

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE TESTS OF LOWER  
EXTREMITY ARTERIES**



MAY 1993

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This report was prepared in the Philadelphia Regional Office, under the direction of Joy Quill, Regional Inspector General and Robert A. Vito, Deputy Regional Inspector General.

Participating in this project were:

Robert Katz, Project Leader  
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**To obtain a copy of this report, call the Philadelphia Regional Office at (215) 596-0607.**

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE TESTS OF LOWER  
EXTREMITY ARTERIES**



MAY 1993    OEI-03-91-00950

# EXECUTIVE SUMMARY

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## PURPOSE

To review Medicare carriers' utilization review practices for noninvasive tests of lower extremity arteries.

## BACKGROUND

Peripheral vascular disease (PVD) is the general term applied to a group of distinct diseases and syndromes involving the arteries, veins, connective tissues, and vessels of the extremities. Although vascular diseases may occur in any body part containing blood vessels, many victims of PVD experience symptoms in their legs, such as pain, cramps, numbness, coldness, and weakness. Physicians use a wide array of noninvasive techniques to diagnose the presence, location, and extent of conditions, such as atherosclerosis (narrowing of the arteries), which interfere with the flow of blood to or from the extremities.

Diagnostic arterial tests of the lower limbs have increased dramatically in recent years. Medicare Part B allowed amounts virtually doubled for these tests in all settings and specialties from 1987 to 1990. In 1991, total allowed dollars exceeded \$71 million. In terms of total Part B billings, the leading specialties include general surgeons, thoracic surgeons, and internal medicine specialists. These 3 groups accounted for more than 410,000 services totaling some \$34 million in allowances.

The Health Care Financing Administration (HCFA) recognizes limb arterial studies (as well as other related noninvasive vascular tests) as "services where abuses have been identified, and medical review should be undertaken." Such services are included as an alert to carriers in the Medicare Carriers Manual. The alert enables carriers to facilitate the identification of aberrant practice patterns.

In order to determine how Medicare reviews claims for these tests, we contacted 36 carriers representing 58 geographical jurisdictions to obtain their coverage guidelines and pertinent policies. Responses were received from 34 carriers serving 56 jurisdictions. We analyzed the criteria and methods carriers use to evaluate and control utilization. We obtained statistical information from HCFA.

This is one in a series of Office of Inspector General reports on carriers' utilization review efforts in areas that appear on HCFA's Postpayment Alert List (PAL) of abusive services.

## **FINDINGS**

▶ **Over half the carriers have special utilization policies.**

Over half of the carriers responding to our inquiries had some type of utilization review safeguard in place. These safeguards consisted of prepayment thresholds or special policies related to coverage, documentation, and/or equipment requirements.

▶ **Coverage policies could produce savings to the Medicare program.**

Medicare could realize savings nationally by adopting policies such as prepayment threshold policies. Based on the experience of four carriers which have threshold limits of two tests a year per physician per beneficiary, Medicare would save about \$5.7 million annually.

## **RECOMMENDATION**

We believe the monetary benefits of tighter utilization policies, such as prepayment thresholds, are evident. The HCFA has convened a workgroup to review coverage policies for these tests. They plan to issue new coverage guidelines. We recommend that HCFA continue to work with carriers to ensure that there are sufficient safeguards to prevent the unnecessary utilization of lower extremity tests. These safeguards may include the policies that are currently utilized by some carriers.

## **COMMENTS AND OIG RESPONSE**

The HCFA concurred with our recommendation. In HCFA's view, a variety of approaches might be appropriate to curtail unnecessary utilization in addition to prepayment thresholds. We agree that various approaches could result in savings. Our recommendation contains sufficient flexibility to embrace workable monitoring techniques at any phase of utilization review. We hope the examples of carrier practices which we have described in this report will be helpful to the Noninvasive Vascular Testing Work Group, which has been convened by HCFA to address such issues.

We have refined our savings estimate based on more recent data, and made minor changes in the report based on HCFA's technical comments. The full text of HCFA comments are contained in Appendix B.

The Assistant Secretary for Planning and Evaluation reviewed the report and expressed concurrence.

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# INTRODUCTION

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## PURPOSE

To review Medicare carriers' utilization review practices for noninvasive tests of lower extremity arteries.

