



UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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HUMAN RESOURCES
DIVISION

December 16, 1981

Dr.Carolyn Davis, Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D. C. 20201



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Dear Dr. Davis:

Subject: Guidance and Information Needed on the Use of
Machine Readable Claims Under Medicare and Medicaid
(HRD-82-30)

We surveyed the extent that Medicare and Medicaid providers (1) use machine readable claims 1/ and billing service companies and (2) the implications of their use on claims processing agent (Medicare contractors and Medicaid agencies or fiscal agents) operations such as administrative costs, utilization and quality control reviews, and reimbursement determinations. We were also interested in whether there were any potential conflicts of interest between claims processing agents and billing service companies. The information we obtained shows that the Health Care Financing Administration (HCFA) needs to improve controls over machine readable claim systems in use under Medicaid and obtain information so that it can develop policies for implementing the most effective and efficient systems for using such claims.

SCOPE AND METHODOLOGY

We performed most of the survey work in HCFA Region IV (Atlanta). Five of the nine Medicare carriers in the region receive and process machine readable claims and all eight State Medicaid agencies or their fiscal agents receive and process such claims. We also obtained limited information on the use of machine readable claims in HCFA Regions V (Chicago), VI (Dallas), and IX (San Francisco).

1/As used in this report, machine readable claims refers to those systems using electronic media such as magnetic tape and computer terminals to input claim data. It does not include optical character reader systems because, in these systems, providers or billing companies do not input data to the claim processing agents electronically; they use paper claim forms.

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In Region IV, we reviewed the machine readable claims processing systems at two Medicare carriers--Florida Blue Cross and Blue Shield and South Carolina Blue Cross and Blue Shield--and at the State Medicaid agencies in Georgia and Alabama. We selected the two Medicare carriers and the Georgia Medicaid agency because available information showed that their machine readable claims volumes were the highest in the region on a percentage of claims processed basis. We selected the Alabama Medicaid agency because it uses a fiscal agent which processes a higher percentage of machine readable claims than any other fiscal agent in the region.

We reviewed the systems used by six billing companies for preparing and submitting machine readable claims on behalf of Medicare and Medicaid providers in the areas covered by the Medicaid agencies and Medicare carriers that we visited. We selected the billing companies, from lists provided by the Medicaid agencies and Medicare carriers, based on the billing companies' size, range of services, and location.

In Alabama and Georgia, we also visited a total of 21 selected Medicaid providers and reviewed their support for a total of 400 randomly selected machine readable claims. The 21 providers consisted of 10 pharmacies in Alabama and 10 physicians and one medical lab in Georgia. We selected the providers based on their geographic location, number of claims submitted during a randomly selected claim payment cycle, and the billing service company they used.

We reviewed HCFA and State policies and requirements for using machine readable claims and available records on the volume of machine readable claims processed and the benefits associated with their use. We also held discussions with HCFA headquarters and regional office officials and officials at the selected Medicaid agencies, Medicare carriers, billing companies, and providers.

HCFA NEEDS TO ISSUE GUIDANCE
TO STATE MEDICAID AGENCIES

HCFA has established controls for the use of machine readable claims in the Medicare program, but not in the Medicaid program. HCFA's guidelines in the Medicare carrier and intermediary manuals (1) specify the format for submitting machine readable claims, (2) require HCFA approval of carrier and intermediary machine readable claim systems, (3) require agreements between the provider, billing company and carrier insuring that providers are held ultimately accountable for the machine readable claims submitted, (4) require that carriers conduct onsite audits to verify the claim data submitted, and (5) require billing companies to maximize the number of line items on claims, thereby reducing

the number of claims required to be processed. In addition, HCFA's contracts with carriers and intermediaries prohibit carriers and intermediaries (or their parents, subsidiaries or affiliated organizations) from providing billing services to providers. This prohibition should prevent conflicts of interest.

HCFA has not issued similar guidelines to State Medicaid agencies or assisted them in developing machine readable claims systems, even though machine readable claims are widely used in the Medicaid program. Information we obtained from four HCFA regions showed that Medicaid machine readable claims systems, excluding those processing only Medicare/Medicaid crossover claims and optical character reader claims, were being used in 16 of the 22 States in these regions. States like Georgia, Michigan, and Ohio currently receive a substantial part of their total claims volume in machine readable form. Georgia, for example, received about 4.7 million, or 46 percent, of its total 10.2 million claims on magnetic tape in fiscal year 1980. Michigan receives about 40 percent of its 40 million Medicaid claims and Ohio about 50 percent of its 15 million claims on magnetic tape. Other States such as Florida and Tennessee have established machine readable claims systems more recently and do not yet receive a high volume of these claims--only about 5 and 7 percent of their total claims volume, respectively.

