PROBLEMS WITH CODING OF PHYSICIANS SERVICES: MEDICARE PART B

OFFICE OF INSPECTOR GENERAL

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PROBLEMS WITH CODING OF PHYSICIAN SERVICES: MEDICARE PART B

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EXECUTIVE SUMMARY

PURPOSE

Health services and supplies are reported and billed to Medicare by way of a numeric coding system. This inspection was conducted to:

(1) determine whether there are significant problems regarding coding of physician office and hospital visits;
(2) identify and examine reasons for coding problems; and
(3) recommend corrective measures, as appropriate.

BACKGROUND

Medicare is a federally funded program providing health care to the aged and disabled. The program is administered by the Department of Health and Human Services, Health Care Financing Administration (HCFA).

Medicare is divided into two parts. Part A includes hospital services and supplies. Part B includes physicians' services and "durable medical equipment" such as wheelchairs. This inspection deals with Part B. Payments for Part B Services and supplies are made through private insurance companies, known as "carriers," working under contract with HCFA.

In 1983, HCFA required all carriers to institute the HCFA Common Procedures Coding System (HCPCS). The use of HCPCS was intended to bring about uniformity in interpretation and reporting of medical services and supplies provided to Medicare beneficiaries. Under HCPCS, physician services are reported as five-digit codes defined in the American Medical Association's *Current Procedural Terminology* (CPT). Some services, such as physician office or hospital visits, are also designated by a procedure "level" which takes into consideration the wide variations in skill, effort, time, responsibility and medical knowledge required under different circumstances.

This inspection examines the issue of uniform coding and factors which influence coding choices. It analyzes statistics on the frequency of specific procedure codes billed to Medicare carriers. As a means to verify and interpret the statistical findings, interviews were held with 142 persons knowledgeable of physician billing habits, predominantly at the HCFA regional offices and Medicare carriers.

FINDINGS

- There are wide variations in coding of office and hospital visits under what is intended to be a uniform coding system. Problems described here relate to coding of "established

patient office visits" and "subsequent hospital care" (daily visits to hospitalized patients).

- The principal reason is differences in interpretation of the services each code represents. Differences in interpretation may be attributable to the large number of office and hospital visit codes available under CPT and a lack of clear distinction among code level descriptions.

- Reimbursement is also a factor, although code selection is intended to be based solely on the services rendered.

RECOMMENDATIONS

The HCFA should:

- Consult with the American Medical Association (AMA) to reduce the number of codes.

- Consolidate codes for payment purposes.

- Designate codes for "routine" office and hospital visits.

- Consult with the AMA on terminology changes and modification of the CPT manual.

- Educate providers on proper coding.

HCFA COMMENTS

The HCFA recognizes the problems which exist with coding of physician services and agrees with all of the OIG's recommendations for correcting them. A HCFA representative recently presented the OIG's findings and recommendations to the AMA's CPT-4 Editorial Panel at a meeting in Washington, D.C. Other discussions between HCFA and the AMA regarding coding problems have also taken place over the past several months. The HCFA believes these actions "... *will have a positive effect on resolving the concerns and issues raised in this audit.*"

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare is a federally funded program which provides health care to the elderly and disabled. It is administered by the Department of Health and Human Services, Health Care Financing Administration (HCFA). Services covered under Medicare are divided into two general areas. The first, known as "Part A," includes hospital services and supplies. The second, "Part B," includes physicians' services and "durable medical equipment" such as wheelchairs. This inspection deals with Part B.

Reimbursement through Private Carriers

Payments for services or supplies covered under Part B are made through private insurance companies ("carriers") under contract with HCFA. Each carrier has responsibility for processing claims in a designated geographic area. The HCFA provides direction to the carriers on all payment matters. It is also responsible for assuring that carriers are adhering to program policies and procedures governing payment.

Procedure Codes for Billing

In the past, physicians and suppliers submitted bills to carriers using narrative descriptions or numeric codes to identify the services they had rendered. Many different coding systems were used. Little similarity existed among the many methods used to bill Medicare.

In 1983 HCFA required all carriers to adopt the HCFA Common Procedures Coding System (HCPCS). The use of HCPCS was intended to bring about uniformity in defining and reporting medical services. This uniformity would enable HCFA to analyze Medicare services nationwide and would provide reliable information for Medicare policy making. Such analyses were not possible under the former hodgepodge of billing methods.

Present Coding System

Under HCPCS, physician services are described through use of the American Medical Association's *Current Procedural Terminology* (CPT). The CPT consists of a series of five-digit codes each representing a particular service (procedure). When the procedure is a physician visit, the extent of the service rendered is also designated by a procedure "level." These levels take into consideration the wide variations in skill, effort, time, responsibility and medical knowledge required under different circumstances.

The following table shows the code and corresponding level designations for "established patient office visits" (any visit after the first) and "subsequent hospital care" (daily visits in a

hospital after the day of admission). Recent data obtained from HCFA indicates that these two services together account for nearly 25 percent of the total number of services billed, and 16 percent of the total payments made under Part B.

