

June 1990

MEDICARE

HCFA Can Reduce Paperwork Burden for Physicians and Their Patients



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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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June 20, 1990

Congressional Requesters:¹

In response to your request, this report addresses ways the Health Care Financing Administration should reduce the Medicare part B paperwork burden on health care providers and the elderly.

Unless you publicly announce the report's contents earlier, we plan no further distribution of this report for 30 days. At that time we will provide copies to the Secretary of Health and Human Services, the Director of the Office of Management and Budget, and other interested parties.

You may reach me on (202) 275-5451 if you or your staff have any questions. Major contributors to this report are listed in appendix IV.

Sincerely yours,

A handwritten signature in cursive script that reads "Janet L. Shikles".

Janet L. Shikles
Director, Health Financing
and Policy Issues

¹The requesters of this report are listed in appendix I.

Executive Summary

Purpose

The paperwork required to process claims under the Medicare program is burdensome and confusing to many of Medicare's beneficiaries, as well as to providers of Medicare-covered services. A number of Members of Congress asked GAO to study the paperwork required in the claims process for Medicare part B. GAO reviewed the process to determine whether

- opportunities exist to help providers submit complete claims,
- notices to beneficiaries explain claims decisions clearly, and
- electronic services, such as electronic mail, could reduce paperwork.

GAO selected these areas for review because they showed significant potential for (1) reducing Medicare paperwork and (2) improving communications between beneficiaries, providers, and Medicare contractors.

Background

Medicare insures 33 million elderly and disabled Americans and processes over 400 million part B claims annually. The Health Care Financing Administration (HCFA) pays contractors to (1) process and pay claims for Medicare benefits and (2) send benefit notices of payment decisions to beneficiaries and providers.

Representatives of provider and beneficiary organizations have expressed concern about the complexity and burden of the Medicare claims process. The findings of government and provider organization surveys indicate three areas of particular concern: First, there are indications that neither beneficiaries nor providers are clear about what information is required on claims forms. If claims are not completed correctly before filing, contractors must ask claimants for additional information, resulting in delays and more paperwork. Second, benefit notices to beneficiaries, concerning actions taken on their claims, are unclear. Unclear notices can result in increased frustration with the claims process; they also reduce the usefulness of the notice as an internal control against provider fraud or error. Third, surveys have found that providers find communications with contractors, to obtain information about their claims, frustrating and burdensome.

Results in Brief

Millions of incomplete Medicare claims forms are filed each year, and HCFA's contractors must ask providers or beneficiaries for the missing information. Incomplete claims impose a paperwork burden on providers and beneficiaries, delay payments, and increase Medicare's administrative costs. HCFA could alleviate these problems by identifying

effective techniques for obtaining complete and accurate claims information.

The benefit notices HCFA contractors send to beneficiaries, explaining claims decisions, are ineffective—unclear and lacking essential information. As a result, (1) beneficiaries are poorly informed of the actions Medicare contractors have taken on their claims and (2) the effectiveness of the notice, as a means to detect provider fraud or error, is diminished.

Electronic services, such as electronic mail and automated filing, could help ease the paperwork burden and administrative costs to providers and contractors; these services could also reduce payment time.

Principal Findings

Incomplete Claims Increase Costs and Paperwork

Each year, beneficiaries and providers file millions of incomplete claims forms (45 million during fiscal year 1989) with HCFA's contractors. Much of the missing information is basic data that identify the beneficiaries or the services provided. Correspondence to obtain this information incurs administrative costs, delays payment, and creates more paperwork. (See pp. 13-14.)

The efforts of a HCFA contractor GAO visited suggest one way to address the incomplete claims problem. This contractor targets its educational program to providers that consistently file incomplete claims. The program appears to have significantly reduced the number of incomplete claims. (See pp. 14-15.)

Efforts to educate providers are all the more worthwhile in light of the Omnibus Budget Reconciliation Act (OBRA) of 1989, which requires providers to complete and file all Medicare claims for their patients, as of September 1, 1990. (See p. 15.)

Ineffective Benefit Notices

The Medicare benefit notices explain the following to beneficiaries: what services the contractor approved; how much Medicare paid; and who the payment is made to. GAO found that descriptions of services were vague; provider names on notices were not always specific enough to

identify the actual provider; and other information was incomplete, confusing, or unnecessary. As a result, beneficiaries do not always understand what actions were taken on their claims and paperwork increases if they request clarification. (See pp. 17-25.)