## BACKGROUND

Physicians use a wide array of noninvasive techniques to diagnose the presence, location, and extent of conditions, such as atherosclerosis (narrowing of the arteries), which interfere with the flow of blood to or from the extremities. These techniques include Doppler and plethysmography tests.

- ▶ Doppler tests: Using ultrasound principles, Doppler devices emit high frequency soundwaves which detect the flow of blood or pinpoint an arterial irregularity, such as an obstruction.
- ▶ Plethysmography: Literally meaning "to record an increase," this technique detects vascular obstructions by temporarily blocking blood flow circulation and recording and measuring any changes which result.

### *Medicare Coverage and Guidance*

The HCFA recognizes limb arterial studies (as well as other related noninvasive vascular tests) as "services where abuses have been identified, and medical review should be undertaken." Such services are included as an alert to carriers in a special Postpayment Alert List (PAL) in Section 7514 of the Medicare Carriers Manual. Carriers use the PAL to facilitate identification of aberrant practice patterns. Practitioner services included in the PAL are not limited by physician specialty.

Based on a special review by a medical directors' workgroup, HCFA issued these instructions in 1989:

"The rapid proliferation of noninvasive vascular testing modalities presents a challenge to third party payers in determining appropriate reimbursement policies. While the patient clearly benefits from escaping the risks inherent in angio/venography (an invasive test), the very safety of the noninvasive tests may encourage overutilization. Carrier medical review policies must therefore be clear and well developed regarding these tests."

Carriers can utilize a number of medical review policies, including prepayment thresholds. Prepayment thresholds (or screens) identify claims that merit additional review prior to payment. Carriers frequently review the billing histories for providers and beneficiaries identified through these screens. Sometimes carriers request additional medical information before these claims are approved for payment.

***Medicare Reimbursement***

Diagnostic arterial tests of the lower extremities (also referred to as arterial or vascular tests of the lower limbs) have increased dramatically in recent years. Allowed amounts virtually doubled for all settings and specialties from 1987 to 1990, according to Part B Medicare Annual Data (BMAD) statistics. In 1991, total dollars dropped to \$71,231,617 even though total allowed services climbed to 801,415, according to the Part B Extract Summary System (BESS) file compiled through June 1992.

CALENDAR YEAR	TOTAL DOLLARS ALLOWED	ALLOWED SERVICES	AVERAGE ALLOWED AMOUNT
1987	\$38,368,126	425,190	\$ 90
1988	51,035,060	524,375	97
1989	66,598,454	650,224	102
1990	75,357,808	713,595	106
1991	71,231,617	801,415	89

Section 4108 of the Omnibus Budget Reconciliation Act of 1990, which mandated reductions in reasonable charges in the technical components of certain high-volume diagnostic tests, including arterial tests of the lower limbs, may have caused the decline in total dollars allowed in 1991.

According to BESS statistics for 1991, a wide variety of specialties conduct diagnostic arterial tests of the lower limbs. Three of the highest specialties (in terms of total dollars allowed) are general surgeons (\$16 million), thoracic surgeons (\$9 million), and internal medicine specialists (\$9 million). These groups accounted for more than 410,000 services totaling some \$34 million in allowances.

**METHODOLOGY**

We contacted 36 Medicare carriers representing 58 geographical jurisdictions to obtain coverage guidelines and pertinent policies. Responses were received from 34 carriers



representing 56 jurisdictions. Because the policies of an individual carrier may vary from jurisdiction to jurisdiction, in this report we refer to each jurisdiction as a carrier.

Analysis focused on criteria and methods carriers use to evaluate and control utilization. We obtained statistical information from HCFA's BMAD and BESS files, and obtained technical and clinical information from standard medical references and the Medicare Carriers Issues Manual (MCIM).

We used the 1991 Part B sample file<sup>1</sup> to calculate national savings which would be realized if all specialties had a threshold of two tests per year, with additional tests requiring medical justification. To estimate the savings resulting if all carriers adopted a screening threshold of two tests a year (per physician, per beneficiary), we compared utilization rates in the four carriers with this threshold to utilization rates in the other carriers.

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

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<sup>1</sup> The Part B sample is a one percent random sample selection of Medicare beneficiaries from HCFA's Common Working File. It is maintained by the Office of Inspector General.