CPT CODE AND CORRESPONDING LEVEL

OFFICE	LEVEL	HOSPITAL
90030	Minimal	N/A
90040	Brief	90240
90050	Limited	90250
90060	Intermediate	90260
90070	Extended	90270
90080	Comprehensive	90280

Reimbursement Amounts

Reimbursement rates for the various code levels are set by each carrier for its own area. Carriers establish their rates based on "prevailing charge localities," specific geographic areas where physicians' charges for services are very similar. In most instances, the higher the level of service billed the higher the reimbursement.

Uniformity Lacking

The HCFA Part B Medicare Annual Data System (BMAD) provides calendar-year data by procedure code for *every* procedure processed by each carrier for the year. Under a uniform coding system, one would expect to find similar billing patterns from carrier to carrier. Analysis of the 1984 BMAD, however, reveals that patterns of billings for "established patient office visits" and "subsequent hospital care" vary greatly. Not even a semblance of the uniformity sought under HCPCS is evident in the BMAD statistics.

PURPOSE

This inspection examines in detail the lack of uniformity in coding of claims in these two high volume areas: physician office visits by established patients, and physician visits to hospitalized patients.

The inspection has three main objectives:

(1) to determine whether there are significant problems regarding coding of office and hospital visits;

(2) to identify and examine reasons for coding problems; and

(3) to recommend corrective measures, as appropriate.

METHODOLOGY

Findings reported here are based on analysis of data contained in the Part B Medicare Annual Data (BMAD) Procedures File for 1984-1986. Other documents and statistics related to physicians' coding of medical services, listed in appendix A, provided documentation of the coding process and the conclusions of prior studies.

To help interpret the statistical findings, 142 persons knowledgeable of physician billing habits were interviewed. These individuals were: 99 persons (including 9 physicians) from all 47 Medicare carriers; 15 from HCFA's central office and 24 from HCFA's 10 regional offices; 3 from other government offices; and 1 from the American Medical Association.

FINDINGS

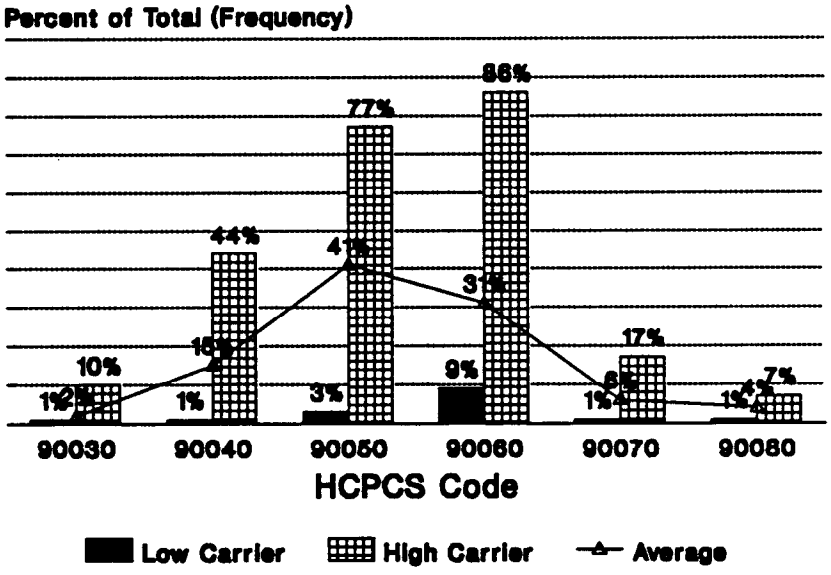
THERE ARE WIDE VARIATIONS IN CODE USAGE

An analysis of the 1985 and 1986 (latest available) BMAD statistics reveals that 1984 variations in billing patterns among carriers continue. The following charts illustrate some of these variations.

Figure A shows, for example, that for code 90060 one carrier had 86 percent of its total billings for "established patient office visits" at this level. Another had just 9 percent. The average percentage of this code reported by all carriers was approximately 31 percent.

Information on patterns of billings at all carriers is contained in appendix B of this report.