The benefit notices may be the first notices beneficiaries receive for claims providers have filed; these notices therefore are an opportunity for beneficiaries to verify that they received the services providers billed. Moreover, many contractors do not send beneficiaries notices when they approve payment on certain claims. As a result, the effectiveness of benefit notices as a means to detect provider fraud or error is undercut (See p. 25.)

HCFA does not monitor the effectiveness of benefit notices. Without surveying beneficiaries, for example, HCFA cannot ascertain the (1) clarity of the benefit notices or (2) inclusion of information essential to beneficiaries. In addition, contractor practices for notifying beneficiaries of Medicare payments to providers are, in many cases, contrary to HCFA policy. (See pp. 26-27.)

Reducing Costs and Paperwork by Electronic Services

By increasing electronic services, such as electronic claims filing, HCFA could reduce providers' costs and paperwork, as well as Medicare's administrative costs. Contractors can process an electronic claim for 35 cents less than a paper claim. Because OBRA now requires HCFA to encourage and develop a system that can pay electronic claims faster, electronic filing should increase. In spite of the potentially high cost of the computer systems needed to file claims electronically, GAO found that some contractors and commercial insurers have already developed systems that make electronic filing available to more providers. (See pp. 29-31.)

HCFA could also simplify the claims process by encouraging electronic, rather than mail and telephone, communications between providers and contractors. GAO found that some contractors already offer electronic options, such as systems that allow providers to determine the status of claims, thus reducing costs for correspondence, telephone inquiries, and associated delays. HCFA, however, believes electronic communications would be too costly. (See pp. 32-34.)

Recommendations to the Secretary of Health and Human Services

GAO recommends that the Secretary of Health and Human Services direct the HCFA Administrator to assume greater leadership in reducing the paperwork burden created by the Medicare claims process. (See pp. 16, 27-28, and 35.)

Agency Comments

HCFA agrees that reducing paperwork for physicians and their Medicare patients is a worthy objective and reported a number of steps it is planning or taking to clarify or reduce program paperwork. HCFA also agrees that further automation of the claims process, through electronic communications, will reduce paperwork for physicians; in addition, HCFA noted a number of actions that will be taken to promote greater use of electronic communications. (See app. III.)

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Abbreviations

ASIM	American Society of Internal Medicine
GAO	General Accounting Office
HCFA	Health Care Financing Administration
NEIC	National Electronic Information Corporation
OBRA	Omnibus Budget Reconciliation Act of 1989

Introduction

Medicare contractors annually process hundreds of millions of claims from health care providers or Medicare beneficiaries. Providers and beneficiaries report that paperwork involved in this process is often burdensome and confusing. A number of Members of Congress asked GAO to (1) study the issue of the paperwork associated with the Medicare program and (2) identify ways to streamline the claims process.¹

Background

Medicare is a federal health insurance program authorized by title XVIII of the Social Security Act (beginning at 42 U.S.C. 1395) that covers (1) most Americans 65 years of age or older and (2) certain Americans under 65 years of age who are disabled or have chronic kidney disease. The Health Care Financing Administration (HCFA), in the Department of Health and Human Services, administers Medicare and establishes the regulations and policies under which the program operates.

Medicare part A, Hospital Insurance for the Aged and Disabled, primarily covers services furnished by hospitals, home health agencies, and skilled nursing facilities; part B, Supplementary Medical Insurance for the Aged and Disabled, primarily covers physician services. In fiscal year 1989, Medicare paid an estimated \$58.4 billion for services under part A and \$37.5 billion under part B, insuring about 33 million people in total.

We have focused our work on part B claims since they (1) involve a higher volume of claims than part A and (2) affect more beneficiaries and health care providers.

Processing of Part B Claims

To administer Medicare part B, HCFA pays 34 contractors (consisting of Blue Cross and Blue Shield organizations and commercial insurance companies), referred to as carriers, to process and pay claims.² These claims are submitted in two ways: (1) assigned—that is, the physician or supplier submits the claim and is paid by the carrier or (2) unassigned—that is, the beneficiary or, sometimes, the physician, as a service to the

¹Appendix I lists all requesters

²Although some part B claims are processed by part A contractors, this report addresses the carrier part B process only since carriers process the vast majority of part B claims.