## FINDINGS

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### **Over half the carriers have special utilization policies.**

Many carriers responded to HCFA's warnings about the abusive nature of arterial limb tests by instituting special policies to control the incidence of inappropriate testing. More than half of the responding carriers (32 of 56) had some type of utilization review safeguard in place. These safeguards consisted of prepayment thresholds or special policies related to coverage, documentation, and/or equipment requirements.

The 32 carriers accounted for approximately \$29.5 million in allowances in 1991 or about 46 percent of the total allowances for the responding 56 carriers.

Carrier monitoring efforts vary widely. Such efforts include focused techniques as well as intensive, periodic reviews of arterial limb tests. Some carriers are heavily involved in prepayment monitoring while others depend solely on postpayment reviews. One carrier reported that its utilization review section evaluates every vascular test billed by podiatrists because of medical necessity concerns. Another carrier characterized these claims as, "Very hard to monitor except manually." Conversely, another carrier said they never do any prepayment monitoring.

The HCFA demonstrated its continued concern when it convened a technical advisory group in June 1992 to reevaluate coverage policies for these tests. They expect to issue new coverage guidelines in the future.

### ***Prepayment Thresholds***

Thirteen carriers utilize prepayment thresholds as a primary means of controlling unnecessary or inappropriate testing. Because of carrier confidentiality concerns, we will not identify the carriers. A chart depicting the threshold policy for each of the 13 carriers appears on the next page.

CARRIER	SPECIALTY INVOLVED	THRESHOLD
A	Physicians Podiatrists	2 @ 365 Days 1 @ 180 Days
B	All	1 @ 6 Months
C	All	1 @ Year Each Leg; 2 @ Year if Vascular Surgery
D	All	1 @ Year Each Leg; 2 @ year if Vascular Surgery
E	All	Preoperative/Non- Surgery: 1 @ 12 Months  Postoperative: 1 compl Test 1st 12 months; Limited Tests @ 3 Months Thereafter
F	Podiatrists	Vascular Tests Not Covered
G	All	1 @ 12 months
H	All	1 @ 12 Months
I	Podiatrists	Vascular Tests Not Covered
J	Podiatrists	Vascular Tests Not Covered
K	Podiatrists	Vascular Tests Not Covered
L	Podiatrists	1 Preoperative Test a Year
M	All	1 @ 365 Days; Postoperative: 3 First Year, 1 a Year Thereafter

### *Other special policies*

Nineteen carriers have instituted special policy guidelines stressing coverage, documentation, and/or equipment requirements. Several carriers delineate which symptoms or diagnoses would justify reimbursement for these tests. For example, one carrier stipulates which symptoms justify coverage, such as "intermittent claudication" or "ulcer of lower limbs." Other carriers stipulate what constitutes acceptable documentation; for example, one carrier requires physicians to use equipment which produces "hard-copy output." (See Appendix A for a list of the 19 jurisdictions and summaries of their special policies.)

### **Coverage policies could produce savings.**

Medicare could realize savings nationally if carriers used prepayment thresholds as the basis for their prepayment review safeguards before applying other coverage criteria.

Four carriers have implemented prepayment thresholds of two tests a year per physician per beneficiary. Based on the experience of the 4 jurisdictions in 1991, we estimated 64,915 tests would not have been performed if this limit had been in place nationally. Based on the average cost of about \$89<sup>2</sup> per test, about \$5.7 million would have been saved annually. Potential savings over the next 5 years exceeds \$28 million. (See Appendix C for further details of our calculations.)

The unnecessary utilization of lower extremity tests results in unwarranted Medicare expenditures. According to BMAD statistics for 1990, more than 200,000 beneficiaries received multiple lower extremity tests. Some beneficiaries received as many as 14 tests from the same physician. To use one of these beneficiaries as an example, a prepayment threshold of two tests a year per physician could have effected potential savings of \$1272 in allowances just for this one beneficiary if additional tests were deemed unnecessary (12 x average 1990 allowance of \$106).

Four carriers do not cover vascular tests performed by podiatrists. If all vascular tests performed by podiatrists were not covered, Medicare could save about \$8.8 million annually or \$44 million over the next 5 years. This figure, however, does not take into account that some beneficiaries currently having tests done by a podiatrist may have the test done by another physician specialty.

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<sup>2</sup>Based on a one percent national sample of 1991 services maintained by the Office of Inspector General.