Figure A **Bills to Carriers for Established Patient Office Visits (1986)**



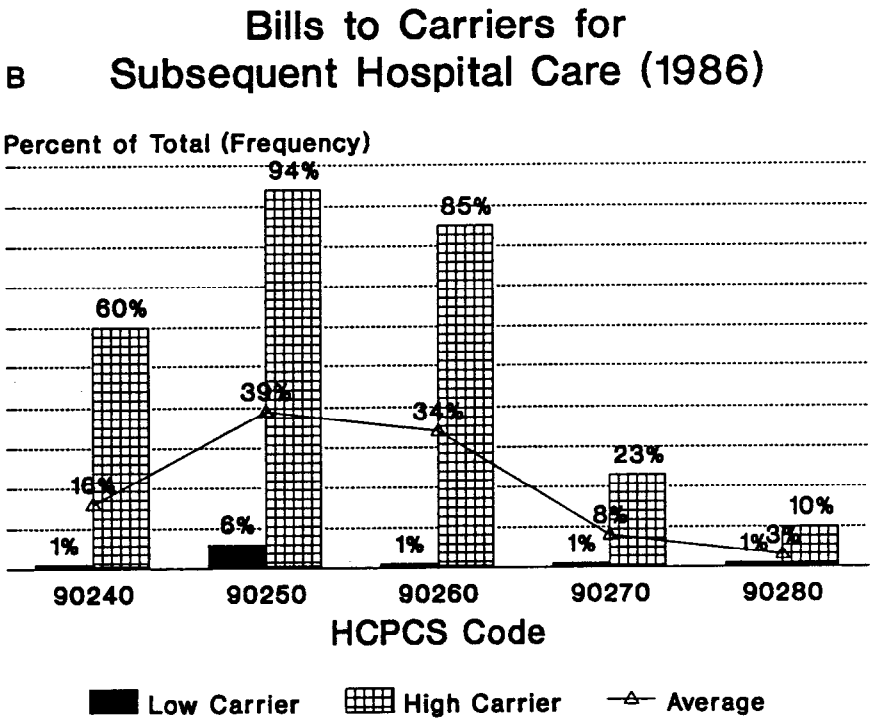
PRINCIPAL REASON IS DIFFERENCES IN INTERPRETATION

Both Group Health Insurance (GHI) and Empire Blue Shield pay claims for portions of New York City. The city is considered one prevailing charge locality for purposes of setting reimbursement rates. However, while GHI has 85 percent of its billings for subsequent hospital care at the intermediate level (90260), billings at Empire are more evenly distributed, with only 34 percent at the intermediate level. Similarly, Blue Shield of Montana and Equicore of Wyoming both serve predominantly rural populations. Blue Shield, however, has 53 percent of its hospital visits billed at the "brief" level (90240), while Equicore has only 10 percent at

this level. These and similar comparisons show that differences in billing patterns cannot be attributed to differences in the geographic location of Medicare patients.

The nature of the coding problem was examined in interviews with HCFA and carrier staff. These interviews revealed that the principal reason for variations in billing patterns among carriers is the differences in interpretation of codes by both carriers and providers. (Providers of Medicare Part B services are physicians and suppliers of medical services.) When carriers first converted to HCPCS, HCFA permitted them considerable flexibility in translating the codes under their old systems into the new CPT codes. This flexibility led, for example, to some carriers converting an old 9004 ("routine follow-up office visit") to the CPT code 90040 while others converted this code to CPT code 90050.

Figure B



No National Policy on Coding "Routine" Visits

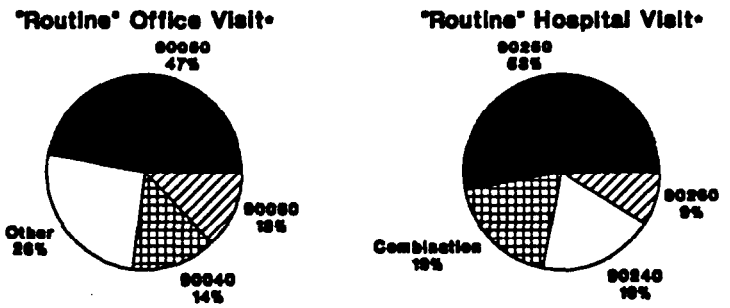
Variations in how carriers converted their old coding systems into the new are most evident in the differences in what CPT codes they chose to designate the "routine" level for office and hospital visits. "Routine" is defined as the service a physician would normally be expected to render most often.

These differences for routine visits were noted several years ago by HCFA's Region VI office in Dallas. Regional staff requested clarification from the HCFA central office (appendix C). The HCFA's response (appendix D) states that the 90050 and 90250 (limited) levels of office and hospital visits are the "most correct" codes to designate routine services. The response further states that it is possible that some carriers, based on reimbursement considerations, may have designated both the "brief" and "limited" levels as routine. While this is not the preferred

method, HCFA apparently considers it acceptable. According to HCFA staff, levels *higher* than the limited level would not be correct. With the exception of Dallas, HCFA has not communicated this position to any of its other nine regional offices.

As illustrated by the following charts, carriers continue to consider a number of different codes, or combinations of codes, as routine. Only about half of the carriers indicated they would use the 90050 or 90250 code which HCFA considers to be "most correct":

Carrier Respondent Opinions
Figure C



* (Established Patient)

Lack of uniformity in the coding of routine services causes providers to lose confidence in both the carriers and the Medicare program. The absence of a national policy on the appropriate code to designate the routine level also increases carriers' difficulties in dealing with individual providers on coding problems.