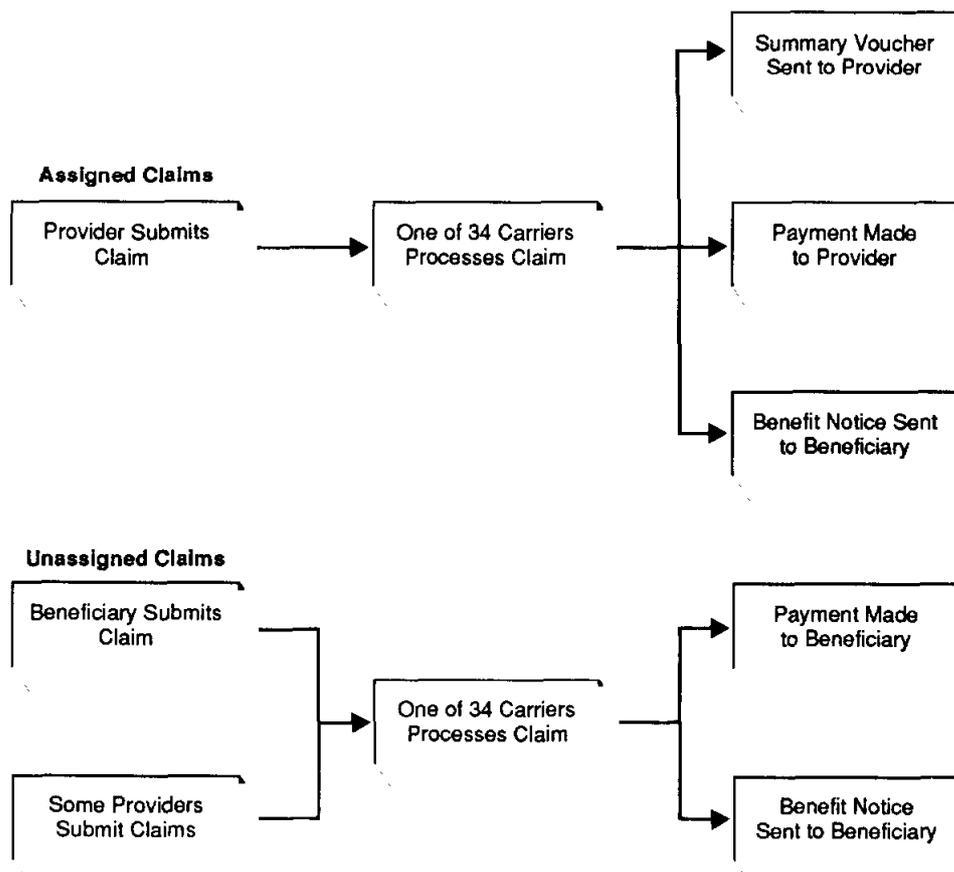
beneficiary, submits the claim to the carrier, which then pays the beneficiary. In fiscal year 1989, about 80 percent of claims were assigned.³

After a beneficiary or provider submits a claim, a carrier reviews it to determine whether (1) the beneficiary is eligible for Medicare benefits and (2) the services are covered and medically necessary. On the basis of this review, the carrier determines whether (1) the claim should be paid or denied or (2) more information is needed to make a decision. To request this additional information, a carrier generally sends a letter to either the beneficiary or the provider. When the carriers determine that claims should be paid, they also determine the amount Medicare will pay.

A carrier notifies the beneficiary and provider of the action taken on an assigned claim, using the Medicare form "Your Explanation of Medicare Benefits" (in this report, called a benefit notice) for beneficiaries and a summary voucher form for providers. For unassigned claims, notice is generally sent only to the beneficiary. In fiscal year 1989, carriers processed 411 million claims, sending the beneficiaries benefit notices for almost every one, thus making the notice one of the most prominent parts of the paperwork in the Medicare program. This process is shown in figure 1.1.

³Under the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), health care providers will be required, beginning September 1, 1990, to complete and file all Medicare claims for their patients, whether the claim is assigned or unassigned.