## RECOMMENDATION

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We believe the monetary benefits of tighter utilization policies, such as prepayment thresholds, are evident. The HCFA has convened a workgroup to review coverage policies for these tests. They plan to issue new coverage guidelines. We recommend that HCFA continue to work with carriers to ensure that there are sufficient safeguards to prevent the unnecessary utilization of lower extremity tests. These safeguards may include the policies that are currently utilized by some carriers.

# COMMENTS

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## Comments and OIG Response

The HCFA concurred with our recommendation. In HCFA's view, a variety of approaches might be appropriate to curtail unnecessary utilization in addition to prepayment thresholds. We agree that various approaches could result in savings. Our recommendation contains sufficient flexibility to embrace workable monitoring techniques at any phase of utilization review. We hope the examples of carrier practices which we have described in this report will be helpful to the Noninvasive Vascular Testing Work Group, which has been convened by HCFA to address such issues.

The HCFA suggested that the technical and/or professional components of tests involving lower extremity arteries may have been overvalued, thus resulting in excessive payments. The HCFA felt OIG should examine this issue. We will consider adding this issue to our workplan.

The Assistant Secretary for Planning and Evaluation reviewed the report and expressed concurrence.

## Technical comments

The HCFA suggested the chart on page 2 indicate whether the figures are based on a calendar or fiscal year. We revised the chart to reflect that the figures represent calendar years.

The HCFA questioned our cost projections based on more than 517,000 tests. This figure should have read 51,797 tests. However, we have revised and refined our calculations using complete 1991 data recorded through June 1992. The revised estimate rises to an annual savings of about \$5.7 million (64,915 cases with savings multiplied by an average payment of \$89 based on the one percent national sample maintained by our office). The \$89 figure represents the average payment for lower extremity tests using complete figures recorded through June 1992. The previously cited figure of \$98 reflected figures recorded at the close of December 1991. Additional information may be found in Appendix C.

The full text of HCFA comments appears in Appendix B.

## APPENDIX A

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Nineteen carriers implemented special policies relating to coverage, documentation, and/or equipment requirements. Because of concerns about the confidentiality of carrier policies, we will not identify the carriers.

CARRIER	POLICY
A	Acceptable symptoms delineated.
B	Test must produce hard-copy output with a bidirectional flow.+
C	Medical necessity review conducted on all claims.
D	Acceptable diagnoses delineated.
E	Test must produce hard-copy output using bidirectional vascular flow/imaging.
F	Acceptable diagnoses delineated.
G	Test must produce hard-copy output signed by physician.
H	Defines requirements for limited and complete tests.
I	Documentation must accompany claims.
J	Acceptable diagnoses delineated.
K	Covered only in cases of planned surgical intervention.
L	Acceptable symptoms delineated.
M	Covered only in cases of planned surgical intervention.
N	Patient record must contain hard-copy output/imaging.
O	Claims must include a report of clinical findings and test results.+
P	Acceptable symptoms delineated.
Q	Acceptable symptoms delineated.
R	Acceptable diagnoses delineated.
S	Medical records must contain documentation.

+ Applies specifically to podiatrists.

# APPENDIX B

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## COMMENTS ON THE DRAFT REPORT





# Memorandum

Date *William Toby, Jr.* APR 12 1993  
 From William Toby, Jr.  
 Acting Administrator

Subject Office of Inspector General (OIG) Draft Report: "Medicare Tests of Lower  
 Extremity Arteries," OEI-03-91-00950

To Bryan B. Mitchell  
 Principal Deputy Inspector General

We reviewed the above-referenced draft report concerning the results of  
 OIG's review of carriers' use of special policies to combat unnecessary and  
 inappropriate noninvasive tests of lower extremity arteries.

We agree with OIG's recommendation that the Health Care Financing  
 Administration should continue to work with carriers to ensure that sufficient  
 payment safeguards are in place for Medicare-covered noninvasive tests of  
 lower extremity arteries. However, we do not agree with OIG's projected  
 savings for the nationwide implementation of the use of prepayment  
 thresholds prior to the application of other coverage criteria. Our detailed  
 comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft  
 report. Please advise us if you agree with our position on the report's  
 recommendation at your earliest convenience.