Too Many Codes Are Available

Many carrier staff state that in their opinion physicians are often confused by the large number of CPT codes available to describe office and hospital visits (six and five respectively). Additionally, many respondents perceive a lack of meaningful distinction among the various CPT coding levels, particularly the "brief" and "limited" levels. This appears to be a major factor in accounting for differences in interpretation of "routine" and other visit codes.

Under most of the carriers' previous coding systems, there were fewer codes than under the present CPT system. Some of these former systems had codes termed "routine" for office and hospital visits. Carrier respondents indicate that many physicians preferred to use these codes almost exclusively rather than having to chose the "correct" code from among several. Many believe that physicians still prefer this manner of billing.

In consideration of these points, respondents representing 70 percent of the Medicare carriers feel that the number of codes for office and hospital visits should be reduced.

REIMBURSEMENT IS ALSO A FACTOR

While differences in interpretation of codes by carriers and providers account for most of the variations in coding of office and hospital visits, other factors also contribute.

Many carrier staff indicate that a number of physicians may seek to maximize reimbursement by billing a higher level code than appropriate for the service rendered. In numerous cases, this was substantiated by carriers' findings in postpayment review of physicians' claims. Several carriers suggested that this problem may be accelerating as Congress imposes measures, such as fee freezes, to control spiraling Medicare outlays.

Carriers also point out that the coding selection process which is used in the physician's office frequently includes consideration of the amount the carrier will reimburse for a billed service. Although code selection should be based solely on the type of service rendered, those who prepare the bills often match the physician's normal charge for an office or hospital visit to the code which pays the same amount, and bill accordingly.

The attitude expressed by several carrier representatives, including one medical director, supplied another example of the influence of reimbursement factors on coding. These persons noted that if physicians consistently bill just one code for established patient office visits and one for subsequent hospital care, over time the reimbursement "highs and lows will balance out."

One of the larger carriers explained that they urge physicians to use the appropriate codes, but they routinely accept the intermediate level code (90260) for daily hospital visits throughout the hospital stay. Carrier representatives acknowledge that the patient should be improving the closer he comes to the day of discharge. Thus, he should not require the more extensive services represented by code 90260 at the end of his stay. However, the carrier reasons that reimbursement is about the same using code 90260 for each day as it would be using the higher level codes at the beginning of the stay and the lower codes toward the end.

Other Factors Contribute to the Problem

Still other factors which could lead to variations in coding were mentioned by carrier personnel:

- Physicians may be reluctant to use the current CPT codes describing "brief" or "limited" visits out of concern that these terms imply inferior service.

- Many specialists believe they should bill the higher level codes because they are specialists, regardless of the actual service rendered.

- Some physicians, as well as some carrier staff, believe that the more *time* spent with the patient the higher the code that should be used. (The CPT already takes into consideration the time each service should take.)

- In the CPT booklet the definitions of code levels are in a different section than the codes themselves. Associating the two is somewhat inconvenient.

HCFA and the Congress Consider Solutions

Several activities are currently underway to address specific coding problems and their underlying causes.

In order to deal with providers who may be coding services inappropriately, HCFA has mandated that all carriers use prepayment screens for certain procedure codes. These screens detect instances of physicians billing for more than a specified number of a single procedure for one patient over a given period of time. When these cases are identified by the screening process, carriers must review all claims for medical necessity before making payment.

However, there are problems with this approach. The same screens apply to all carriers equally. They assume a uniformity in application and definition of codes which does not exist. As an example, if HCFA required carriers to examine all claims for service code 90260 when over six per month are submitted, some carriers would have to examine most of these claims. This would be the case for carriers which consider 90260 the appropriate code for a "routine" hospital visit.

The Omnibus Budget Reconciliation Act of 1986 (OBRA) requires that the Secretary of HHS, by no later than July 1, 1989, "...group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered." If this requirement is applied to "subsequent hospital care" and "established patient office visits" much of the coding problem will be resolved. The HCFA, which is acting for the Secretary in this matter, has not yet decided whether these services will be included in the code grouping OBRA requires.

RECOMMENDATIONS

Consult with AMA to Reduce Number of Codes

Findings: Carriers report that physicians are sometimes confused by the number of codes available under CPT for office and hospital visits. Carrier staff also perceive a lack of meaningful distinction among the various coding levels. Respondents representing 70 percent of all carriers believe fewer visit codes are necessary. Physicians may prefer to use just one code rather than chose the "correct" code from among several. Finally, some carriers accept billings from physicians who use only one code even when it is apparent that different level services were rendered. They rationalize that, for reimbursement purposes, "the highs and lows will balance out."

Recommendation: The HCFA should consult with the AMA to reduce the number of codes available under CPT for "established patient office visits" and "subsequent hospital care."

Impact: This would bring the coding system more in line with actual billing practices. It would also reduce the incidence of inappropriate coding, and its accompanying effect on reimbursement, by providing fewer choices and greater distinction between code levels.

