negotiations with the MTS offerors by (1) emphasizing the need for flexibility and expandability of the system design to accommodate emerging requirements and (2) requesting a separately priced proposal for addressing Medicare banking and payment functions should the agency choose to include these functions as part of the new system.

After the award of the design contract, we outlined for HCFA staff concerns we had in 14 different areas of Medicare benefits payment administration. These areas involve computer edits, internal controls, and related safeguards in the current benefits payment process that should be addressed as requirements for the new system are being defined. The HCFA managers responsible for MTS have already tasked a number of staff-level workgroups to address 10 of the 14 areas we identified and have agreed to address the other 4 areas as MTS requirements are formulated.

As noted above, HCFA has already taken a number of steps to ensure that a broad range of functions involved in administering Medicare benefits--including those involving electronic claims receipts and payments--can be addressed by GTE. As GTE formulates and evaluates alternatives for the design of MTS, HCFA needs to ensure that the full range of potential changes in the Medicare program be known to GTE so that these possibilities can be accommodated over the life of the system. This input from HCFA is needed very soon so that (1) the sensitivity of the alternative system designs to possible programmatic changes can be clearly identified and described and (2) the level of risk posed by the need to modify or adapt MTS based on these changes can be evaluated in an effective manner. Also, HCFA needs to address several previously identified weaknesses and limitations in the current system that have not yet been covered by the workgroups so that existing problem areas are not passed on to MTS.

Therefore, we are currently recommending that HCFA:

- o provide GTE with program and operations planning scenarios addressing issues that could have a major impact on MTS over its useful life for the contractor's use in evaluating alternative system designs; and
- o cover all previously identified weaknesses and limitations in computer edits and related safeguards that have not yet been addressed during the requirements analysis phase before detailed specifications are formulated.

As we continue our monitoring of the MTS initiative, we plan to review the overall effectiveness of system requirements affecting the appropriateness and accuracy of benefit payments. We also plan to assess the progress of HCFA and its MTS contractors in analyzing and evaluating alternative design approaches for meeting current and anticipated program needs.

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INTRODUCTION

BACKGROUND

The Medicare program, authorized by title XVIII of the Social Security Act as amended (Act), helps pay medical costs for about 33 million people aged 65 years and older, as well as for 4 million people with disabilities. The HCFA, within Department of Health and Human Services (HHS), administers the two Medicare trust funds: Medicare Health Insurance (HI) and Supplementary Medical Insurance (SMI). The HI trust fund finances benefits under Medicare Part A, which may be provided by inpatient hospitals, skilled nursing facilities (SNF's), home health agencies (HHA's), and hospices. The SMI trust fund finances medical services under Medicare Part B, which include services from physicians, hospital outpatient departments, durable medical equipment (DME) suppliers, and various other suppliers of health services such as clinical laboratories (labs), ambulances services, diagnostic testing, and x-ray services.

From the inception of the Medicare program, fiscal intermediaries (FI's), under agreements authorized by section 1816 of the Act, have paid and assisted HCFA in the administration of Medicare benefits related to health services received by beneficiaries from institutional providers (e.g., inpatient hospitals, hospital outpatient departments, and SNF's). At the same time, carriers, under contracts authorized by section 1842 of the Act, have performed similar functions for services received by beneficiaries from physicians and other suppliers of Medical services and equipment (e.g., labs and DME suppliers). Collectively, FI's and carriers are referred to as Medicare contractors. In Fiscal Year 1994, HCFA expended more than \$1.5 billion to have these contractors pay nearly 614 million Medicare claims in excess of \$147 billion.

The HCFA promotes the timely and economic delivery of covered health care services to entitled and eligible Medicare beneficiaries; promulgates beneficiary awareness of, and access to, these services; and pursues efficiency and quality within the total health care delivery system. Among HCFA's primary objectives are the management, processing, and payment of Medicare claims in the most appropriate and cost-effective manner possible.

CURRENT MEDICARE CLAIMS PROCESSING ENVIRONMENT

Since the early 1980's, HCFA has sought to improve the processing of Medicare claims by fostering increased use of electronic claims submission by health institutions, medical providers, and suppliers. Claims processing costs associated with computer software changes have continued to increase, however, partially due to the greater frequency of program changes mandated by the Congress. At the same time, funds needed for Medicare operations have been limited due to an extended period of budget austerity.

To help control claims processing costs, HCFA pursued a strategy to reduce the number of systems used in Medicare claims processing. For example, HCFA consolidated Medicare contractor processing systems and sites under its Shared Systems and Shared Processing initiative and implemented a national system for prepayment authorization of all Medicare bills and claims--CWF--in 1990.

Despite these efforts, the Medicare claims processing environment today remains fragmented. More than 60 computer sites operated by Medicare contractors receive, edit, authorize, adjudicate, and pay Medicare Part A bills and Part B claims using at least 14 different Shared Systems and CWF. Each of the Shared System maintainers¹ and the CWF National Maintenance Contractor² is responsible for the implementation of all software changes needed to meet HCFA's requirements and for distributing systems documentation and software to its user processing sites. National data is maintained only at the HCFA Data Center (HDC) in Baltimore.

This fragmentation of systems and processing has, at times, resulted in (1) extended implementation times for upgrades and enhancements, (2) limits in the effective use of available technologies resulting from the high cost for conversion and/or transition, (3) inconsistencies in claims adjudication, and (4) constraints on gathering quality data for managing the Medicare program.

FUTURE DIRECTIONS IN MEDICARE CLAIMS PROCESSING--THE MEDICARE TRANSACTION SYSTEM

Recognizing these limitations in the current claims processing environment, in the early 1990's HCFA began to formulate new strategies to improve its Medicare computer systems. At the same time, HCFA continued to examine ways to (1) increase Medicare administrative efficiencies, (2) achieve greater uniformity in program operations, (3) improve controls over program expenditures, (4) improve its ability to identify and deter program fraud and abuse, and (5) improve the level of service to its beneficiaries and providers.

Central to HCFA's strategy is an initiative to implement MTS. The MTS will be a national, integrated processing system, to be operated at a limited number of sites, that will replace all the shared systems and CWF. The HCFA expects MTS to shorten implementation time for legislative and administrative changes and improve HCFA's capability to monitor benefit payments. The new system is anticipated to be phased in, at a small number of sites, beginning in 1997 with full implementation before the end of 1999.

In 1992, the HCFA issued a Request for Proposals (RFP) to procure services for the analysis, design, development, validation, implementation and maintenance of MTS. In the beginning of 1994, HCFA competitively awarded an 18 million, 6-year contract to GTE--one of three offerors responding to its RFP--for MTS design, development, implementation assistance, and software maintenance. Subsequently, HCFA competitively awarded another \$3 million contract to Intermetrics for independent verification and validation of the MTS requirements, design, and computer software to help assure itself that the new system will meet its needs. (See Exhibit 1.)

Early in 1993, while the MTS contract awards were still in progress, HCFA established 11 workgroups to analyze overall Medicare contractor and claims processing functions. Input from these workgroups was needed to tie residual functions of the Medicare contractors into the MTS design and to ensure a smooth transition into the MTS operating environment. In July 1994, HCFA reorganized and expanded the original 11 workgroups into 24 MTS Needs and Requirements Workgroups to assist GTE prior to the system requirements analysis phase. (The nature and scope of assignments given to the MTS Needs and Requirements workgroups are summarized in table form at Appendix A.)

The GTE is currently in the requirements analysis phase of its MTS contract. The objectives of this phase call for the validation of agency needs, evaluation of alternative concepts to satisfy these needs, exploration of alternatives, and determining the course of action to be pursued. In conjunction with HCFA's efforts to identify improvements and enhancements for the new system, the design contractor is responsible for defining current baseline requirements (i.e., detailed functional specifications covering existing operations) by (1) analyzing some of the existing shared systems to identify the functions they perform and how they are performed and (2) matching requirements derived from the shared systems with those identified in the HCFA Business Function Model--a comprehensive set of narratives and descriptions defining HCFA's business processes. In addition, GTE is responsible for rounding out the requirements baseline and documenting future systems requirements through interviews with Medicare contractor personnel and HCFA staff.