Attachment

IG	_____
FDIG	_____
DIG-AS	_____ /
DIG-EI	_____ /
DIG-OI	_____
AIG-MP	_____ /
OGC/IG	_____ /
EX SEC	_____ /
DATE SENT	4/14

1993 APR 14 PM 2:10  
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 GENERAL

**Comments of the Health Care Financing Administration (HCFA)**  
**on Office of Inspector General (OIG) Draft Report:**  
**"Medicare Tests of Lower Extremity Arteries"**  
**OEI-03-91-00950**

**Recommendation**

That HCFA continue to work with carriers to ensure that there are sufficient safeguards to prevent the unnecessary utilization of lower extremity tests. These safeguards may include the policies that are currently utilized by some carriers.

**HCFA Response**

We agree. The Noninvasive Vascular Testing Work Group, convened by HCFA and composed of Medicare carrier medical directors, is working to develop model local medical review policies for tests of lower extremity arteries and transcranial dopplers.

Although OIG focused on prepayment review, we believe a variety of policies and approaches might be appropriate and ought to be considered by OIG when reviewing this area. They include the following:

- The thrust of HCFA utilization review activities is moving to a postpayment basis. The effectiveness of prepayment review versus targeted postpayment review should be evaluated. Prepayment review may not be cost-effective, given the relative costs of manual review compared with the payment amount for lower extremity and transcranial doppler tests. Reliance on prepayment review without other checks also runs the risk of increasing utilization, if physicians become aware of screen parameters and take advantage of the situation.
- It may also be beneficial to examine payment for these tests. Specifically, it has been suggested that the payment amounts for the technical and/or professional components of these tests are too high. The rates could be too high given the way that technical components were determined or because these tests are in the low range of the work scale and physicians responding to the Harvard survey may have overestimated the value of the services at the low end of the work scale.

In addition, OIG found that special utilization policies could produce savings to the Medicare program, and used as an example the adoption by four carriers of a screening threshold of two tests a year, per physician, per beneficiary. While nationwide implementation of this policy might achieve some savings, OIG does not present any rationale for its selection of this policy (versus more or less stringent policies) as a baseline policy. OIG also does not address the appropriateness of placing emphasis solely on volume and cost, without regard to a determination of the appropriate utilization of the test involved.

### Technical Comments

Background, page 2 - the chart and/or the accompanying text should indicate whether the figures are based on a calendar or fiscal year.

Findings, page 6, second paragraph under "Coverage Policies Could Produce Savings" -the paragraph states that \$5 million could be saved annually based on the experience of the four jurisdictions which used prepayment thresholds in 1991. This savings estimate assumes that nearly 518,000 tests would not have been performed if the same prepayment threshold had been in place nationally and is based on the average cost of about \$98 per test.

This conflicts with the chart on page 2 which indicates that the average allowed amount in 1991 was \$89. The problem may be as simple as transposed digits or it could be a case of using calendar year figures in one instance and fiscal year data in the other.

Finally, the estimated \$5 million in annual savings appears to be incorrect based on the data provided. The number of tests (518,000) multiplied by the average cost per test (\$98) produces savings totaling over \$50 million. This figure exceeds the total dollars allowed in 1987 and 1988 for all diagnostic tests of the lower extremities. Perhaps OIG means to say that over the entire 5-year period of 1987-91, 518,000 tests would have been performed. Assuming 20 percent or roughly 104,000 fewer tests would have been performed in 1991, at an average savings of \$98 per test, savings for 1991 would still exceed \$10 million.

## APPENDIX C

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### ESTIMATED SAVINGS BASED UPON LIMITING THE NUMBER OF TESTS PER BENEFICIARY

To estimate the potential savings attributable to limiting the number of tests, we reviewed the 1991 experience of Medicare carriers. Four carriers implemented prepayment thresholds of two tests a year per physician per beneficiary prior to 1991. Using a one percent sample of Medicare Part B payments for 1991 reflecting data through December 1991, we developed the following distributions.

Number of Tests per Beneficiary	All Carriers		Four Carriers with Limitations (2/Year)	
	Number of Tests	Number of Beneficiaries	Number of Tests	Number of Beneficiaries
1 Test	477,700	477,700	71,800	71,800
2 Tests	111,800	55,900	12,000	6,000
3 Tests	59,700	19,900	5,100	1,700
4+ Tests	50,400	12,600	2,400	600
Average Number of Tests per Beneficiary		1.24		1.14

Based upon this data, we determined the carrier limitation of two tests per beneficiary per physician would produce an 8.1 percent reduction in the number of tests performed. At the close of June 1992, Part B data indicates that 801,415 tests were performed for a total allowed amount of approximately \$71,232,000. Applying this 8.1 percent reduction, we estimated that approximately \$5,769,000 could be saved in the amount allowed if this two-test limit were applied nationwide.