HCFA Comments: The HCFA agrees with this recommendation and has been working on this problem for some time. Discussions focused on reducing the number of codes have recently taken place between HCFA and the AMA.

Consolidate Codes for Reimbursement Purposes

Findings: Bills are often prepared in physicians' offices by matching the physician's charge with the carrier's reimbursement schedule, rather than with the appropriate code for the service actually rendered. Carriers have noted instances of physicians using a higher level code than appropriate in order to increase reimbursement. Some carriers may be accepting a higher level of coding than appropriate for "routine" services. The HCFA is required by OBRA to group (combine) procedure codes for payment purposes in situations where distinctions between levels are unclear.

Recommendation: Concurrent with seeking to reduce the number of codes available, HCFA should pursue consolidation of visit codes for payment purposes.

Impact: This would reduce the impact that inappropriate coding has on Medicare outlays and fulfill the intent of OBRA.

HCFA Comments: The HCFA agrees with this recommendation. A letter was recently sent from HCFA to the AMA outlining potential coding consolidations.

Define "routine" Level

Findings: There are large variations in usage of CPT codes for "established patient office visits" and "subsequent hospital care." These variations are most evident where the "routine" level of service is being billed under a number of different codes. The HCFA has designated the codes it believes "most correct" for routine services but has not promulgated this information nationally.

Recommendation: The HCFA should inform all carriers and providers of the codes it considers "most correct" for routine office and hospital visits and then assure its instructions are applied consistently.

Impact: Consistency of interpretation from carrier to carrier will improve the credibility of the coding system. Consistency will also strengthen carriers' positions in dealing with coding problems with individual providers. Further, it will allow HCFA to better use payment data by visit codes for trend analysis and policy making in such areas as fee schedules.

HCFA Comments: The HCFA agrees with this recommendation. A HCFA representative recently met with an AMA Ad Hoc Committee on Visits and Levels of Service. The meeting focused on the need for uniform understandings by Medicare carriers and the physician community regarding what codes describe "routine" visits and consultations, as well as how codes should be used by physicians in the various specialty fields.

Consult with AMA on Other Changes

Findings: Carriers report that some physicians may be reluctant to code their claims at the CPT levels termed "minimal," "brief" and "limited" due to the negative implications of these terms. Respondents also point out that the present format of the CPT book makes it inconvenient to associate the description of the level of service with the corresponding code.

Recommendation: The HCFA should discuss with AMA changing the terminology used to describe services so as to neutralize its effect on coding choice. Easier association of code *level* with the codes, at least for higher volume areas such as physician visits, should also be discussed with AMA.

Impact: These changes would eliminate two factors which appear to inappropriately bias the code-selection process.

HCFA Comments: The HCFA agrees with the recommendation. At the recent meeting between a HCFA representative and the AMA Ad Hoc Committee on Visits and Levels of Service, the need to avoid terminology that has negative connotations in the narrative descriptions of certain codes was discussed.

Educate Providers on Proper Coding

Findings: Carriers report that physician specialists often feel they should bill the higher level CPT codes simply because they are specialists. Some physicians believe the more time they spend with a patient the higher the code level they should bill. The current CPT system *already* takes into consideration the time and level of skill needed to perform various levels of services. These should not be factored in again by the physician.

Recommendation: The HCFA, along with the carriers, should better inform physicians of HCFA's interpretation of proper use of CPT codes.

Impact: Better physician understanding of the CPT system will help to reduce inappropriate coding of services.

HCFA Comments: The HCFA agrees with the recommendation. This concern was also discussed at the recent meeting between a HCFA representative and the AMA Ad Hoc Committee on Visits and Levels of Service.

APPENDIX A

Data Sources

Part B Medicare Annual Data (BMAD), Procedures File, 1984, 1985, and 1986

Carrier Annual Management Reports as Submitted to HCFA

AMA's Physicians' Current Procedural Terminology
(4th edition), 1984-1988

Physician Payment Review Commission's *1988 Report*
to Congress

HCFA Common Procedures Coding System, Conversion/Implementation Manual and User Guide

Office of Technology Assessment report: *Payment for Physician Services* (1986)

Various HCFA/Carrier policy memoranda and guidelines

APPENDIX B

Carrier Billing Frequencies for Office and Hospital Visits

(Computed from 1986 BMAD, Procedures File)

ESTABLISHED PATIENT OFFICE VISITS

(PERCENTAGE OF TOTAL SERVICE FREQUENCY WITHIN 90030-80 CODE RANGE, 1986)