The requirements analysis phase of MTS is now scheduled for completion by November 1995. By that time, most of the key decisions affecting the design of the new system will have already been made.

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. We undertook this assignment as part of the Office of Inspector General's (OIG) oversight responsibility for Medicare program operations and as a continuation of our efforts, begun in the 1980's, to help HCFA foster a more streamlined and efficient Medicare claims processing environment. This *Status Report* presents the results of our monitoring of MTS activities and issues and covers the period beginning in January 1993 through the end of December 1994. In March 1995, we shared a working draft of this report with HCFA staff for purposes of discussion and obtaining comments or suggestions on content and presentation. We are reporting our findings now to assist HCFA in its analysis of MTS requirements, planning future MTS steps, and formulating regulatory changes and legislative proposals needed for fully effective MTS implementation.

In a prior report which dealt with long-term issues related to CWF,³ we recommended that HCFA needed to follow a more strategically oriented approach to streamlining, consolidating, and integrating Medicare claims processing. The HCFA indicated agreement with our findings and noted that the implementation of MTS would satisfy our recommendations. Based on HCFA's response, and because it is intended to control virtually all Medicare benefits payments, we began monitoring HCFA's MTS initiative in January 1993, while it was still in the planning phase. While we discussed our findings as we progressed with HCFA staff responsible for MTS planning and implementation, we did not issue formal reports because (1) some of our findings covered issues related to procurements in progress which could only be handled in a timely manner through discussion and (2) other findings related to issues of health care and Medicare reforms that were actively being considered by the Congress for which the outcome could not be predicted.

We did, however, share two draft internal documents with HCFA staff for their review and for purposes of discussion. In the first, dated June 1993, we presented a summary of results from our monitoring efforts covering the period prior to the award of the MTS design contract. The objectives addressed in the June 1993 draft were to (1) evaluate whether HCFA sufficiently addressed all critical factors in project planning before awarding contracts to support the design and development of the MTS and (2) identify any vulnerabilities in the planning process. To accomplish these objectives, we used the General Accounting Office's (GAO) audit guide for assessing acquisition risk.⁴ We reviewed applicable laws, regulations, and HHS instructions, guidelines, procurement documents and correspondence; the MTS Request for Proposals; and prior HCFA, OIG, and GAO reports related to major system acquisitions.

In February 1994, we provided a second internal document to HCFA--a draft staff paper which outlined previously reported deficiencies and limitations in the overall administration of Medicare benefits, claims processing, and Medicare financial

management that could be addressed through improved internal systems controls, computer edits, or related safeguards. We intended that the February 1994 draft document be a resource for HCFA staff to use during the analysis of MTS requirements. The HCFA management did, in fact, include it in the set of materials provided to the applicable Needs and Requirements workgroups.

We continued our monitoring by evaluating the MTS workgroups' emphasis on (1) the need for a flexible and adaptable system design to help HCFA meet emerging and long-term program needs, (2) the full scope of Medicare claims processing functions--including the payment process and allied banking functions, and (3) the deficiencies and limitations identified in the February 1994 OIG draft document referenced above.

In order to accomplish these objectives, we obtained and reviewed documentation on the MTS Needs and Requirements workgroup assignments to determine the status of actions taken to address previously identified OIG concerns. We focused primarily on evaluating (1) the assumptions and constraints established for the MTS Needs and Requirements workgroups and (2) the nature and extent of the assignments given to these workgroups. Our scope did not extend, however, to evaluating the effectiveness of the MTS requirements, themselves. Where it was not clear what the workgroups were tasked to do, we went a step further by reviewing additional documentation, such as the detailed reports prepared by the workgroups.

Furthermore, at HCFA's request, we participated--albeit to a limited extent due to staffing and resource limitations--on 1 of the original MTS workgroups and on 3 of the 24 MTS Needs and Requirements Workgroups. As part of this effort, we: (1) provided detailed input for consideration by HCFA in the formulation of accounting and financial management requirements, (2) indicated our concerns for improvements in program safeguards against payments to sanctioned providers, and (3) suggested refinements in cost-reporting and reconciliation of cost and billing data. We also provided technical comments and issued two reports^{5,6} which offered extensive input for HCFA's consideration in the establishment of controls within MTS over EDI in general and specifically related to electronic billing and payment.

The objectives of our review did not require that we perform a review of internal controls. We performed our field work primarily at HCFA headquarters in Baltimore, Maryland during the period January 1993 through February 1995. Additional field work applicable to our findings and recommendations is described in the OIG reports cited in the *Endnotes*.

RESULTS OF REVIEW

Our monitoring of the MTS initiative found that HCFA has taken a number of steps to ensure that a broad range of functions involved in administering Medicare benefits--including those involving electronic claims receipts and payments--can be addressed as part of the analysis of requirements for the new system. Before awarding the MTS design contract to GTE, HCFA emphasized the need for flexibility and expandability of the system design to accommodate emerging requirements. The HCFA also requested a separately priced proposal for addressing Medicare banking and payment functions should the agency choose to include these functions as part of the new system.

We also found that, since awarding the MTS contracts to GTE and Intermetrics, HCFA has made a concerted effort to improve the administration of Medicare benefits and processing of Medicare claims through implementation of the new system. The HCFA has involved a number of its most experienced managers and staff in a rigorous, top-down effort to examine virtually all aspects of day-to-day Medicare operations that will be supported by MTS and to identify ways that the administration of the program can be streamlined. The HCFA has also solicited our views on current problems and future issues as a basis for analyzing requirements for the new system.

So far, HCFA has identified a number of specific areas where improvements in computer edits and related safeguards are needed and has tasked various workgroups to address needed improvements in the development of MTS requirements. Of particular note is HCFA's decision to establish separate MTS workgroups to address issues of program edits, electronic claims controls, enforcement of Medicare secondary payer (MSP) provisions, and vulnerabilities of Medicare claims processing and payment to fraud and abuse. We are especially pleased that HCFA has also formulated plans to replace the multiple accounting systems now being used by the Medicare contractors with a fully integrated accounting system and to convert the accounting process for Medicare benefit payments from the current cash-draw down to an accrual basis. These steps, if carried through into MTS implementation, should significantly improve the internal controls and financial management environment in which the Medicare program operates.

Some additional steps could be undertaken, however, to ensure the effectiveness of MTS in addressing future, as well as current, Medicare requirements. To ensure that the design of the system will be flexible enough to accommodate future program and operational changes, HCFA needs to make GTE aware of the range and scope of program policy and administrative changes possible over the next 10-15 year life of the system. The GTE needs this information so that flexibility and adaptability can be built into the system design. Also, HCFA needs to address several previously identified weaknesses and limitations in the current system that have not yet been covered by the workgroups so that existing problem areas are not passed on to MTS.

THE MTS DESIGN SHOULD BE FLEXIBLE AND ADAPTABLE TO MEET CURRENT, EMERGING, AND FUTURE NEEDS

According to GAO,⁴ risk assessment is the process of identifying potential risks in a system under development and determining the significance of each risk in terms of its likelihood and impact on the acquisition cost, schedule, and ability to meet the agency's needs. Risk assessments may have their greatest impact if carried out early, when acquisition plans and strategy to manage and control the identified risks can more easily be altered. Failure to clearly and accurately define information technology requirements poses high risk of technical failures, unmet user needs, cost overruns, and schedule delays.

In June 1993, before the MTS design and independent verification and validation contracts were awarded, we expressed our concerns to HCFA that some critical factors in project planning to support the design and development of MTS needed to be addressed. In particular, we noted that HCFA needed to give bidders more clear and complete information for the purpose of scoping their MTS proposals, primarily because of the uncertainty surrounding some of the issues that might affect the scope of the systems design, such as health care reform.