As discussed below, we noted some weaknesses in the machine readable claims system established in Alabama and Georgia that could lead to problems. Unless HCFA establishes requirements similar to those it has established in Medicare, it will have no assurance that States will establish adequate systems for receiving and processing machine readable claims.

HCFA action needed to
avoid potential problems

Alabama and Georgia require the provider and the billing company it uses to execute an agreement to ensure that the provider is directly and ultimately responsible for the accuracy of claims submitted on its behalf. However, neither State had an adequate means of matching the providers to the billing companies to ensure that providers were not switching billing companies without informing the State or executing the required agreements. In response to our findings, the Georgia Medicaid agency revised its agreement with providers to specify that it would only process claims submitted by the billing company identified in the agreement. Also, a Georgia Medicaid official told us that the agency intends to add an indicator to its provider data base that would enable it to match a provider with the billing company authorized to submit claims on the provider's behalf. An Alabama Medicaid official told

us that the State needed to change its system to insure that only those providers and billing companies who had executed proper agreements were submitting machine readable claims. The official, however, did not specify how or when the State would take action on this matter.

One billing company that served Georgia Medicaid providers (and providers in 14 other States) had a practice of submitting separate claims for each procedure performed by a physician instead of grouping the procedures performed during each patient visit. This practice unnecessarily inflates the number of claims and may result in increased processing costs. Georgia Medicaid officials believe the effect of this billing company practice on administrative costs is small because, in Georgia, the State Medicaid agency processes its own claims. In Alabama, however, this type of billing company practice could have a significant effect on Medicaid claims processing costs because the State pays its fiscal agent a flat fee for each claim paid. The Alabama fiscal agent had developed a proposal that, if adopted by the State Medicaid agency, would add physician and hospital claims to the existing machine readable claim system which at the time of our survey only received and processed pharmacy claims. In States like Alabama that pay fiscal agents on a per claim basis, billing companies' failure to maximize line items on claims could increase processing costs.

State Medicaid agencies, such as Alabama, using fiscal agents could experience problems if fiscal agents have ownership interests in billing companies because potential conflicts of interest could arise from the relationship between the fiscal agent processing the claims and the billing company submitting them. We did not identify any conflicts of interest between the Alabama fiscal agent and the billing companies operating in the State. However, the State Medicaid agency's contract with the fiscal agent did not preclude the fiscal agent from having interests in billing service companies. There is no HCFA guidance for the Medicaid program on this conflict of interest issue. On the other hand, the contracts that HCFA has with Medicare carriers and intermediaries prohibit them from having interests in billing service companies.

Recent HCFA actions

HCFA has developed a proposed new system requirement that would require Medicaid Management Information System (MMIS) States to be able to receive inpatient hospital claim data in the machine readable format now required by the Medicare program. This requirement is part of a package of proposed MMIS systems requirements which is currently in the HCFA review process. HCFA has indicated that certain requirements would be issued. However, the systems requirements will

not establish any controls or guidelines for the use of machine readable claims.

HCFA NEEDS TO GATHER AND
ANALYZE DATA ON THE BENEFITS
ON MACHINE READABLE CLAIMS

Medicare and Medicaid claims processing agents are using several different types of machine readable claims systems which input claim data electronically. These include magnetic tape, computer terminals, system-to-system communication, diskette or "floppy disk", and touch-tone telephone input. These systems have inherent benefits according to the limited data available. HCFA, however, has not evaluated these different types of systems to determine their relative advantages and disadvantages, or their advantages over paper claims, so that it can establish policies that will effectively promote the use of the most effective systems.

Data available shows machine
readable claims have cost benefits

According to Bureau of Program Operations officials, HCFA headquarters has not developed information on the cost savings associated with machine readable claims over paper claims in either the Medicare or Medicaid programs. Limited available data, however, shows that machine readable claims offer significant potential savings to the Federal Government and the States.