Figure 1.1: Steps in the Part B Claims Process



Concerns About the Medicare Claims Process

Recent studies raise concerns about the burden of paperwork in the claims process for Medicare. First, there are indications that neither beneficiaries nor providers are clear about what information is required on claims forms. In September 1989, the Physician Payment Review Commission reported that of the nearly 2,000 beneficiaries who responded to its survey, about 9 percent had paid medical bills out-of-pocket during the past year rather than file a claim with Medicare.¹ For beneficiaries with unsubmitted claims exceeding \$75 for the past year, the reason most often reported was that filing a claim is too complicated

¹Physician Payment Review Commission, *Background Paper 89-1—Assignment and the Participating Physician Program: An Analysis of Beneficiary Awareness, Understanding, and Experience* (Sept. 1989).

and time-consuming. On the basis of a 1987 survey, the American Society of Internal Medicine (ASIM) reported that about 71 percent of its physician members surveyed believed Medicare requires unnecessary documentation.⁵

Second, the Medicare benefit notices sent to beneficiaries do not communicate information clearly. The Physician Payment Review Commission reported in 1989 that beneficiaries were having difficulty understanding the notices. The commission surveyed a sample of beneficiaries, sending each a notice for an unassigned claim and asking questions about it. The commission found that (1) 66 percent of the respondents could not determine beneficiary liability; (2) 69 percent could not identify whether the provider participated in the Participating Physician and Supplier Program;⁶ and (3) 43 percent could not figure out whether the annual deductible had been met.

Finally, the 1987 ASIM survey indicates that communications between carriers and physicians can be difficult and frustrating. Of the physicians ASIM surveyed, about 76 percent reported difficulty reaching a carrier by telephone to obtain information; 63 percent reported incidents in which carriers did not respond to letters within 6 weeks; and 60 percent reported incidents in which carriers did not respond to letters at all. Focusing on physicians that have decided to be nonparticipating physicians, ASIM reported that a major reason for nonparticipation, many physicians said, was that inquiries and appeals are inefficiently handled. Although ASIM has not updated its survey since 1987, an ASIM official told us that many of the problems noted in the 1987 survey still exist.

Objectives, Scope, and Methodology

As agreed with the congressional requesters, GAO's overall objective was to identify ways to (1) clarify or reduce paperwork in the Medicare part B program and (2) streamline the claims process. On the basis of discussions with congressional staff, we agreed to determine whether

- opportunities exist to help providers submit complete claims;
- benefit notices sent to beneficiaries explain carrier decisions clearly; and
- electronic services, such as electronic mail, could reduce paperwork.

⁵American Society of Internal Medicine, 1987 Carrier Accountability Monitoring Project: A Survey of ASIM Members' Experience With Medicare Carriers

⁶The Congress created this program under the Deficit Reduction Act of 1984 (P.L. 98-369). In return for agreeing to accept assignment, participating physicians and suppliers receive faster payment along with other benefits.

GAO selected these three areas to examine because they showed significant potential for realizing our objective. We reviewed the first area because requesting additional information increases paperwork, delays payment to beneficiaries and providers, and results in added costs to the Medicare program. We reviewed the second area because beneficiaries and organizations representing the elderly have cited the benefit notice as a major reason for beneficiary confusion and frustration with the Medicare program. When beneficiaries do not understand the actions taken on their claims by carriers, they may write or call Medicare carriers for clarification, thus increasing program administrative costs. We reviewed the third area because electronic services could facilitate paperless and more efficient communications between providers and carriers.

We did our work at HCFA's headquarters in Baltimore, three HCFA regional offices, three Medicare carriers, and three commercial health insurance companies. On certain aspects of the claims process, we also solicited the views of the 31 Medicare carriers that we did not visit. In addition, we contacted individual providers and groups representing them or the elderly, hereafter referred to as provider or beneficiary organizations.

During our work, we did the following: held discussions with officials of HCFA, three carriers, and three commercial insurance companies; reviewed HCFA's guidance to its carriers; discussed HCFA's monitoring of carrier activities with HCFA officials; and analyzed carrier reports on additional information requested from providers and beneficiaries. In addition, we reviewed a random sample of benefit notices for assigned and unassigned claims; because this sample was small in comparison with the total volume of notices sent, the results of our analysis are not generalizable. The details of the scope of our work and methodology are presented in appendix II.

We did our field work from May 1988 through September 1989, in accordance with generally accepted government auditing standards.