In an effort to provide bidders with clearer and more complete data, HCFA, in its negotiations with MTS offerors, emphasized the need for flexibility and expandability of the system design to accommodate emerging requirements. Since GTE and Intermetrics were to have addressed this need in their best and final proposals, HCFA has some basis for moderating the level of resources proposed by the MTS contractors in future negotiations of contract changes.

The HCFA has not yet provided information in sufficient detail, however, to enable GTE and Intermetrics to fully assess the viability of alternative MTS designs to major changes in requirements that might occur during their periods of performance. For example, substantive changes in the (1) nature, volume, and geographic point of origin of transactions or (2) degree of interconnectivity needed with other computer systems and data communications networks could materially affect the choice of an MTS design alternative for implementation. If such changes were to be necessary after a design decision has been made, significant rework costs to alter the basic design of the system to accommodate them--beyond the incremental costs of the changes, themselves--may be incurred.

Furthermore, since HCFA intends for MTS to have a useful life of 10 to 15 years, it is essential that the design of the system be flexible and adaptable to accommodate changes in requirements over that span of time. Otherwise, the benefits of shorter timeframes for implementation of systems changes when required by law (e.g., eligibility criteria, scope of coverage, or payment methodologies) or Administration policy (e.g., benefits administration or program oversight) are not likely to be realized.

The HCFA staff already plan to develop a series of program scenarios describing the range of possible changes they foresee in the Medicare program and have discussed with us the advisability of sharing these scenarios with the MTS design contractor. Because the continuity of Medicare program operations may ultimately depend on the capability of the MTS design to accommodate change, we support HCFA's sharing and discussing the full range of possible changes that are expected to occur in the Medicare program with its design contractor.

Accordingly, use of these scenarios as a key input in the analysis of alternatives would afford HCFA with the opportunity to have GTE evaluate--and Intermetrics independently review--the capability of each design alternative to accommodate a broad range of possible program changes. Furthermore, by eliciting formal analyses from GTE and Intermetrics on the effects of potential program changes on the MTS design early in the life of the project, HCFA would be in a much better position to evaluate the reasonableness and viability of proposed MTS contract changes later on. And, by making it clear to GTE and Intermetrics that their analyses of alternatives might influence the nature and extent of future contract changes, HCFA, GTE, and Intermetrics would all likely come to a fuller realization of risks and limitations associated with each design alternative considered.

Thus to ensure the flexibility and adaptability of the MTS design and reduce the risk of future rework costs, we believe that HCFA should proceed with (1) providing its design contractor--before the analysis of alternatives called for in the contract--with a set of broadly described future program and operating scenarios generally agreed to by HCFA management and the Administration and, to the extent possible, reflecting the Congress' thoughts; and (2) direct GTE to evaluate--and Intermetrics to independently review--the sensitivity of each MTS design alternative to these scenarios and to base design recommendations, at least in part, on the results of the sensitivity analysis.

We recommend, therefore, that HCFA provide GTE with program and operations planning scenarios addressing issues that could have a major impact on MTS over its useful life for use in evaluating alternative system designs.

HCFA's Comments on OIG Recommendation

The HCFA agreed with this recommendation and indicated that, since December 1994, it has provided GTE with several program and operations planning scenarios such as: the telecommunications and volumetric studies that address substantive changes in the nature, volume, and geographic point of origin of transactions expected under MTS; a "Medicare Target Scenario" document which includes HCFA's vision of Medicare operations in the year 2005; and an "MTS Operating Capability" document which defines HCFA's expectations concerning the functionality of MTS from day one and when MTS is fully transitioned. (See Appendix C.)

REMAINING IDENTIFIED WEAKNESSES IN CLAIMS PROCESSING SHOULD BE ADDRESSED DURING THE MTS REQUIREMENTS ANALYSIS PHASE

The HCFA has already made good progress in considering known weaknesses and limitations in current claims processing as part of its effort to define future system requirements. Of the 14 areas we presented to HCFA in February 1994, 10 have already been assigned to the MTS Needs and Requirements workgroups for their analysis. (See Appendix B.) We believe, however, that the four areas described below also need to be addressed as the analysis of MTS requirements proceeds:

Prospective Payment System Patient Transfers We previously identified \$8.4 million in overpayments⁷ which occurred because Medicare claims for 6,616 transfers between prospective payment system (PPS) hospitals were erroneously reported and paid as discharges.

Normally, Medicare payments for discharges are higher than payments for transfers. In a follow-up review we determined that, while a system edit detects most overpayment situations, it does not detect transfers that are improperly coded as discharges to hospitals, or distinct parts of hospitals, which are not participating in PPS. We estimated that correction of this problem will result in future annual savings of \$8.1 million per year.

In our February 1994 draft document, we stated that, as part of the MTS system requirements definition process, HCFA should determine what changes in data reporting and editing are needed to prevent payment of patient transfers as discharges. We also suggested that HCFA consider establishing computer edits that check all patient discharges against readmissions to help ensure that the patient transfers are

properly recognized as such by the system and are not paid as discharges. The HCFA has not yet taken action to address this issue.

**Diagnosis Related
Group Payment
Window**

A recent OIG review showed that approximately \$8.6 million in improper billings and subsequent payments for nonphysician outpatient services were made to hospitals under PPS for the period November 1990 through December 1991.⁸ These payments were improper because they were for services rendered within a 72-hour window of a subsequent hospital admission, associated with the outpatient services by diagnosis related group (DRG). Under PPS, such outpatient services should not be paid for separately, but rather as part of the DRG rate. Furthermore, in earlier reviews, we reported^{9,10} that inadequate FI computer system edits and procedures to properly administer payment for outpatient services provided within the DRG payment window--and the lack of evaluation of these edits--constituted an internal control weakness that led to millions of dollars in overpayments for nonphysician services.

In February 1994, we suggested that HCFA consider using MTS to identify and track potential improper payments by implementing computer edits for outpatient related services rendered within the DRG payment window. Our results since then⁹ indicate that HCFA needs to implement more sophisticated edits and controls to prevent separate payment for admission-related, nondiagnostic outpatient services rendered within the window. Based on our monitoring of MTS and discussions with HCFA officials, however, it appears that the DRG payment window issue has not been addressed in the MTS workgroup assignments.

Clinical Laboratories A recently completed OIG review¹¹ showed that the Medicare Part B program (through FI's for outpatient department services and carriers for physician-ordered tests) is paying single-test payment rates for chemistry tests commonly performed on automated laboratory equipment. This results in unnecessary increased costs to the Medicare program. Single-test payment rates are paid because HCFA's guidelines regarding chemistry tests subject to paneling have not been updated to add tests as laboratory technology has advanced. Our review identified 10 tests which are appropriate for paneling, but are not on the list of chemistry tests that should be paneled. Savings to the Medicare program would be about \$216 million annually if the 10 tests identified were included as panel tests nationwide. The HCFA, however, agrees that only 8 of the 10 tests should be added to the national list of chemistry tests to be paid as part of the panel rate. We estimate that paying for these 8 tests only as part of the panel rate would save Medicare \$130 million annually.

We believe that the MTS requirements analysis phase now presents HCFA with the opportunity to (1) update the national list of chemistry tests subject to paneling as laboratory technology advances and (2) establish requirements for computer edits so

that tests which should be paid as part of a panel rate are not paid for individually. So far, HCFA has not pursued this opportunity.

Outpatient Surgical Services

In our February 1994 draft document, we discussed two OIG reviews related to hospital outpatient surgical services where we had identified (1) an overstated ambulatory surgical center payment amount due, in part, to insufficient edits in the FI systems to properly account for facility charges when multiple claims are submitted for a single 1-day surgery¹² and (2) procedure coding differences between the hospital outpatient department and the physician for the same 1-day surgery.¹³ At that time, we indicated that HCFA needed to (1) look at how application controls for processing outpatient claims could be strengthened as part of the analysis of requirements for MTS and (2) improve the correlation of data from the hospital outpatient department and the physician to ensure consistent and appropriate payment across Medicare Part A and Part B for outpatient services.