In September 1980, the Region IV Medicare Director, in an initial effort to obtain cost savings data, requested the four Medicare carriers then using machine readable claim systems in Region IV to submit cost savings estimates associated with the use of those claims. Two carriers estimated savings of 48 and 62 cents, respectively, for each machine readable claim processed. In calendar year 1980, these two carriers processed a total of 1.9 million and 229,000 machine readable claims respectively; indicating Federal savings of over \$1 million. Another carrier reported that it did not yet have sufficient volume to realize any savings and a regional official considered the estimate of the fourth carrier unreliable because the carrier had insufficient experience with machine readable claims. A regional official said that the region did not verify the data submitted by the carriers nor make an independent analysis of cost savings associated with machine readable claims.

The State Medicaid agencies in Michigan and Georgia estimated that they save 56 and 34 cents, respectively, for each claim submitted on magnetic tape. Michigan receives about 16

million claims on magnetic tape annually while Georgia receives about 4.7 million. Based on these estimates, the two States annually avoid costs totalling \$9 and \$1.6 million, respectively, by using machine readable claims instead of paper claims. Based on calendar year 1980 Federal Medicaid claims processing sharing rates for these two States, the Federal share of this savings would be about \$7.9 million. The other State Medicaid agencies that we contacted did not have any cost savings data available.

Also, we found indications of potential savings associated with the use of machine readable claims in our survey of the Medicare and Medicaid billing systems in use at the Los Angeles County/University of Southern California Medical Center 1/. Our analyses of the billing systems in use at the Medical Center showed total potential savings of about \$750,000 for a Medicare and Medicaid workload totalling 189,500 claims. We estimated the Federal share of these savings at about \$300,000. The estimate was based on the Medical Center fully automating its billing system: in other words, submitting 100 percent of its Medicare and Medicaid claims in machine readable format.

Machine readable claims create these cost savings for processing agents by eliminating data entry and manual handling of claims during processing. Processing agents also avoid the costs of preparing and mailing paper claims forms to providers who use machine readable claims.

Providers can also benefit from using machine readable claims through improved cash flow--as a result of faster claims payment--and reduced mailing costs. Noninstitutional providers such as physicians, pharmacies, and medical labs could incur additional costs for transforming claim data to machine readable form either by buying or leasing and operating equipment or by paying a billing company for preparing and sending claims. Any additional costs incurred by institutional providers would tend to reduce the savings estimates cited above because billing activities are usually allowable costs for these providers under Medicare and Medicaid.

MORE FLEXIBLE AUDIT REQUIREMENT NEEDED

It may be possible to reduce the number of audits of Medicare providers which submit machine readable claims to carriers. HCFA currently requires an annual audit of these providers. Although

1/Report to the HCFA Administrator on GAO's study of the Medicare and Medicaid billing systems in use at the Los Angeles County/University of Southern California Medical Center, dated June 19, 1979.

HCFA has not specified an acceptable error rate for machine readable claims, the results of carrier audits show that machine readable claims for many have relatively low error rates.

Current Medicare requirements

Medicare carriers must conduct onsite audits, at least annually, of providers submitting machine readable claims "to determine that the automated bill reflects the source document accurately, and that the application of coding to procedure and diagnosis was correct". Carriers must also verify that providers have beneficiary signatures on file that acknowledge receipt of the services being claimed.

HCFA had required intermediaries to conduct periodic reviews of machine readable claims and the scope of the audits was very similar to that required of carriers. However, HCFA deleted this requirement in July 1981.

Annual audits may not always be necessary

In the 102 audits completed by South Carolina Blue Cross and Blue Shield we reviewed, the carrier found deficiencies in only four audits.

Florida Blue Cross and Blue Shield, on the other hand, found some deficiencies in most of the audits we reviewed; however, the occurrence error rates ^{1/} were relatively low (under 3 percent) in over 20 percent of the audits. Of the 72 audits reviewed, 65 were complete audits covering procedure coding, documentation and signatures. The remaining 7 audits were for signature only.

Of the 65 complete audits, no deficiencies were found in 8 (12 percent) instances; 7 providers (11 percent) had error rates of less than 3 percent; and 6 (9 percent) had error rates of 5 percent or less. Of the seven audits for signatures only, four had deficiencies in less than 3 percent of the claims and the remaining had deficiencies in at least 5 percent of the claims audited.

