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# MEDICARE BILLING

# Commercial System Will Allow HCFA to Save Money, Combat Fraud and Abuse

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Mr. Chairman and Members of the Subcommittee:

We are pleased to join you today in examining the actions of the Health Care Financing Administration (HCFA)—an agency of the Department of Health and Human Services (HHS)—in assessing the benefits of commercial claims-auditing software for nationwide implementation with its Medicare processing systems. Such software can be a critical tool in helping HCFA address fraud and abuse in the Medicare program. Fraud and abuse within Medicare is pervasive; accordingly, we have designated the program a high-risk area for the federal government.[1] According to HHS' Office of Inspector General, incorrect coding by physicians cost Medicare about $1.7 billion in improper payments during fiscal year 1997, an increase of about $630 million from fiscal year 1996.

Commercial systems to detect inappropriate coding/billing have been available for several years. As early as 1991 commercial firms marketed specialized auditing systems that identified inappropriately coded claims. Both the HHS Inspector General and we have noted the potential value of such systems. In 1991, the Inspector General reported that commercially available claims-auditing systems had the potential to save $12 million annually at one Medicare processing site alone.[2] Similarly, in 1995 we reported that such systems could save Medicare about $600 million annually if implemented on a nationwide basis.[3]

Instead of acquiring available commercial software, however, HCFA initially chose to develop its own system. In 1991, HCFA directed its Medicare insurance carriers to begin developing edits to be included in its claims-auditing systems. In 1994, it awarded a contract for further development of these edits, which it called the correct coding initiative—a system HCFA now owns and operates. According to HCFA, these edits helped Medicare save about $217 million in 1996 by successfully identifying inappropriate claims. Now, 3 years after our recommendation, HCFA has tested a commercial system and found that it could indeed save substantially higher sums—in this case, about $465 million annually *in addition* to the savings resulting from the coding initiative. Consequently, HCFA now plans to acquire this commercial claims-editing capability as soon as possible.

[1]High-Risk Series: Medicare (GAO/HR-97-10, February 1997).

[2]Manipulation of Procedure Codes by Physicians to Maximize Reimbursement, Office of Inspector General, Department of Health and Human Services, CIN: A-03-91-00019, August 30, 1991.

[3]Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

In a report being released today, we analyzed HCFA's progress in testing and acquiring a commercial system for identifying inappropriate Medicare bills.[4] My statement today will discuss how HCFA tested this commercial system, its initial management decisions and their consequences, and its current plans for immediate implementation.

## HCFA's Test Methodology

HCFA used a test methodology that was comparable with processes followed by other public insurers who have successfully tested and implemented such commercial systems. Other public insurers—such as the military's TRICARE, Veterans Affairs' CHAMPVA, and the Kansas and Mississippi Medicaid offices—each used four key steps to test their claims-auditing systems prior to implementation. Specifically, they (1) performed detailed comparisons of their payment policies with systems' edits to determine where conflicts existed, (2) modified the commercial systems' edits to comply with their payment policies, (3) integrated the systems into their claims payment systems, and (4) conducted operational tests to ensure that the integrated systems processed claims properly. This is a comprehensive approach that requires significant time to complete. For example, TRICARE took about 18 months for two sites and allowed about 2 years for its remaining nine sites.

HCFA's approach was similar. From contract award on September 30, 1996, through its conclusion 15 months later at the end of December 1997, both HCFA and contractor staff made significant progress in integrating the test commercial system and evaluating its potential for Medicare use nationwide. HCFA used both a policy evaluation team and a technical team to concentrate separately on these aspects of the test.

A detailed comparison of the commercial system's payment policies with those of Medicare identified conflicting edits—inconsistencies that in some cases would increase and in others decrease the amount of the Medicare payments. For example, the commercial system would pay for the higher cost procedure of those deemed mutually exclusive, while Medicare dictates paying for the lower cost procedure. (A mutually exclusive procedure would be, for instance, the same patient's receiving both an open and a closed treatment for a fracture.) Conversely, the commercial claims-auditing system would deny certain payments for assistant surgeons, while Medicare allows them. These and all other

[4]Medicare Billing: Commercial System Could Save Hundreds of Millions Annually (GAO/AIMD-98-91, April 15, 1998).

identified conflicts were provided to the vendor, who modified the system's edits to make them consistent with HCFA policy.

The technical team carried out three critical tasks. First, it developed the design specifications and related computer code necessary for integrating the commercial system into the Medicare claims-processing software. Second, it integrated the claims-auditing system into the system that processes Medicare part B claims.[5] Finally, the team conducted numerous tests of the integrated system to determine its effect both on processing speed and accuracy. HCFA management was kept apprised of the status of the test through regular progress reports and frequent contact with the project management team.