Helping Providers Improve Medicare Claims Submitted

Each year, providers and beneficiaries submit millions of claims without complete information. In order to process these claims, carriers frequently need to request the missing information from beneficiaries or providers, which increases administrative costs, delays payment, and increases paperwork in the Medicare claims process. In fiscal year 1989, 45 million claims—about 1 out of every 9—were incomplete.

The effectiveness varied for the techniques carriers use to reduce the number of incomplete claims. One carrier targeted educational assistance to providers who habitually submitted incomplete claims. This targeting appeared to have substantially reduced the number of incomplete claims filed with this carrier. Since providers currently file at least 80 percent—soon they will be filing all—of Medicare claims for beneficiaries, improving provider claims submitted is an important way to reduce paperwork in the Medicare program. HCFA does not identify the techniques that are most effective in reducing incomplete claims, although it does give carriers funds for provider education.

Millions of Claims Incomplete and Require Additional Information

In fiscal year 1989, providers or beneficiaries did not include all the information carriers needed to make payment on about 45 million of the 411 million claims processed.¹ On about 28 million of these claims, the carrier had to contact the provider, beneficiary, or other sources, and these claims contributed to delays in payment and to the complexity and burden of the claims process. Moreover, incomplete claims involve more carrier time and handling and, therefore, are more costly to process than complete claims.

Of the data missing from incomplete claims, GAO found that much was basic information required on the claims forms. Reports on requests for additional claims information, prepared by two of the three carriers GAO visited,² showed that the information carriers requested generally fell into one of three categories:

- beneficiary information, which is requested on the claim form, including such data as the beneficiary's name, the nature of the illness, and information on any other health insurance;

¹ Available data do not indicate whether claims filed by providers or by beneficiaries are more likely to contain incomplete data.

² HCFA does not require carriers to prepare reports on requests for additional information. The third carrier we visited did not prepare these reports.

-
- service information, which is requested on the claim form, including such data as the date(s) of service, charges, and the name and address of the provider; and
 - medical information, beyond that normally asked for on the form, generally including detailed information showing the need for the services claimed.

GAO found that a large percentage of requests related to beneficiary or service information that should have been filled in on the original claim form. For a 3-month period in 1989, the two carriers that prepared the reports sent about 337,000 requests to beneficiaries and providers for additional information. We analyzed about 225,000 of these requests—90 percent of which were sent to providers and 10 percent to beneficiaries.³ We found that about 42 percent of requests to providers and 87 percent of requests to beneficiaries were for missing beneficiary or service information. The other 58 percent of provider requests and 13 percent of beneficiary requests were generally for medical information. This indicates that a substantial portion of all requests sent by the two carriers could have been avoided if claims contained all required information when first submitted.

Targeted Education May Result in More Complete Claims

To keep providers informed about the data that need to be filed with claims and about changes in Medicare policy, HCFA funds carriers for provider education. HCFA does not, however, require carriers to submit information on educational assistance; consequently, HCFA does not learn of programs that may result in more complete claims submissions and fewer requests for information. Concerning educational programs for the three carriers we visited, our review disclosed that some programs may be more effective than others in improving the quality of claims submissions.

One of the carriers we visited targets its provider education to providers who consistently fail to furnish information needed to process claims. The carrier identifies these providers by reviewing monthly reports of requests to providers for additional information. Carrier staff conduct training seminars on claims preparation for these providers, carrier officials stated, as well as offering personalized assistance to individual providers and provider groups. The officials believe, they stated, staff

³For this analysis, we did not include requests used infrequently (less than 1 percent of all requests sent) in order to gain a more general view of information requests. We also excluded requests that pertained to other possible health insurance coverage because only one of the two carriers' reports contained this information.

efforts improve the quality of provider-submitted claims. Neither of the other two carriers targets its educational assistance to those providers who most frequently submit incomplete claims. These carriers, carrier officials told us, make available educational assistance that generally includes answering telephone inquiries, conducting seminars and workshops, and sending providers newsletters to keep them aware of program changes.

We compared data for the two carriers that prepare reports on requests for additional information; we found evidence that targeting educational assistance to selected providers may result in more complete claims:

- The carrier that targeted educational assistance made about 3.6 requests per 1,000 claims processed for additional beneficiary or service information. In contrast, the carrier that did not target educational assistance made about 23.5 requests for such information per 1,000 claims processed.
- Only about 15 percent of requests directed to providers by the first carrier involved missing beneficiary or service information, indicating providers generally submitted complete claims. For the other carrier, however, such requests accounted for about 72 percent of requests directed to providers, indicating that providers were less proficient in submitting complete claims.