More flexible audit requirement could result in savings

A more flexible approach to requiring annual audits of providers submitting machine readable claims could result in reductions in carrier administrative costs. In May 1981,

^{1/}The occurrence error rate reflects any error detected whether or not the error results in an erroneous payment.

the HCFA Representative at Florida Blue Cross and Blue Shield proposed to the Acting Medicare Bureau Director, Region IV, that providers with a pattern of compliance be switched to a 2 year instead of 1 year audit cycle. Out of 260 providers audited by Florida Blue Cross and Blue Shield in the 12 month period ending April 30, 1981, 97 (37 percent) had an occurrence error rate below 10 percent for at least 2 years which this carrier considered acceptable. The HCFA Representative estimated that if these 97 providers were changed to a 2 year audit cycle savings would be about \$43,000.

HCFA has not determined what level of errors would be acceptable and needs to do so to enable institution of flexible audit cycles.

Lack of Medicaid auditing requirement

HCFA has not established requirements for auditing machine readable claims submitted under Medicaid against their source documents. Neither Alabama nor Georgia conduct routinely scheduled onsite audits at Medicaid providers who use machine readable claims to determine the accuracy of the claims and the adequacy of support for them. Medicaid officials in both states acknowledge the need for onsite audits of these claims but they said that limited resources have prevented them from conducting these audits. The results of our reviews at the 21 Medicaid providers in Alabama and Florida that we visited also support the need for at least selective onsite audits of machine readable claims. At the 21 providers visited, we reviewed 400 machine readable claims and found that 15 or 3.75 percent of them contained errors which resulted in erroneous payments and that supporting documentation was inadequate for many others. Examples of inadequate documentation and errors are:

--In Alabama where we reviewed 242 pharmacy claims the prescriptions on file in support of 13 claims were not signed by a physician and in another case no prescription was on file to support the claims. Also, in one case, the drug dispensed did not agree with the prescription on file and in four cases the quantity dispensed did not agree with prescriptions. Furthermore, recipient signatures were not obtained as required by the State to support receipts of 19 prescriptions.

--In Georgia, where we reviewed 143 physician and 15 laboratory claims, 22 physician claims contained the incorrect diagnosis code and one contained an incorrect product code.

To ensure that machine readable claims accurately reflect the services provided and do not result in erroneous payments, Medicaid

should have an auditing requirement for these claims. Such a requirement should be designed to mirror Medicare's requirements which could then permit a single audit for both programs for billing service companies submitting claims to both programs.

CONCLUSIONS

Even though machine readable claims are already widely used in the Medicaid program, HCFA has only established controls over their use in the Medicare program. Issuing the proposed MMIS system requirement on uniform tape format for institutional billing is a necessary step toward establishing Medicaid guidance, but additional operational guidance similar to what has been provided Medicare contractors is needed to help HCFA ensure that States establish adequate controls for the use of machine readable claims.

HCFA has not gathered and analyzed sufficient data on the different types of machine readable claims systems used by Medicare and Medicaid claims processing agents to determine their relative advantages and disadvantages, or their benefit over paper claims. HCFA needs this data on a nationwide basis to enable it to establish policies implementing the most effective and efficient systems for processing claims in the Medicare and Medicaid programs.

HCFA can reduce the administrative costs incurred by carriers in processing machine readable claims by establishing acceptable error rates and a policy of requiring audits on a less frequent basis than annually where providers demonstrate compliance of an acceptable level.

RECOMMENDATIONS

We recommend that you issue guidance similar to that under Medicare which will assist State Medicaid agencies in implementing machine readable claim systems and in establishing controls for their use.

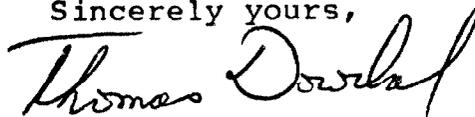
We also recommend that you gather and analyze sufficient data on the different types of machine readable claims systems used by Medicare and Medicaid claims processing agents to determine their relative advantages and disadvantages and their relative costs and benefits so policies encouraging the most effective and efficient systems for Medicare and Medicaid can be developed.

Finally, we recommend that you establish an acceptable error rate for machine readable claims and revise the current policy on onsite verification audits to allow less frequent audits of providers demonstrating compliance rates that meet the established requirements. Medicaid audit requirements should be made compatible

with Medicare requirements so that a single audit for both programs would be possible.

We would appreciate receiving any comments you might have regarding the matters in this report.

Sincerely yours,

A handwritten signature in cursive script that reads "Thomas Dowdal". The signature is written in dark ink and is positioned above the typed name.

Thomas Dowdal
Group Director