HCFA found that the edits in this commercial system could save Medicare up to $465 million annually by identifying inappropriate claims. Specifically, HCFA's analysis showed that the system's mutually exclusive and incidental procedure edits[6] would save about $205 million, and the diagnosis-to-procedure edits[7] could save about $260 million. HCFA's analysis was based on a national sample of paid claims already processed by Medicare part B and audited for inappropriate coding with HCFA's internal software. We reviewed the reports of HCFA's estimated savings, but did not independently verify the national sample from which these savings were derived. However, the magnitude of savings—$682 million, including the savings derived from HCFA's internal software, which HCFA reported at $217 million for 1996—is in line with our 1995 estimate that about $600 million in annual savings are possible.[8]

On November 25, 1997, HCFA officials notified the Administrator of the successful test of the commercial system. This was a far different conclusion than the one reported by HCFA 2 months earlier, while testing was ongoing. At a September 29, 1997, hearing before this subcommittee, a senior HCFA official stated that the agency was testing the commercial system as a stand-alone system against Medicare's claims-processing system. He testified that "for the month of August, our system, the CCI

[5]Medicare part B claims are those submitted by providers, such as physicians, laboratories, and outpatient clinics; part A covers hospitals, home health agencies, and other in-patient-facility care.

[6]An incidental procedure is one that is clinically integral to and covered by the primary procedure, such as control of intraoperative bleeding with a tonsillectomy.

[7]Diagnosis-to-procedure edits compare bills for procedures that are unexpected for a given diagnosis, such as a corneal transplant with a diagnosis of pneumonia.

[8]As with any claims editing, some of the denied items will likely be appealed and paid. The estimates are not adjusted for this.

system [correct coding initiative] achieves savings of $422,000 more than the [commercial] system would have achieved if that would have been what we were using. We were outperforming a [commercial] product." However, as we testified at that same hearing,[9] the test needed to compare the commercial system as a *supplement* to the existing one, rather than as a *replacement*. Before HCFA completed its test it did compare the commercial system as a supplement. This comparison showed that commercial systems offer the potential for substantial Medicare savings.

## Management Decisions Could Have Cost Months and Hundreds of Millions of Dollars

Despite the successful outcome of the test, two early management decisions, if left unchanged, would have significantly delayed national implementation of claims-auditing software in the Medicare program. First, the use of the test system was limited to its single Iowa location, thereby requiring another contract for nationwide implementation. Second, HCFA's initial plan following the test was to proceed with developing its own edits, rather than to acquire those available through commercial systems. This plan would not only have required additional time before implementation, but could well have resulted in a system less comprehensive in its capacity to flag suspect claims than what is available commercially. I would now like to provide some details surrounding both of these decisions.

### Limited Test Contract Precluded Speedy Nationwide Implementation

HCFA's contract limited the use of the test system to its Iowa site and did not include a provision for implementation throughout the Medicare program if the test proved successful. As a result, additional time will now be needed to award another contract to implement the test system's claims-auditing software or any other approach nationwide. According to a HCFA contracting official, it could take as much as a year to award another contract using "full and open" competition—the method normally used for such implementation. This entails preparing for and issuing a request for proposals, evaluating the resulting bids, and awarding the contract. HCFA's estimated savings of up to $465 million per year demonstrates the costs associated with delays in implementing such payment controls nationwide.

Along with additional time and lost savings from the lack of early nationwide implementation, awarding a new contract could result in additional expense to either develop new edits or for substantial rework to

[9]Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse (GAO/T-AIMD-97-176, September 29, 1997).

adapt the new system's edits to HCFA's payment policies if a contractor other than the one performing the original test wins the competition. If another contractor were to become involved, much of the work HCFA performed during the test period would have to be redone. Specifically, another company's claims-auditing edits would have to be evaluated for potential conflict with agency payment policy.

Other options were open to HCFA from the beginning. For example, HCFA could have followed the approach used by TRICARE, whose contract provided for a phased, 3-year implementation at its 11 processing sites following successful testing. According to HCFA's Administrator, the agency is doing what it can to avoid any delays resulting from the limited test contract. The Administrator said HCFA is evaluating legal options to determine if other contracting avenues are available, options that would allow expedited national implementation of commercial claims-auditing software.

