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Group 3 Report

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UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D C 20548

HUMAN RESOURCES DIVISION

JAN 11 1978
Room 6864
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Mr. Robert A. Derzon, Administrator
Health Care Financing Administration
Department of Health, Education, and
Welfare

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Dear Mr Derzon

We have recently completed a survey of Medicare carriers' use of prepayment computer edits to prevent duplicate payments. Medicare Bureau statistics show that carriers detected about \$360 million in duplicate claims during fiscal year 1976 using prepayment edits. However, during that year, an additional \$1.6 million in duplicate claims were found during postpayment reviews and payees voluntarily returned about \$2 million in duplicate payments which had not been detected by the carriers.

Information obtained from 28 carriers in five Medicare Bureau regions showed that most of the carriers use prepayment computer edits which do not fully comply with the Bureau requirements. Our tests at one of the carriers showed that this has resulted in duplicate payments. Although we have not determined the total number or amount of duplicate payments involved, they could be significant for those carriers whose edits differ considerably from the Bureau's requirements. Additionally, some carriers have edits that are probably resulting in unnecessary manual reviews.

Our survey also shows that the Bureau needs to change its requirements for the computer edits used to automatically deny duplicate claims to include matches with claims still in process. This change would reduce the number of manual reviews and also reduce the potential for errors that might be made in the manual review process.

These matters are discussed in greater detail below.

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MOST CARRIERS ARE NOT COMPLYING
WITH BUREAU REQUIREMENTS

Bureau instructions specify computerized editing criteria to be used by carriers in screening claims to identify (1) duplicate claims to be disallowed without clerical intervention and (2) potential duplicate claims to be subjected to manual review. According to Bureau officials, use of these criteria is mandatory for all carriers. However, most of the carriers we surveyed used editing criteria that varied from Bureau criteria.

Part B Medicare claims can be submitted to a carrier by either the provider or the beneficiary of services and the carrier can make payments to either party. A claim can involve one service or a number of services rendered over a period of days, weeks, or months. Information describing each service is coded by carrier personnel and entered into the carrier's computer as a line item.

In some cases, claims list services which have been billed to the carrier on previous claims. In other cases, the same service may be listed on the claim more than once. Duplicate claim edits are used to identify these situations so that a second payment will not be made for the same service. In these edits, the computer compares line items with each other to determine whether an individual service has been entered for processing and payment more than once.

Medicare instructions provide for the computer to automatically deny a line item if it is an exact duplicate of a line item which has already completed processing. Exact duplicate line items are defined as those in which the beneficiary and provider numbers, the date and place of service, the amount charged, the type of service, and the procedure code have all been coded the same.

In some cases, two line items may not be coded exactly the same even though both represent the same service. Recognizing this, the Bureau requires carriers to have edits for potential duplicate claims. In these edits, the computer compares line items for specified similarities. If these similarities are met, the suspect line items are manually reviewed by clerical personnel.

Although the regional offices are responsible for assuring that the carriers use the editing criteria required by the Bureau, the regional personnel we contacted did not know for the most part what editing criteria was being used. Further, the Annual Contractor Evaluation Reports generally do not provide complete information on the edits used by the carriers.

We visited one regional office and telephoned four others to determine the editing criteria being used by their carriers. Officials in the Kansas City, Boston, Atlanta, and San Francisco regional offices told us it would be necessary to contact the carriers to get the information. An official in the Chicago regional office was able to list the editing criteria for all but two carriers, but said the information might not be current.

To obtain information about the carriers' editing criteria, we prepared questionnaires and the five regional offices mentioned above had their carriers complete the questionnaires. The information from these questionnaires is provided in the enclosure. Only one of these carriers (Mutual of Omaha) had edits which were the same as the Bureau's requirements. The remaining 27 carriers had editing criteria which was either narrower or broader than that prescribed by the Bureau.

Narrower criteria means that the carrier requires more data fields to match than those required by the Bureau before a line item will be identified as a potential duplicate. Broader criteria means that fewer data fields must match, thereby causing more line items to be identified as potential duplicates. Thus, while broad criteria increases the potential for detecting duplicate claims, it also increases the number of claims that must be manually reviewed.

Effect of using
narrow criteria

Use of editing criteria which is too narrow results in duplicate claims not being detected. At Kansas City Blue Shield, we reviewed the edit used to compare line items from different claims which involve the same provider. We found that Kansas City had narrowed the criteria for this edit by requiring that, in addition to beneficiary number, service data, and type of service, the place of service also must match

We ran tests against one of the six claims history tapes at this carrier and estimated the results for all six tapes. Kansas City carrier officials told us that the five other tapes were comparable to the one we tested.

We estimate that adding place of service to the edit caused Kansas City Blue Shield to overlook, each month, about 80 duplicate claims amounting to approximately \$1,400. To detect the 80 duplicate claims, we estimate that an additional 331 potential duplicates would have to have been manually reviewed, which would take a total of about 7 hours. Carrier officials agreed that manual review of the additional claims would be cost effective.

Because other carriers have added not only place of service, but also other data fields to their editing criteria, we believe that there is potential for a significant number of duplicate payments by these carriers. As shown in the enclosure, 12 of the carriers were using criteria which was narrower than both options of the Bureau's criteria for comparing line items from different claims involving the same provider.

Effect of using criteria
which is too broad

Use of editing criteria which is too broad can result in unnecessary manual examinations of line items. Nineteen of the carriers were using criteria which was broader than the Bureau's criteria in at least one of the two edits used for comparing line items from the same claim. These carriers may be making unnecessary manual reviews

NEED TO CHANGE EDIT USED TO
DENY EXACT DUPLICATES AUTOMATICALLY

The Bureau carriers' manual states that duplicates which match on all fields of completed claims are to be disallowed automatically without clerical intervention. The manual, however, does not require the automatic disallowance of exact duplicates still in process.