While HCFA has taken some action to address correlation of data between the hospital outpatient department and the physician, HCFA has still not committed itself to establishing computer edits to account for facility charges when multiple claims are submitted for 1-day surgery. Because our previous review identified overpayments due to insufficient edits in the FI systems to properly account for facility charges, we believe that this issue should be addressed in the MTS requirements.

We discussed the above areas with HCFA officials. They recognize that not all relevant issues were addressed in the workgroup assignments and agreed to address all relevant issues during the requirements analysis phase. We believe that it is critical that the identified problems be effectively addressed in a timely manner so that they are not carried over into the new system.

We recommend, therefore, that HCFA cover all previously identified weaknesses and limitations in computer edits and related safeguards that have not yet been addressed during the requirements analysis phase before detailed specifications are formulated.

HCFA's Comments on OIG Recommendation

The HCFA's comments have not changed since its response to our March 1995 working draft when it stated that:

- o The MTS Edits and Exceptions Workgroup has reviewed the need to develop edits to address *PPS patient transfers*. Because the National Uniform Billing Committee denied HCFA's request for an additional code to double check the transfer/discharge designation, HCFA decided that any other method would not be cost-effective. The HCFA has indicated that MTS would have the ability to edit all patient discharges against admissions to another acute care facility.
- o The MTS Edits and Exceptions Workgroup discussed how *outpatient bills for services rendered within the DRG payment window* should be handled. The workgroup concluded that exhaustive editing to better identify cases where the window would apply is not cost-effective, even if automated.
- o The *clinical laboratories* area was addressed. The HCFA Bureau of Program Operations has already prepared manual and edit changes to bring FI lab edits for automated multichannel tests in line with OIG recommendations.
- o The *outpatient surgical services* area was also addressed. The HCFA has a corrective action plan which requires that instructions be given to the FI's for edits to prevent acceptance of ambulatory surgical center bills subsequent to the original claim.

Because HCFA's positions in these areas were taken after the period included in the scope of our review, we were not able to evaluate them. We do plan to examine these areas further, along with the issue of overall effectiveness of system requirements affecting appropriateness and accuracy of benefit payments, as we continue our monitoring of MTS.

AREAS OF FUTURE AUDIT EMPHASIS

In addition to assessing the effectiveness of planned computer edits and related safeguards affecting benefit payments, we plan to review the progress of GTE and Intermetrics in accomplishing their contracted MTS tasks. And, we want to determine how other current and anticipated program needs are being addressed by these contractors and HCFA during the MTS requirements analysis and system design phases.

INDEPENDENT VERIFICATION AND VALIDATION

Verification is the process of evaluating a system or component to determine whether the products of a given development phase satisfy the conditions imposed at the start of that phase (e.g., determining whether computer program specifications are consistent with the overall system design and whether the computer programs themselves are coded in conformance with programming specifications). *Validation* is the process of evaluating a system or component during or at the end of the development process to determine whether it satisfies specified requirements (i.e., does the end product meet the user's stated needs.) The application of these processes to systems development in Federal systems is addressed in Federal Information Processing Systems Publication 101, *Guideline for Lifecycle Validation, Verification, and Testing of Computer Software* (June 8, 1983). It is generally recognized that, in order to be effective, verification and validation responsibilities should be organizationally independent (technically, managerially, and financially) from those of design and development. The practice of contracting for *independent verification and validation* in large systems projects originated with the Department of Defense and spread through the Federal sector during the 1980's. Typically, the cost for independent verification and validation can run as much as 30 percent of the development cost, primarily because of the separation of duties of independent verification and validation staff and their limited access to system designers and developers.

APPENDICES

APPENDIX A

SCOPE OF THE MTS NEEDS AND REQUIREMENTS WORKGROUP ASSIGNMENTS

IN JULY 1994, THE MTS ANALYSIS TEAM, CHARTERED BY HCFA MANAGEMENT TO PROVIDE GTE WITH A FRAMEWORK FOR DEVELOPMENT OF MTS REQUIREMENTS, RECONSTITUTED THE ORIGINAL SET OF 11 MTS WORKGROUPS (WHICH HAD BEEN ESTABLISHED TO ANALYZE MEDICARE CONTRACTOR AND CLAIMS PROCESSING FUNCTIONS) INTO 24 MTS NEEDS AND REQUIREMENTS WORKGROUPS. EACH OF THE 24 WORKGROUPS HAS BEEN GIVEN A DISTINCT AREA OF RESPONSIBILITY BY THE MTS ANALYSIS TEAM FOR WHICH IT MUST FIRST RESOLVE OPEN ISSUES OF SCOPE (THE RANGE OF FUNCTIONS THAT THE NEW SYSTEM WILL SUPPORT), FUNCTIONALITY (HOW THESE FUNCTIONS WILL BE SUPPORTED) AND INTERNAL CONTROLS (HOW SIGNIFICANT RISKS - SUCH AS SYSTEMS SECURITY IN PAPERLESS, OPEN SYSTEMS PROCESSING ENVIRONMENT - WILL BE DEALT WITH). BASED ON HOW THESE ISSUES ARE RESOLVED, THE WORKGROUPS ARE TO THEN IDENTIFY AND DEFINE FUTURE SYSTEM REQUIREMENTS. ONCE THE INDIVIDUAL WORKGROUP PRODUCTS HAVE BEEN REVIEWED BY HCFA MANAGEMENT AND OVERLAPPING AND/OR CROSSCUTTING ISSUES BETWEEN THE WORKGROUPS HAVE BEEN RESOLVED, THE FINAL WORKGROUP PRODUCTS WILL BE GIVEN TO GTE AS A PRIMARY BASIS FOR THE REQUIREMENTS ANALYSIS PHASE OF THE MTS EFFORT.

THE TABLE SHOWN IN THIS *APPENDIX* PROVIDES A DESCRIPTION OF THE NATURE AND SCOPE OF ASSIGNMENTS FOR EACH OF THE 24 MTS NEEDS AND REQUIREMENTS WORKGROUPS.

APPENDIX A--MTS NEEDS AND REQUIREMENTS WORKGROUP ASSIGNMENTS

NAME OF MTS WORKGROUP	SCOPE OF MTS WORKGROUP ASSIGNMENT
1. Beneficiary Enrollment	<ul style="list-style-type: none"> ○ Review and analyze issues relating to beneficiary entitlement and eligibility, including premium collection, end stage renal disease method selection, hospice election, and managed care plan election. ○ Determine the availability of data elements needed to satisfy program, payment, inquiry, management, and reporting needs. ○ Review and analyze the requirements underlying the various beneficiary data files--maintained at Social Security Administration, HCFA, CWF, and the local contractors in the current environment--and recommend the extent to which duplicate files and processing can be eliminated under MTS. ○ Determine how the data should be maintained to ensure its ongoing validity under MTS. ○ Determine the enrollment/eligibility data elements that should be released to providers, other health payers, and other potential users on a national basis. ○ Determine the role of MTS in the tracking of premium payments, collection of premium arrearages from entitlement payments, or in the suspension of entitlement for failure to pay premiums.
2. Provider Enrollment/Data	<ul style="list-style-type: none"> ○ Develop action plan and build new a national enumeration system for health care providers. ○ Review and analyze issues relating to provider-specific data necessary for Medicare claims processing and cost report processing--including but not limited to pricing variables, various fraud and program monitoring indicators, and administrative data (such as address and ownership data)--to be housed in or separate from the Medicare provider database. ○ Build the Medicare provider database with government resources, or work with GTE, FI's, and carriers to establish and enter applicable data into the provider database. ○ Define future processes and data requirements for local contractors to follow in enrolling, verifying and certifying health care providers in the Medicare program. ○ Determine what data elements are required to respond to program, payment, inquiry, management, and reporting needs related to provider enrollment.