## Initial HCFA Plan to Develop Own Edits Expensive and Ineffective

In reporting the test results, HCFA representatives recommended that the HCFA Administrator award a contract to develop HCFA-owned claims-auditing edits to supplement the correct coding initiative, rather than acquire these edits commercially. They provided the following rationale: First, this approach could cost substantially less than commercial edits because HCFA would have the option of changing contractors for edit updates, it would not have to pay annual licensing fees, and the developmental cost would be much less than purchasing the capability commercially. Second, according to HCFA officials, this approach would result in HCFA-owned claims-auditing edits, which are in the public domain and consequently allow HCFA to disclose its policies and coding combinations to providers, as it currently does with the correct coding initiative edits. Officials also explained that if a commercial vendor bid, won, and agreed to allow its claims-auditing edits to enter the public domain, HCFA would allow the vendor to start with its existing edits, which should shorten development time.

We found serious flaws in this approach—in terms of cost, overall effectiveness, and underlying assumptions. First, upgrading the edits by moving from the initial contract developer to one unfamiliar with them would not be easy or inexpensive; it is a major task, facilitated by a thorough clinical knowledge of the existing edits. Second, the annual licensing fees that HCFA would avoid with its own edits would be offset to some degree by the need to pay a contractor with the clinical expertise to

keep the edits current. Third, while the commercial software could cost more than developing HCFA-owned edits, this increased cost has already been more than justified by HCFA's test results demonstrating that commercial edits provide significantly more Medicare savings. Finally, the cost of delay is significant: HCFA has realized no savings from such commercial software over the past 6 years.

Moreover, we found that HCFA's plan to fully disclose its edits to the medical community is not required by federal law and is not followed by other public insurers; it could also result in limiting the number of potential contractors with an interest in bidding. In May 1995 HHS' Office of General Counsel informed HCFA that no federal law or regulation precludes it from protecting the proprietary nature of the edits and the related computer logic used in commercial claims-auditing systems. Further, HCFA's Deputy Director of the Provider Purchasing and Administration Group stated that the agency has no explicit Medicare policy requiring it to disclose to providers the specific edits used to audit their claims. Rather than disclosing the edits, other public insurers, such as CHAMPVA and TRICARE, notified providers that they were implementing the system, and supplied examples of categories of edits that would be used to check for such disparities as mutually exclusive claims.

Finally, while it is true that development time would likely be shortened if a commercial claims-auditing vendor were awarded the contract and used its existing edits as a starting point, it is doubtful that such vendors would bid on the contract if resulting edits were to be in the public domain. This response was confirmed to us by an executive of a company that has already developed a claims-auditing system; he said he would not enter into such a contractual agreement if HCFA insisted on making the edits public because this would result in the loss of the proprietary rights to his company's claims-auditing edits.

HCFA's plan to develop its own edits was also inconsistent with Office of Management and Budget (OMB) policy in acquiring information resources.[10] HCFA has not demonstrated the cost-effectiveness of its plan to develop edits internally. In fact, a prime example showing otherwise is HCFA's own estimate that every year it delays implementing claims-auditing edits of the caliber of those used in the commercial test system in Iowa, about $465 million in savings could be lost.

[10]OMB Circular A-130, 8b(5)(b) states that in procuring information resources, agencies shall "acquire off-the-shelf software from commercial sources, unless the cost-effectiveness of developing custom software to meet mission needs is clear and has been documented."

Developing comprehensive HCFA-owned claims-auditing edits could take years, during which time hundreds of millions of dollars could be lost annually due to incorrectly coded claims. To illustrate: HCFA began developing its database of edits in 1991 and has continued to improve it over the past 6 years. While HCFA reported that its correct coding initiative identified $217 million in savings in 1996 (in the mutually exclusive and incidental procedure categories), this database did not identify an additional $205 million in those categories identified by the test edits, nor does it address the diagnosis-to-procedure category, where the test edits identified an additional $260 million in possible savings. HCFA has no assurance that its own edits would be as effective as those available commercially.

## Current Plans Will Expedite Implementation of Commercial Edits

This past March, after considering our findings and other factors, the HCFA Administrator said that the agency's plans had changed. She said that HCFA plans to begin immediately to acquire and implement commercial claims-auditing software in as expedited a manner as possible.

We are encouraged that after a slow start, HCFA now plans to move quickly to take advantage of the comprehensive claims-auditing capability that is available, and we are looking forward to seeing HCFA's milestones for expeditiously implementing this capability. Typically, such milestones would include dates for awarding a contract for the commercial claims-auditing edits, initiating and completing implementation at the first Medicare site, and implementing the edits at the remaining Medicare processing sites.

Mr. Chairman, this concludes my statement. I would be happy to respond to any questions that you or other members of the Subcommittee may have at this time.

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