NUMBER	CARRIER NAME	% 90030	% 90040	% 90050	% 90060	% 90070	% 90080
00510	BLUE SHIELD-AL	02	16	28	45	06	02
00520	BLUE SHIELD-AR	02	23	45	25	04	00
00528	BLUE SHIELD-AR (LA)	01	20	32	37	06	02
00542	BLUE SHIELD-CA (NORTHERN)	02	09	47	31	07	02
00550	BLUE SHIELD-CO	04	12	26	33	17	06
00570	BLUE SHIELD-PA (DE)	01	16	24	47	08	02
00580	BLUE SHIELD-PA (DC)	01	06	09	66	12	04
M00590	BLUE SHIELD-FL	01	13	16	58	12	04
00621	HEALTH CARE SER.-IL	06	26	37	21	07	02
M00630	BLUE SHIELD-IN	21	15	19	31	08	02
00640	BLUE SHIELD-IA	02	09	61	21	02	00
00645	BLUE SHIELD-NE	02	17	54	22	03	00
00650	BLUE SHIELD-KS	01	07	74	15	02	00
00660	BLUE SHIELD-KY	02	03	38	52	03	00
00690	BLUE SHIELD-MO	01	13	11	60	10	03
00700	BLUE SHIELD-MA	10	11	28	40	08	02
00710	BLUE SHIELD-MI	01	03	54	33	06	02
00720	BLUE SHIELD-MN	04	03	52	32	06	02
00740	BLUE SHIELD-MO (KC)	02	07	52	32	06	02
00751	BLUE SHIELD-MT	04	04	39	39	09	03
00780	BLUE SHIELD-NM (NW,UT)	03	04	75	12	03	02
00801	BLUE SHIELD-NY (WESTERN)	01	17	41	28	08	04
00803	EMPIRE BLUE SHIELD (NYC)	00	02	43	33	09	04
00820	BLUE SHIELD-ND,SD	04	13	30	35	12	04
00865	BLUE SHIELD-PA	01	13	10	63	11	03
00870	BLUE SHIELD-RI	02	05	67	18	03	01
00880	BLUE SHIELD-SC	01	08	77	09	02	00
00900	BLUE SHIELD-TX	02	17	43	25	05	02
00910	BLUE SHIELD-VT	01	09	38	42	06	02
00930	WA PHY. SER.	02	11	48	31	05	02
00951	PHY. SER.-WI	02	18	44	23	03	01
00973	PUERTO RICO-BS	01	10	46	33	07	02
01020	AETNA-AK	03	30	44	17	05	01
01030	AETNA-AZ	01	14	42	33	07	02
01120	AETNA-HI	01	21	45	28	01	00
01290	AETNA-NV	01	10	41	37	08	02
01360	AETNA-NM	02	16	44	29	06	02
01370	AETNA-OK	02	13	55	24	05	02
01380	AETNA-OR	02	13	55	24	05	02
02050	TRANSAMERICA-CA	02	05	31	42	15	04
05130	EQUITABLE-ID	03	12	61	18	03	01
05440	EQUICORE-TN	02	12	54	24	04	01
05530	EQUICORE-WY	03	20	50	21	03	01
10071	RRB	02	20	56	33	07	02
10230	TRAVELERS-CT	01	14	26	30	07	02
10240	TRAVELERS-MN	02	18	44	25	06	02
10250	TRAVELERS-MS	02	03	44	40	08	02
10490	TRAVELERS-VA	00	06	35	47	07	02
11240	GEN. AM. LIFE.-MO	01	10	44	36	03	01
13110	PRUDENTIAL-GA	01	05	49	33	07	02
13310	PRUDENTIAL-NJ	00	02	56	22	07	02
13340	PRUDENTIAL-NC	02	13	43	25	03	01
14330	OHI-NY	00	01	43	36	07	02
16360	NATIONWIDE OH	01	21	43	28	04	01
16510	NATIONWIDE WV	01	16	50	24	05	02
21200	BLUE SHIELD-ME	03	08	53	24	06	02
	AVERAGE %	02	15	41	31	06	04
	1985 AVERAGE %	03	18	41	30	05	03
	HIGHEST %	10	44	77	66	17	07
	LOWEST %	00	01	03	03	01	01
	AVERAGE ALLOWED	$11.54	$15.28	$18.34	$22.68	$29.10	$42.35

M HCFA indicates data for Blue Shield Florida and Blue Shield Indiana may not be accurate. Accordingly, figures from these carriers were not used for highest or lowest columns.

Note: All figures of less than 12 are represented by "00".