APPENDIX A--MTS NEEDS AND REQUIREMENTS WORKGROUP ASSIGNMENTS

NAME OF MTS WORKGROUP	SCOPE OF MTS WORKGROUP ASSIGNMENT
<p>3. Claims Control, Management, Determination and Electronic Data Interchange</p>	<ul style="list-style-type: none"> ○ Develop procedural and data requirements relating to receipt, control, front-end editing, tracking, and routing of hard-copy and EMC claims, including no-pay bills. ○ Develop procedural and data requirements relating to maintenance of claims history, establishment of claims audit trails and storage of hard-copy and EMC claims. ○ Develop requirements to protect the security and confidentiality of claims-related data, and provide contingency planning for emergency processing, backup and recovery in the event of a disaster or interruption to normal operations. ○ Address issues related to processing/application of prices, deductibles, coinsurance, interest, offsets, and other additions/deletions to claims payment amounts. ○ Define the EDI vision for MTS. ○ Work with health payer standards bodies to develop health care EDI transaction standards and convey those standards to the MTS design contractor. ○ Analyze control environment for EMC claims. ○ Determine requirements/incentives for local contractors to maintain or increase levels of EMC ○ Determine what data elements are required to respond to program, payment, inquiry, management, and reporting needs. ○ Determine the claims processing status or other data elements that should be released to providers or their billing agents, or other potential users.
<p>4. Adjustment Processing</p>	<ul style="list-style-type: none"> ○ Review and analyze all adjustment processing requirements (including PRO adjustments) to identify deficiencies and/or inefficiencies in current processes. ○ Analyze and develop the adjustment processing capabilities of the future MTS system, for example: <ul style="list-style-type: none"> --Automatic adjustment of all claims affected by an action. --Automatic benefit coordination of adjustment actions. --Needed audit trails and storage of records on adjustments.

APPENDIX A--MTS NEEDS AND REQUIREMENTS WORKGROUP ASSIGNMENTS

NAME OF MTS WORKGROUP	SCOPE OF MTS WORKGROUP ASSIGNMENT
5. Edits and Exceptions Processing	<ul style="list-style-type: none"> ○ Review and analyze GTE "current logical model" to ensure that all current requirements relating to claims editing and the processing of exceptions would be fully considered. ○ Develop a "master list" of all required edits, both current and future. ○ Coordinate with other workgroups to identify and define all exceptions processing requirements.
6. Pricing/Interim Rates/Pass-Throughs	<ul style="list-style-type: none"> ○ Review and analyze GTE "current logical model" to ensure that all current requirements relating to claims pricing algorithms and the determination and execution of interim rates and pass-throughs are fully considered. ○ Develop action plan for "scrubbing" contractor pricing data and transporting pricing operations to the MTS environment. ○ Analyze and identify data requirements needed from MTS system by FI's to develop interim rates and make pass-through payments.
7. Appeals	<ul style="list-style-type: none"> ○ Review and analyze issues relating to individual claims appeals under the MTS. ○ Review and analyze current administrative processes for handling appeals (including HMO and PRO appeals) to identify opportunities for standardization of processes. ○ Identify types of appeals-related information to be housed in MTS. ○ Identify new methods for tracking appeal activity through MTS and new methods for reporting on trends in appeals through analysis of appeal-related information maintained in MTS.
8. Budget and Administrative Costs	<ul style="list-style-type: none"> ○ Analyze options for future budget development and execution methodologies. ○ Develop design requirements for MTS to support budget development.

APPENDIX A--MTS NEEDS AND REQUIREMENTS WORKGROUP ASSIGNMENTS

NAME OF MTS WORKGROUP	SCOPE OF MTS WORKGROUP ASSIGNMENT
9. Debt Collection Procedures	<ul style="list-style-type: none"> ○ Analyze issues relating to debt collection procedures, suspension of payments, etc., and identify opportunities for standardization. ○ Ensure that overpayment tracking and management data needs are fully identified and incorporated into the MTS system. ○ Ensure that all accounting data and transactions related to debt collection activities are identified and built into core accounting system.
10. Provider Statistical and Reimbursement/Cost Reports	<ul style="list-style-type: none"> ○ Analyze current/future system process and data support to cost reporting, audit and settlement function. ○ Analyze whether functionality of various systems (i.e., STAR, HCRIS, etc.) should be incorporated into the MTS software. ○ Analyze issues related to cost report appeals.
11. Medical Review, Fraud and Abuse, and Quality of Review/ Improvement: Data and Systems Needs	<ul style="list-style-type: none"> ○ Analyze data needs for medical review, fraud and abuse, and Peer Review Organization quality review. ○ Develop MTS requirements relating to profiling, trend analysis, etc.
12. Medical Review Procedures	<ul style="list-style-type: none"> ○ Analyze current/future medical review (MR) case processing requirements. ○ Analyze issues involved in standardizing MR edits and parameters used to establish local MR edits.
13. Fraud and Abuse Procedures	<ul style="list-style-type: none"> ○ Analyze current/future system support requirements for fraud case handling and processing. ○ Analyze issues and identify requirements relating to abuse monitoring.
14. Quality Assurance and HCFA Oversight	<ul style="list-style-type: none"> ○ Analyze quality assurance (QA) system issues and develop future system internal QA requirements. ○ Analyze issues relating to defining new basis for contractor management in the MTS environment.

APPENDIX A--MTS NEEDS AND REQUIREMENTS WORKGROUP ASSIGNMENTS

NAME OF MTS WORKGROUP	SCOPE OF MTS WORKGROUP ASSIGNMENT
15. Coordination of Benefits	<ul style="list-style-type: none"> ○ Analyze issues relating to Medicare secondary payer process and data requirements. ○ Develop action plan for building coordination of benefits system and databases in future MTS system. ○ Analyze issues relating to crossover claims processing and data requirements.
16. Customer Information Needs	<ul style="list-style-type: none"> ○ Analyze customer (beneficiary, provider and payer) needs for information from MTS. ○ Identify and analyze issues relating to support of inquiry response functions. ○ Review and recommend types of customer inquiries (written, telephone and electronic) to be tracked and/or counted in MTS. ○ Identify the potential information needs of beneficiaries, providers, payers and other Federal health insurance programs who have the potential to be supported by the MTS. ○ Define standard action codes for logging in correspondence and tracking correspondence.
17. Public Relations	<ul style="list-style-type: none"> ○ Analyze contractor outreach and provider training issues in the MTS environment, and other public relations activities carried out by Medicare contractors. ○ Identify information that could be held in MTS to support public relations activities.
18. Jurisdiction	<ul style="list-style-type: none"> ○ Inventory and analyze all current jurisdiction rules and how various workload categories depend on them. ○ Identify, analyze and recommend possible improvements to Medicare processing in the MTS environment that could result from modification of jurisdiction rules. ○ Analyze impact on workload distribution of various jurisdiction scenarios.
19. Accounting System	<ul style="list-style-type: none"> ○ Identify, analyze and define process, data and transaction requirements for the accounting system to be built into MTS. ○ Ensure that deficiencies in current financial reporting are addressed to facilitate full compliance with the Chief Financial Officers Act of 1990 and the Federal Managers' Financial Integrity Act (FMFIA) of 1982. ○ Analyze issues relating to future operation of the Medicare banking function.

APPENDIX A--MTS NEEDS AND REQUIREMENTS WORKGROUP ASSIGNMENTS

NAME OF MTS WORKGROUP	SCOPE OF MTS WORKGROUP ASSIGNMENT
20. Program and Management Data Needs	<ul style="list-style-type: none"> ○ Coordinate with other workgroups to ensure that all future data needs required to support business functions are identified and transmitted to the MTS contractor. ○ Coordinate with other workgroups to ensure that all future data needs required to support management oversight are identified and transmitted to the MTS contractor. ○ Coordinate with other workgroups to ensure that their planning adequately addresses management controls in the MTS environment to assure compliance with the FMFIA. ○ Assure that data needs of the research community are adequately considered in MTS planning. ○ Ensure that GTE works to obtain all necessary input from Medicare contractors regarding their management and processing data needs.
21. Local Variations	<ul style="list-style-type: none"> ○ Identify, inventory and analyze all local variations in Medicare processes/data collection/outcomes between and among the Medicare contractors. ○ Analyze variations in Explanation of Medicare Benefits messages. ○ Assist in developing transition strategy for managing change to a standardized environment.
22. Health Care Trends and Developments	<ul style="list-style-type: none"> ○ Analyze health care reform legislative implications for MTS processing environment and the MTS contract. ○ Analyze implications of prescription drug legislation for MTS processing environment and the MTS contract. ○ Develop conceptual approach to integrating health reform legislation and possible prescription benefits into the MTS environment.
23. Legislative, Regulatory, and Policy Needs	<ul style="list-style-type: none"> ○ Coordinate with other workgroups to develop a complete inventory of legislative/regulatory/policy changes that would result in greater administrative efficiency such as eliminating "periodic interim payment".
24. "Gatekeeper" Issues	<ul style="list-style-type: none"> ○ Coordinate with all workgroups to identify situations where manual intervention/changes may be required in the future for MTS processing files and systems edits.