If an exact duplicate line item is not automatically denied, the potential duplicate edits should cause the line item to be manually reviewed. Consequently, failure to make automatic denials whenever feasible can result in an unnecessary manual review workload. In addition, human errors in the manual review process can allow duplicate payments to be made.

On one of the six computer tapes of claims history at Kansas City Blue Shield, we identified 16 duplicate payments which were caused by errors made during the manual review process. These payments involved exact duplicate line items which had not been automatically denied because the older line items had not completed processing when the newer line items entered the computer. Had the carrier's automatic denial edit included comparisons with line items still in process, the errors would not have been made because the claims would have been denied automatically.

Although we did not estimate the number of duplicates that required manual review instead of being automatically denied, the number may have been significant because manual review errors should have been made in only a small percentage of the exact duplicates reviewed. We believe this to be true because exact duplicates should be relatively easy to detect.

CONCLUSIONS AND RECOMMENDATIONS

Medicare carriers are not complying with the required criteria for screening duplicate claims. This noncompliance is resulting in duplicate payments and may be resulting in unnecessary manual review of potential duplicates. Regional offices have not ensured adherence to the Medicare Bureau criteria.

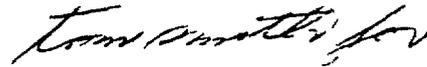
Also, criteria for the edit used to deny exact duplicates automatically should be changed to include comparisons with other claims still in process. The edits presently required have resulted in unnecessary manual review and in some cases, actual duplicates were not detected because of errors made in the manual review process.

We recommend that you require the Medicare Bureau to:

- direct regional offices to ensure that all carriers comply with the Medicare Bureau duplicate detection criteria and to specifically show the carriers' criteria in the Annual Contractor Evaluation Reports,
- change the automatic denial edit criteria to include comparisons with claims still in process.

The Medicare Bureau has taken action on several other matters which we brought to their attention during our survey. Nonetheless, we would appreciate your advising us of any actions taken or planned with regard to the matters discussed in this report.

Sincerely yours,



Robert E. Iffert, Jr.
Assistant Director

Enclosure

ENCLOSURE

ENCLOSURE

CARRIERS' EDIT CRITERIA THE SAME AS(S) BROADER THAN (B) OR NARROWER THAN (N) MEDICARE'S CRITERIA

Region/Carrier	Automatic Denials	POTENTIAL DUPLICATE EDITS					
		Within the same claim		Lines from different claims 1/			
		Same provider	Different providers	Option I		Option II	
				Same provider	Different providers	Same provider	Different providers
Atlanta Region							
Blue Shield of Alabama	S	S	B	S	S		
Florida Group Health	S	S	B	S	S		
Georgia Prudential	S	S	B	S	S		
North Carolina Prudential	S	S	B	S	S		
Blue Shield of South Carolina	B	S	B	S	S		
Tennessee Equitable	N	S	B	S	S		
Boston Region							
Aetna Life and Casualty 4/	S	S	B	N	B	N	N
Connecticut General Life Insurance Co	S	S	S	N	N	N	N
Blue Shield of Massachusetts	S	N	No edit			S	S
New Hampshire/Vermont Physicians Service	B	S	S	N	N	N	N
Blue Shield of Rhode Island	S	B	S	N	N	S	N
The Travelers Insurance Co -5/	S	S	B	S	S		
Union Mutual Life Insurance Co	N	B	B	S	B	B	B
Chicago Region							
Continental Casualty Company	S	S	S	N	S	S	B
Health Care Service Corporation	N	B	B	S	B	B	N
Mutual Medical Insurance	B	No edit	No edit			S	S
Blue Shield of Michigan	B	B	B	N	B	N	N
The Medical Society of Milwaukee County	S	S	B	N	B	N	N
Blue Shield of Minnesota	S	N	No edit	N	B	S	N
Nationwide Mutual Insurance Co	S	B	B	N	B	N	N
Wisconsin Physicians Service	B	N	2/	N	N	N	N
1988 City Region							
General American Life Insurance Co	S	B	B	S	B	B	N
Blue Shield of Iowa	3/	B	B	N	B	N	N
Illinois Blue Shield	S	B	B	N	B	N	N
Iowa City Blue Shield	S	B	B	N	S	N	N
Mutual of Omaha	S	S	S	S	S		
1 San Francisco Region							
California Physicians Service	N	B	B	N	B	N	N
Accidental Life Insurance Co	B	2/	2/	N	2/	N	N
	S = 17	S = 13	S = 5	S = 11	S = 11	S = 5	S = 2
	N = 4	N = 3	N = 0	N = 15	N = 4	N = 12	N = 17
	B = 6	B = 10	B = 18	B = 0	B = 10	B = 3	B = 1
	Other = 1	Other = 1	Other = 2		Other = 1		
		No edit = 1	No edit = 3				

For this edit, the Bureau allows one of two options. Data noted on the enclosure for both options means that the carriers' criteria was not in full compliance with either option.

Processing methods preclude the need for this edit.

The carrier's criteria is broader in one respect, but narrower in another.

The Aetna office in Hartford, Connecticut, applies the computer edits for Aetna field offices in Alaska, Arizona, Hawaii, Nevada, Oklahoma, and Oregon. The Travelers office in Hartford, Connecticut, applies the computer edits for Travelers field offices in Minnesota, Mississippi, and Virginia.