SUBSEQUENT HOSPITAL CARE

(PERCENTAGE OF TOTAL SERVICE FREQUENCY WITHIN 90240-80 CODE RANGE, 1986)

CARRIER NUMBER	NAME	% 90240	% 90250	% 90260	% 90270	% 90280
00510	BLUE SHIELD-AL	11	37	48	08	00
00520	BLUE SHIELD-AR	10	45	40	04	01
00528	BLUE SHIELD-AR (LA)	13	30	44	09	05
00542	BLUE SHIELD-CA (NORTHERN)	05	50	34	12	01
00550	BLUE SHIELD-CO	09	21	37	23	10
00570	BLUE SHIELD-PA (SE)	06	21	58	12	02
M00580	BLUE SHIELD-PA (DC)	09	08	68	13	02
00590	BLUE SHIELD-FL	09	12	31	17	31
00621	HEALTH CARE SER.-IL	13	43	28	09	06
M00630	BLUE SHIELD-IN	24	24	35	12	04
00640	BLUE SHIELD-IA	05	69	21	04	01
00645	BLUE SHIELD-NE	11	23	58	06	02
00650	BLUE SHIELD-KS	42	36	19	02	01
00660	BLUE SHIELD-KY	31	24	31	11	03
00690	BLUE SHIELD-MO	01	06	78	13	01
00700	BLUE SHIELD-MA	16	53	26	03	01
00710	BLUE SHIELD-MI	15	08	69	05	02
00720	BLUE SHIELD-MN	53	36	09	02	00
00740	BLUE SHIELD-MO (KC)	08	63	20	07	02
00751	BLUE SHIELD-MT	53	39	07	01	01
00780	BLUE SHIELD-MA (NH,VT)	04	84	10	02	00
00801	BLUE SHIELD-NY (WESTERN)	17	19	52	11	02
00803	EMPIRE BLUE SHIELD (NYC)	02	49	34	08	06
00820	BLUE SHIELD-ND,SD	60	20	14	04	02
00865	BLUE SHIELD-PA	14	07	58	19	02
00870	BLUE SHIELD-RI	14	73	11	02	00
00880	BLUE SHIELD-SC	05	44	01	00	00
00900	BLUE SHIELD-TX	22	39	27	09	03
00910	BLUE SHIELD-UT	07	58	26	08	01
00930	WA PHY. SER.	11	43	37	08	01
00951	PHY. SER.-WI	08	53	23	08	08
00973	PUERTO RICO-BS	51	14	17	09	08
01020	AETNA-AK	38	32	25	05	00
01030	AETNA-AZ	09	39	37	13	02
01120	AETNA-HI	09	64	23	04	00
01290	AETNA-NV	08	43	39	09	02
01360	AETNA-NM	11	43	37	07	01
01370	AETNA-OK	41	37	17	03	01
01380	AETNA-OR	10	58	26	05	01
02050	TRANSAMERICA-CA	02	31	45	20	01
05130	EQUITABLE-ID	09	61	22	06	02
05440	EQUICORE-TN	16	32	42	08	02
05530	EQUICORE-WY	10	52	34	05	00
10071	RRB	18	30	40	09	03
10230	TRAVELERS-CT	45	28	17	07	03
10240	TRAVELERS-MN	15	47	28	07	03
10250	TRAVELERS-MS	11	38	38	08	04
10490	TRAVELERS-VA	07	33	49	09	02
11260	GEN. AM. LIFE.-MO	10	44	33	09	05
13110	PRUDENTIAL-GA	07	37	41	10	05
13310	PRUDENTIAL-NJ	04	48	35	07	03
13340	PRUDENTIAL-NC	10	56	25	07	02
14330	GHI-NY	01	04	85	07	03
16360	NATIONWIDE OH	38	21	31	06	03
16510 *	NATIONWIDE WV	18	25	41	12	05
21200	BLUE SHIELD-ME	05	67	25	02	01
	AVERAGE %	16	39	34	08	03
	1985 AVERAGE %	18	39	33	07	02
	HIGHEST %	60	94	85	23	10
	LOWEST %	01	06	01	00	00
	AVERAGE ALLOWED	$17.61	$21.33	$26.17	$29.61	$34.81

* HCFA indicates data for Blue Shield Florida and Blue Shield Indiana may not be accurate. Accordingly, figures from these carriers were not used for highest or lowest % columns.

Note: All figures of less than 12 are represented by "00".

APPENDIX C

Request for HCFA Guidance on Coding "Routine" Visits

April 22, 1985

Refer to: DPO-R6-3:JD
UR-PJB

Health Care Financing Administration
Region VI - Dallas

HCPCS Implementation and Postpayment Utilization Review for Upcoding

Phillip Nathanson, Director
Bureau of Health Standards and Quality

Prior to the implementation of HCPCS, we looked on codes 9004 (routine follow-up office visit) and 9024 (routine hospital visit) as the codes for office and hospital visit services we would normally expect a physician to provide most of the time. If, in reviewing a physician through postpayment utilization review, we found a physician who was billing the Medicare program for a substantially larger number of higher level service (e.g., 9005) than the routine service (i.e., 9004), we considered the physician's practice as being a potential "upcoding" situation. However, with the implementation of HCPCS, we are now uncertain as to what the routine office and hospital visit codes are. (For example: Would the routine office visit code now (under HCPCS) be 90040, 90050, or would it depend on what the CRVS to HCPCS code pricing conversion was? If the latter, what would be considered the routine code for an office visit if the CRVS 9004 charge data was used to price both the 90040 and 90050 HCPCS codes?)