APPENDIX B

**STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES
PREVIOUSLY IDENTIFIED BY THE OIG**

APPENDIX B

STATUS OF HCFA'S ACTIONS ON MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG

THE FOLLOWING IS A SUMMARY IN TABLE FORM ON THE STATUS OF HCFA ACTIONS ON ISSUES PREVIOUSLY IDENTIFIED IN AN OIG DRAFT DOCUMENT ENTITLED *ISSUES THAT NEED TO BE ADDRESSED IN THE ANALYSIS OF REQUIREMENTS FOR THE MEDICARE TRANSACTION SYSTEM (ISSUES)* DATED FEBRUARY 28, 1994. THE PURPOSE OF THIS DRAFT DOCUMENT WAS TO ASSIST HCFA DURING DEFINITION OF REQUIREMENTS BY IDENTIFYING AREAS NEEDING IMPROVEMENT IN THE CURRENT MEDICARE CLAIMS PROCESS THAT MIGHT BE CORRECTED THROUGH IMPLEMENTATION OF THE NEW SYSTEM. THE TABLE IS DIVIDED INTO THREE COLUMNS: (1) FUNCTIONAL CATEGORIES BY AREA--MEDICARE PART A, PART B AND CROSSCUTTING ISSUES; (2) PROGRAM EDIT AND RELATED SAFEGUARD ISSUES IDENTIFIED PREVIOUSLY BY THE OIG OR GAO AS WEAKNESSES AND LIMITATIONS IN THE CURRENT MEDICARE CLAIMS PROCESS; AND (3) ACTIONS TAKEN OR PLANNED BY HCFA AS OF DECEMBER 31, 1994, TO THE EXTENT COVERED IN OUR SCOPE.

WE IDENTIFIED 14 AREAS IN THE CURRENT MEDICARE CLAIMS PROCESS REGARDING PROGRAM EDITS AND RELATED SAFEGUARDS. SO FAR, HCFA HAS TASKED THE MTS WORKGROUPS TO ADDRESS 10 OF THE 14 AREAS AND PART OF ANOTHER OF THE 4 REMAINING AREAS. NOTE THAT THE SCOPE OF OUR REVIEW WAS LIMITED TO TRACKING WHAT THE MTS NEEDS AND REQUIREMENTS WORKGROUPS WERE TASKED TO DO AND WHETHER CONCERNS WE PREVIOUSLY IDENTIFIED WERE BEING ADDRESSED. WE ALSO CREDITED HCFA FOR COMMITMENTS TO ADDRESS CERTAIN ISSUES DURING LATER STAGES OF THE REQUIREMENTS ANALYSIS PHASE. WE DID NOT, HOWEVER, EVALUATE THE EFFECTIVENESS OF HCFA'S PROPOSED FUTURE MTS REQUIREMENTS.

**APPENDIX B--STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG**

**FUNCTIONAL
CATEGORIES**

**PROGRAM EDIT AND
RELATED SAFEGUARD
ISSUES**

**ACTIONS TAKEN: The
HCFA tasked the MTS
Needs and Requirements
workgroups to examine...**

MEDICARE PART A:

1. Prospective Payment System (PPS) Patient Transfers	We identified \$8.4 million in overpayments related to Medicare claims for transfers between PPS hospitals being erroneously reported and paid as discharges. ⁸	NO ACTION TAKEN
2. Hospice Benefits	We identified over 3,400 potential duplicate payment claims over \$13 million made to hospitals or skilled nursing facilities for beneficiaries with hospice elections. ¹⁴	...what types of edits would be necessary to address the insufficient edits that already exist in hospice related services. <i>[Edits and Exceptions Workgroup]</i>
3. Diagnostic Related Group Payment Window	A recent OIG review showed that approximately \$8.6 million in improper billings and subsequent payments for nonphysician outpatient services were made to hospitals under PPS for the period November 1990 through December 1991. ⁹	NO ACTION TAKEN

MEDICARE PART B:

4. Physician Self Referrals	Some physicians have entered into financial relationships related to the provision of certain medical services, resulting in the overutilization of these services.	...issues related to physician lab ownership and also the ownership information that must be entered in the National Provider file or MTS to comply with physician ownership requirements in Omnibus Budget Reconciliation Act of 1993. <i>[Provider Enrollment/Data Workgroup]</i>
5. Duplicate Anesthesia Payments	We found that \$368,000 in duplicate anesthesia payments occurred because the claims processing system at the carrier did not detect and control these potential duplicate payments. ¹⁵	...the need for appropriate edits to detect potential fraud/abuse in reporting the "time" portion of anesthesiology services. <i>[Edits and Exceptions Workgroup]</i>

**APPENDIX B--STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG**

**FUNCTIONAL
CATEGORIES**

**PROGRAM EDIT AND
RELATED SAFEGUARD
ISSUES**

**ACTIONS TAKEN: The
HCFA tasked the MTS
Needs and Requirements
workgroups to examine...**

6. Clinical Laboratories

A prior OIG review¹² showed that the Medicare Part B program (through FI's for outpatient department services and carriers for physician ordered tests) is paying single-test payment rates for chemistry tests commonly performed on automated laboratory equipment. Our review identified 10 tests which are appropriate for paneling, but are not on the list of chemistry tests that should be paneled. Savings to the Medicare program would be about \$216 million annually if the 10 tests identified were included as panel tests nationwide.

NO ACTION TAKEN

CROSSCUTTING ISSUES:

7. Medicare Secondary Payer

We identified the following internal control weaknesses as contributing to Medicare Secondary payer overpayments:

- a) Lack of coordination between the Medicare contractors and their private insurance operations.^{16,17}
- b) Lack of accurate and timely information on primary payers for Medicare beneficiaries.^{18,19,20,21,22}
- c) Lack of internal coordination and systems information needed to identify all MSP situations.¹⁷
- d) Failure to identify primary insurers.¹⁸

...how employer and/or insurer records can be matched against MTS data.

[Coordination of Benefits Workgroup]

...(a) how insurer and/or employer eligibility records could be matched with Medicare eligibility records and (b) whether local contractors or MTS should match State data. ***[Coordination of Benefits Workgroup]***

Actions taken is the same as 7(b).

Actions taken is the same as 7(b).