Bryan B. Mitchell  
Principal Deputy Inspector General

OIG Final Report: "Medicare Tests of Lower Extremity Arteries," OEI-03-91-00950

Gerald H. Britten  
Acting Assistant Secretary for  
Planning and Evaluation

Attached is a copy of our final inspection report entitled, "Medicare Tests of Lower Extremity Arteries."

We found that many Medicare carriers--over half the carriers responding to our queries--have instituted special policies to combat unnecessary and inappropriate noninvasive tests of lower extremity arteries. Thirteen carriers implemented prepayment thresholds to curtail utilization improprieties. The HCFA had previously warned carriers about abusive billings for these kinds of tests.

We believe the monetary benefits of tighter utilization policies, such as prepayment thresholds, are evident. Based on the experience of four carriers which have threshold limits of two tests a year per physician per beneficiary, Medicare would save about \$5.7 million annually.

The HCFA has convened a workgroup to review coverage policies for these tests. They plan to issue new coverage guidelines. We recommend that HCFA continue to work with carriers to ensure that there are sufficient safeguards to prevent the unnecessary utilization of lower extremity tests. These safeguards may include the policies that are currently utilized by some carriers.

If you have any questions about this report, please call me or Michael Mangano, Deputy Inspector General for the Office of Evaluation and Inspections, or have your staff contact Penny Thompson at (410) 966-3138.

Attachment

Bryan B. Mitchell  
Principal Deputy Inspector General

OIG Final Report: "Medicare Tests of Lower Extremity Arteries," OEI-03-91-00950

William Toby, Jr.  
Acting Administrator  
Health Care Financing Administration

Attached is a copy of our final inspection report entitled, "Medicare Tests of Lower Extremity Arteries."

We found that many Medicare carriers--over half the carriers responding to our queries--have instituted special policies to combat unnecessary and inappropriate noninvasive tests of lower extremity arteries. Thirteen carriers implemented prepayment thresholds to curtail utilization improprieties. The HCFA had previously warned carriers about abusive billings for these kinds of tests.

We believe the monetary benefits of tighter utilization policies, such as prepayment thresholds, are evident. Based on the experience of four carriers which have threshold limits of two tests a year per physician per beneficiary, Medicare would save about \$5.7 million annually.

The HCFA has convened a workgroup to review coverage policies for these tests. They plan to issue new coverage guidelines. We recommend that HCFA continue to work with carriers to ensure that there are sufficient safeguards to prevent the unnecessary utilization of lower extremity tests. These safeguards may include the policies that are currently utilized by some carriers.

The HCFA concurred with our recommendation. However, they felt other approaches might also be effective in addition to prepayment thresholds. We did not examine alternative approaches. However, our recommendation contains sufficient flexibility to include other utilization review techniques.

If you have any questions about this report, please call me or Michael Mangano, Deputy Inspector General for the Office of Evaluation and Inspections, or have your staff contact Penny Thompson at (410) 966-3138.

Attachment

**Morning Mail:** \_\_\_ Yes  No \_\_\_

**Title:** Medicare Tests of Lower Extremity Arteries

**Reference:** OEI-03-91-00950      **Contact:** Penny Thompson (410) 966-3138

We have released a final inspection report entitled, "Medicare Tests of Lower Extremity Arteries."

In response to warnings from the Health Care Financing Administration (HCFA) about abusive billings for noninvasive diagnostic tests of lower extremity arteries, we found that many Medicare carriers--over half the carriers responding to our queries--have instituted special policies to combat unnecessary or inappropriate tests. Thirteen carriers implemented prepayment thresholds to combat the problem. We believe the monetary benefits of tighter utilization policies, such as prepayment thresholds, are evident. Based on the experience of four carriers which have threshold limits of two tests a year per physician per beneficiary, Medicare would save about \$5.7 million annually. The HCFA has convened a workgroup to review coverage policies for these tests. They plan to issue new coverage guidelines. We recommend that HCFA continue to work with carriers to ensure that there are sufficient safeguards to prevent the unnecessary utilization of lower extremity tests. The HCFA concurred with our recommendation.