Since the implementation of HCPCS, our position to the carriers in our region has been that HCPCS codes 90040 and 90240 are to be considered the routine office visit and hospital visit codes, respectively, for upcoding consideration. We have taken this position because in some cases allowing a physician who was using 9004/9024 in the past as his routine codes to use 90050/90250 now under HCPCS will result in a higher Medicare allowance. For instance, this will occur if the carrier used 9004 to price 90040 and 9005 to price 90050. However, we have recently seen Medicare newsletters that Prudential and General American Life have sent out to their physician communities which indicate that they are considering 90050 and 90250 as the routine codes. (Copies of these newsletters are attached for your reference.) We are sure that Prudential and General American Life took their positions based on the CPT-4 definition of "limited level of service" which does seem to support the use of 90050 and 90250 as routine service codes.

We would appreciate receiving your comments as to which HCPCS codes should be considered the routine codes for postpayment upcoding review purposes. We plan to hold a utilization review work group meeting for our carriers in the near future and therefore would appreciate receiving your response by May 15, 1985.

If we can provide you with any additional information on this matter, please contact John Delaney at FTS 729-6441.

M. J. Christenberry
Program Director
Policy and Operations

APPENDIX D

HCFA Advice on Coding Routine Visits

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date SEP 1 1985

From Director
Division of Data Administration, OIRM, BDMS

Subject HCPCS Implementation and Post Payment Utilization Review for Upcoding

To Mr. J. Christenberry, Program Director
Policy and Operations
Region VI - Dallas

Your request to HSQB inquiring which HCPCS codes should be considered the routine codes for post payment upcoding review purposes has been referred to this office. This response was coordinated with the Bureau of Eligibility, Reimbursement and Coverage (BERC).

As you know, there currently is no uniform national translation table for carriers to follow in converting formerly used visit codes to HCPCS. Also, as you have pointed out, the definitions of the levels of services in the American Medical Association's Current Procedural Terminology (CPT) could lead to a conclusion that CPT/HCPCS codes 90050 and 90250 represent the routine follow-up visit services, rather than codes 90040 and 90240. It seems to us, therefore, that which HCPCS visit codes are for the routine services depends primarily on what a carrier's charge data conversion was. Conversely, whether it used the appropriate charge data in establishing the reasonable charge screens for the HCPCS visit codes depends on which of them it, and the physicians in its service area, consider to be the ones for the routine services.

Outlined below, are some of the alternatives carriers may have followed in this regard, and our comments:

1. If a carrier's charge data conversion was from 1964 CRVS codes 9004/9024 to HCPCS codes 90040/90240, then the changes in the relative frequency of services reported under the latter codes are as you have indicated, the appropriate basis for identifying possible "upcoding" situations. In this instance, it also seems to us that charge data previously collected under 1964 CRVS code 9003 (brief follow-up office visit) would be used to establish the reasonable charge screens for HCPCS code 90030 (minimal service).

2. If a carrier has identified HCPCS codes 90050/90250 as the routine visit services, then the reasonable charges screens for these codes should have been based on data from charges previously made by physicians under 1964 CRVS codes 9004/9024. As you have pointed out, there would otherwise be an unwarranted escalation in the charges allowed for routine visits. Consistent with the above, we think that in this alternative, the charge data for 1964 CRVS code 9003 (brief follow-up visit) should be used to establish the reasonable charge screens for HCPCS code 90040 (brief service) and possible also for HCPCS code 90030 (minimal service). In the latter event, HCPCS code 90040 should be announced to

physicians as being equivalent to 1964 CRVS code 9003, with the expectation that lower charges will be made for code 90030. Alternatively, the instructions in Medicare Carriers Manual section 5205 (Charges for Rare or Unusual Procedures) should be followed in establishing a lower reasonable charge screen for HCPCS code 90030. Further, we would expect that charge data for the 1964 CRVS codes 9005, 9006, 9007, 9025, and 9027, etc., would be used to establish the reasonable charge screens for the HCPCS codes for more extensive follow-up visits.

3. If a carrier has used charge data for 1964 CRVS codes 9004/9024 to price services under the 90040 and 90050/90240 and 90250 HCPCS codes it has, in effect, identified a set of two HCPCS office visit codes and a set of two HCPCS hospital visit codes, with each set describing a single, i.e., routine service. In such a case the relative frequency of services under these sets of codes should be used to identify possible "upcoding" situations.

We prefer that the carriers use the second alternative because our medical consultant thinks this may be most "correct" translation. Also, we emphasize that it is important for each carrier to make sure through its professional relations activities/newsletters that physicians in its service area know what coding and charge data conversions were made, and which HCPCS code(s) should be used to describe what were previously called "brief" and routine etc., visits.

Please refer any questions to Harry L. Savitt at FTS 987-6322.

Thomas T. McCloskey

cc: K. Terry, DRP, HSQB
Regional Office Program Directors
Policy and Operations