**APPENDIX B--STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG**

**FUNCTIONAL
CATEGORIES**

**PROGRAM EDIT AND
RELATED SAFEGUARD
ISSUES**

**ACTIONS TAKEN: The
HCFA tasked the MTS
Needs and Requirements
workgroups to examine...**

7. Medicare Secondary Payer
(Continued)

e) Less than effective working MSP component of CWF.¹⁷

...proposed future requirements to (a) give HCFA the ability to correct data within MTS to update beneficiary data and (b) establish and maintain an MSP database. *[Coordination of Benefits Workgroup]*

f) Failure to adequately review, verify, and file contractor MSP backlog reports.²³

...proposed future requirements to establish controls over beneficiary/provider overpayment which states that MTS must (a) build overpayment tracking for the MSP backlog report, (b) generate notices which prompt local contractors to take action, and (c) build in beneficiary overpayment tracking. *[Coordination of Benefits Workgroup]*

8. Hospital Outpatient Surgical Services

We reported the following two findings related to outpatient surgical services:

a) an overstated ambulatory surgical center payment amount due, in part, to insufficient edits in the intermediary systems to properly account for facility charges when multiple claims are submitted for a single 1-day surgery.¹³

NO ACTION TAKEN

b) procedure coding differences between the hospital outpatient department and the physician for the same 1-day surgery.¹⁴

...(a) ways of checking for exact duplicates, potential duplicates, and/or overlapping claims/charges and (b) ways of assuring that MTS has the capability to make comparisons between line items on different bills. *[Edits and Exceptions Workgroup]*

**APPENDIX B--STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG**

**FUNCTIONAL
CATEGORIES**

**PROGRAM EDIT AND
RELATED SAFEGUARD
ISSUES**

**ACTIONS TAKEN: The
HCFA tasked the MTS
Needs and Requirements
workgroups to examine...**

9. Financial Management Systems

We recommended that HCFA make the following improvements to its financial management systems:

a) Fully integrate the processing, accounting, payment, financial management, and reporting functions wherein all systems can electronically communicate with each other without any manual intervention.

...ways of implementing an integrated accrual accounting system by placing an automated general ledger at the MTS operating sites or Medicare contractor sites. One of the MTS workgroups recommended the integration of the MTS accounting subsystem with other operating systems, such as claims processing, accounts receivable/debt collection, fraud and abuse, etc. *[Accounting System Workgroup]*

b) Establish a linkage between MTS and its general ledger accounting system thereby providing complete electronic documentation and traceability from claims submission through posting to HCFA's general ledger accounts and vice versa.

...ways of implementing an integrated accrual accounting system by placing an automated general ledger at the Medicare contractor or the MTS operating sites. *[Accounting System Workgroup]*

c) Establish an adequate tracking system which identifies and monitors the status of benefit disbursements²⁴, accounts receivable^{25,26}, and accounts payable^{27,28}.

...(a) ways of implementing an integrated accrual accounting system by placing an automated general ledger at the MTS operating sites or Medicare contractor sites; (b) overpayment tracking and management data needs and ensure that these needs are incorporated into the MTS system; and (c) issues related to debt collection procedures, suspension of payments, etc. *[Debt Collection Procedures Workgroup]*

**APPENDIX B--STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG**

**FUNCTIONAL
CATEGORIES**

**PROGRAM EDIT AND
RELATED SAFEGUARD
ISSUES**

**ACTIONS TAKEN: The
HCFA tasked the MTS
Needs and Requirements
workgroups to examine...**

9. Financial Management Systems
(Continued)

d) MTS should be linked with overpayment recovery tracking systems, including those associated with MSP overpayment recovery activities. And, under MTS, overpayment recoveries should automatically result in the generation of the appropriate adjustment transactions for claims previously submitted.

...(a) whether functionality and reporting capacity of the Provider Overpayment Report, Physician/Supplier Overpayment Report, and the new MSP accounts receivable systems should be incorporated into MTS [*Debt Collection Procedures*]; and (b) whether the adjustment processing capabilities of the future MTS system should include automatic (1) adjustment of all claims affected by an action, (2) benefit coordination of adjustment actions, and (3) generation of audit trails and storage of records on all adjustments. [*Adjustment Processing Workgroup*]

10. Prepayment Edits

a) Explore the use of edit packages now used by commercial health insurers where these packages could be readily modified to meet Medicare reimbursement policy.

..."best practices" now employed in the contractor community that should be emulated by HCFA in the MTS processing environment. [*Edits and Exceptions Workgroup*]

b) MTS should enable the tracking of numbers, percentages, and dollar values of claims flagged by prepayment edits, as well as the numbers, percentages, and dollar values of flagged claims that are not resubmitted.

...proposed future requirements that require (a) analyzing claims data to identify possible fraud targets, (b) investigating incidents of potential fraud by selecting and reviewing sample of claims, (c) monitoring provider billing by entering edits designed to identify and prevent fraud and abuse claims payment, and (d) flagging previously processed claims for investigations by distributing and preparing fraud alerts that may impact payment. [*Fraud and Abuse Procedures Workgroup*]

**APPENDIX B--STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG**

**FUNCTIONAL
CATEGORIES**

**PROGRAM EDIT AND
RELATED SAFEGUARD
ISSUES**

**ACTIONS TAKEN: The
HCFA tasked the MTS
Needs and Requirements
workgroups to examine...**

10. Prepayment Edits
(Continued)

c) MTS should also collect sufficient information to permit follow up with submitting providers based on recurring problems in claims preparation and submission.

...a proposed future requirement which requires that MTS track further payments to provide information on continuing possible fraud to OIG, or withhold payments if justified pending resolution. *[Fraud and Abuse Procedures Workgroup]*

11. Provider Profiling and other
Post-payment Review Activities

a) MTS should help detect fraudulent and abusive billing schemes more quickly.

...ways of holding a provider liable for aberrant billing practices by having MTS help the Federal Bureau of Investigations/Department of Justice develop a trail of evidence linking a fraud claim directly to a provider. In addition, the HCFA has already developed a new standard provider agreement to hold providers personally responsible for every claim submitted and to provide sufficient evidence for prosecution of fraud. *[Fraud and Abuse Procedures Workgroup]*

b) MTS should permit retrospective analysis of all previously paid bills and claims based on results of provider profiling so that (1) new, more sophisticated edits can be established and (2) additional potential overpayment cases can be identified through the use of the new edits against historical paid claims data.

...proposed future requirements which will require (a) tracking fraud cases, (b) analyzing claims data to identify fraud targets, (c) performing special fraud studies, (d) investigating incidents of potential fraud, and (e) monitoring provider billing by designing edits to identify and prevent fraud and abuse claims payment. *[Fraud and Abuse Procedures Workgroup]*

12. Electronic Billing and
Payment

a) Determine the most economical and efficient methods for claims submission and payment.³

...the most economical and efficient methods for claims submission and payment. *[Claims, Control, Management, Determination and Electronic Data Interchange Workgroup]*

**APPENDIX B--STATUS OF HCFA'S ACTIONS ON
MTS-RELATED ISSUES PREVIOUSLY IDENTIFIED BY THE OIG**

**FUNCTIONAL
CATEGORIES**

**PROGRAM EDIT AND
RELATED SAFEGUARD
ISSUES**

**ACTIONS TAKEN: The
HCFA tasked the MTS
Needs and Requirements
workgroups to examine...**

12. Electronic Billing and
Payment (Continued)

b) The reliability and trustworthiness of the data gathered through the processing of electronic Medicare claims must be of a sufficiently high level that such data may be (1) readily admissible as evidence in Federal courts and (2) used for other HCFA functions.⁵

...ways of ensuring that the integration of data gathered in a paperless environment is of sufficiently high level to be readily admissible as evidence in a Federal court. *[Claims, Control, Management, Determination and Electronic Data Interchange Workgroup]*

13. Data Security and the Use of
Force Codes

a) Proper controls for data security should be built in and around MTS.

...(a) the use of security devices such as data encryption, passwords, badges with personal identification numbers and (b) current system requirements for physical, technical and administrative security, contingency planning, and backup/recovery. *[Claims, Control, Management, Determination and Electronic Data Interchange Workgroup]*

b) HCFA needs to (1) evaluate the conditions under which to allow the use of force codes to permit timely and cost-effective processing in unusual circumstances, (2) establish the means for authorizing the use of force codes on a individual operator by operator basis, and (3) implement the access controls and audit trails to control and document the use of these codes.

...the need for MTS to have an audit trail to track when and why an override is used on an edit and by whom. *[Edits and Exceptions Workgroup]*

14. Collection of Program
Management Data

The HCFA should reexamine its Medicare data requirements and data collection procedures so that material improvements in program data can be achieved.²⁹

...programmatic and management data needs (e.g., for research, profiling providers by services provided, clinical information) and data quality issues. *[Program and Management Data Needs Workgroup & Medical Review/Fraud and Abuse/Quality of Care Data and Systems Needs]*

APPENDIX C

**FULL TEXT OF HCFA'S COMMENTS
TO THE DRAFT REPORT**



The Administrator
Washington, D.C. 20201

DATE: SEP 27 1995

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report. "Monitoring the Health Care Financing Administration's (HCFA) Medicare Transaction System (MTS)," (A-14-93-02543)

We reviewed the above-referenced report in which OIG presents the results of monitoring MTS activities. The review concerns itself with HCFA's ongoing analysis of MTS systems requirements and future planning needed to maximize the benefits of the new system.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments further.

Attachment

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG) Draft Report: "Monitoring the Health Care Financing
Administration's Medicare Transaction System (MTS) Status Report" (A-14-93-02543)

Recommendation 1

HCFA should provide GTE Government Systems Corporation (GTE) with program and operations planning scenarios addressing issues that could have a major impact on MTS over its useful life for use in evaluating alternative system designs.

HCFA Response

We concur. Since December 1994, HCFA has provided GTE with several program and operations planning scenarios including the volumetric and telecommunication studies. The volumetric study addressed the substantive changes in nature, volume, and geographic point of origin of transactions expected under MTS. In addition, we have given GTE a copy of HCFA's vision of Medicare operations in the year 2005; the "Medicare Target Scenario." HCFA has also prepared a data base containing new requirements extracted from the Needs and Requirements Work group papers and gave it to GTE. In August, HCFA provided GTE with an MTS Operating Capability document, which defines HCFA's expectations concerning the functionality of MTS on day one (September 1997) and in September 1999 when MTS is fully transitioned. Finally, in a collaborative effort, HCFA's Office of Managed Care will be working with GTE to ensure that MTS will meet the needs of a managed care environment.

Recommendation 2

HCFA should cover all previously identified weaknesses and limitations in computer edits and related safeguards that have not yet been addressed during the requirements analysis phase before detailed specifications are formulated.

HCFA Response

The following is an update on previous identified weaknesses.

HCFA's Prospective Payment System Patient Transfers

HCFA planned to add an additional code to the billing form to identify this situation; however, the National Uniform Billing Committee denied our request for an additional code to double check the transfer/discharge designation. We do not believe other mechanisms would be cost effective. We intend for MTS to have the ability to edit all patient discharges against admissions to another acute care facility.

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Diagnosis Related Group Payment Window

Since the issuance of OIG's report, we have updated section 3610 of the Medicare Intermediary Manual to clarify these requirements and tighten CWF edits. The MTS Edits and Exceptions Work Group discussed this issue and concluded that exhaustive editing to examine secondary and tertiary diagnosis codes, for a potential relationship to the principal diagnosis code, would not be cost-effective, even if automated.

Clinical Laboratories

We prepared manual and edit changes to bring fiscal intermediary (FI) lab edits for automated multichannel tests in line with OIG recommendations.

Outpatient Surgical Services

FIs have been instructed to have edits in place which would prevent acceptance of Ambulatory Surgical Center bills subsequent to original claims. Instructions to IS and hospitals were released in April 1995. The effective date for the edits was July 1, 1995.

ENDNOTES

1. These are either commercial software vendors (e.g., GTE Data Services, Electronic Data Systems [EDS]-Federal, Viable Information Processing Systems) or private side divisions of Medicare contractors (e.g., Arkansas Blue Cross, Florida Blue Cross, and The Travelers).
2. At the present time, this contractor is EDS-Federal.
3. *OIG Final Report Review of Medicare Bill and Claim Processing: Opportunities for Long Term Improvement* (A-14-91-02542, dated August 1992).
4. *Information Technology: An Audit Guide for Assessing Acquisition Risks* (GAO/IMTEC-8.1.4, dated December 1992).
5. *OIG final report Electronic Data Interchange: Issues and Challenges* (OEI-12-93-00080, dated March 1994).
6. *OIG Final Report Review of Controls Over Electronic Billing and Payment at Selected Medicare Contractors in Region V--Considerations for the Design of the Medicare Transaction System* (A-05-93-00056, dated October 1994).
7. *OIG Final Report Medicare Hospital Patient Transfers Improperly Reported and Paid As Hospital Discharges* (A-14-89-00021, dated March 31, 1993).
8. *OIG Final Report Expansion of the Diagnosis Related Group Payment Window* (A-01-92-00521, dated July 1994).
9. *OIG Final Report Improper Medicare Payments for Nonphysician Outpatient Services Under the Prospective Payment System February 1986 through November 1987* (A-01-90-00516, dated August 1990).
10. *OIG Final Report Millions in Improper Payments to Hospitals for Nonphysician Services Under the Prospective Payment System* (A-01-86-62024, dated July 1988).
11. *OIG Final Report Review of Chemistry Tests Performed on Automated Laboratory Equipment* (A-01-93-00521, dated January 23, 1995). Interim results from this review were referenced in our February 1994 draft document on edits, program safeguards, and financial management issues.

12. We initially cited results from a pilot review then in progress at FI's located in Region I. Based on the results of this pilot, we expanded the project to a nationwide review, the results of which were issued in the *OIG Final Report Review of Claims Processing for Ambulatory Surgical Services Performed in Hospital Outpatient Departments* (A-01-93-00502, dated September 20, 1994).
13. *OIG Draft Report Review of Ambulatory Surgical Services Performed in Hospital Outpatient Departments - Procedure Coding Differences* (A-01-94-00507, dated August 1994). This report was subsequently issued in final form on December 12, 1994.
14. *OIG Early Alert of Potential Payments for Beneficiaries Electing Hospice Benefits* (A-14-92-02067, dated August 1992).
15. *OIG Final Report Review of Duplicate Anesthesia Payments Processed During the Period October 1986 to September 1988 by Empire Blue Cross Blue Shield* (A-02-91-01013, dated March 1991).
16. *OIG Final Report Extent of Unrecovered Medicare Secondary Payer Funds* (OEI-07-90-00760, dated August 1991).
17. *OIG Final Report Medicare Secondary Payer: Effectiveness of Current Procedures* (OEI-07-90-00761, dated August 1991).
18. *OIG Final Report More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program* (A-09-89-00100, dated March 1990).
19. *OIG Final Report Medicare as a Secondary Payer, Nationwide Employer Project* (A-09-89-00162, dated July 1992).
20. *OIG Final Report Medicare as a Secondary Payer-Review of the Health Care Financing Administrations's Efforts to Implement the Data Match Project* (A-09-91-00103, dated August 1992).
21. *OIG Final Report Review of Selected Part B Medicare Secondary Payer Activities at Blue Shield of Florida* (A-04-91-02004, dated April 1992).
22. *OIG Final Report Follow-Up Review on General Accounting Office Report, More Hospital Costs Should Be Paid by Other Insurers* (A-14-92-00375, dated May 1992).

23. *OIG Final Report Review of the Health Care Financing Administration's Oversight of Medicare Secondary Payer Backlog Claims (A-14-92-02057, dated June 1993).*
24. *OIG Final Report Improvements Needed In Financial Management Systems to Enhance Medicare Financial Reporting (A-14-92-03015, dated March 31, 1993).*
25. *OIG Final Report Review of the Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991 (A-01-91-00525, dated June 1993).*
26. *OIG Final Report Review of Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1992 (A-01-92-00516, dated March 1994).*
27. *OIG Final Report Review of the Internal Control Structure Over the Accounts Payable Balance for the Hospital Insurance Trust Fund at September 30, 1992 (A-05-92-00106, dated June 30, 1994).*
28. *OIG Final Report Review of the Internal Control Structure Over the Accounts Payable Balance for the Supplementary Medical Insurance Trust Fund at September 30, 1992 (A-04-92-02054, dated June 30, 1994).*
29. *OIG Final Report Review of the Health Care Financing Administration's Implementation of the Project to Redesign Information Systems Management (A-14-91-02533, dated April 1992).*