Under the Omnibus Budget Reconciliation Act (OBRA) of 1989, beginning September 1, 1990, providers must file all Medicare claims for beneficiaries. Since all claims will be filed by providers, it becomes even more important to develop effective programs to reduce the number of incomplete claims submitted.

Conclusions

Each year, millions of incomplete claims are filed; carriers must contact beneficiaries or providers to obtain the missing information. Correspondence to obtain this information increases administrative costs, delays payment, and increases the burden on providers and beneficiaries. One carrier targeted educational assistance to providers that frequently submitted incomplete claims and believed targeting contributed to the carrier's sending fewer requests for additional information to providers. HCFA, however, has (1) not examined carriers' provider education assistance and (2) does not know what techniques carriers use to reduce the number of incomplete claims or which ones are effective.

**Recommendation to
the Secretary of
Health and Human
Services**

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to (1) identify effective techniques for reducing the number of incomplete claims filed by providers and (2) encourage carriers to adopt these techniques when appropriate.

**Agency Comments and
Our Evaluation**

HCFA agreed that more can be done to reduce the number of claims needing additional information before they can be processed. In its fiscal year 1991 budget guidelines, HCFA specifically directs carriers to identify problem providers in an effort to provide intensive training in claims submission. In addition, HCFA will also consider studying "best carrier practices" as a means to reduce the number of claims needing additional information.

We believe that HCFA should study carrier techniques that reduce incomplete claims filed by providers. But in addition, HCFA should, in accordance with our recommendations, identify effective techniques being used by some carriers and encourage other carriers to adopt them.

Benefit Notices Sent to Beneficiaries Need to Be More Clear

Improving the clarity of benefit notices sent to beneficiaries would make the Medicare claims process less burdensome and frustrating for beneficiaries. We found that significant changes in benefit notices are needed.

It is essential that a Medicare beneficiary understand the notice in order to know the amount of the Medicare payment, who it was paid to, and what services it covers. Currently, the notices create confusion for beneficiaries. Service descriptions are vague, and individual provider names may not be shown; other information given beneficiaries on notices is contradictory and confusing. Requests for clarification of this information adds to the paperwork burden for carriers and beneficiaries.

In addition to providing beneficiaries with information about their claims for Medicare benefits, notices are a means of detecting whether the services billed by providers were actually received. Messages that are difficult to understand or vague dilute the usefulness of the notice as a check on provider billings. Further, in some cases, carriers do not send notices to beneficiaries, eliminating an opportunity to detect provider fraud or error.

Despite the importance of the notices to Medicare beneficiaries and the program, HCFA has not routinely taken steps to assure that they are clear. HCFA noted that these notices contain messages, intended to protect beneficiary rights in the appeals process, that are necessarily somewhat technical. HCFA can take steps, however, to improve clarity. For example, the Social Security Administration has obtained beneficiary views on the clarity of its notices, but HCFA has not. As to the use of the notices as a means of detecting provider fraud or error, many carriers do not send beneficiary notices when they approve payment on certain claims—contrary to HCFA policy.

Notices Serve Several Purposes

After a beneficiary or provider files a claim, the carrier sends a notice to inform the beneficiary of its decision. Carriers send notices to beneficiaries so that they

- know that their claims were received and acted on,
- know how much Medicare is paying them or their providers and for what service(s),
- can determine how much they owe their providers, and
- can use the notices to file for supplemental insurance.

During fiscal year 1989, carriers sent approximately 400 million notices to Medicare beneficiaries. Specific information shown on a notice includes the name of the physician or supplier who provided the service; a description of the service provided; how much the provider billed and Medicare approved; and, for assigned claims, the amount the beneficiary owes the provider.

In addition to informing the beneficiary about the actions taken by carriers on their claims, the notices are an internal control mechanism to detect and deter fraudulent or erroneous Medicare billings by providers. All assigned claims are filed by providers, and payments are made directly to them rather than to the beneficiaries. Since about 80 percent of all claims are assigned, the beneficiaries are not involved in the claims process for most claims until the carriers send notices to the beneficiaries. At this point, the beneficiaries are able to (1) compare services shown on the notices with their own records or experiences and (2) identify situations in which Medicare has paid for services the beneficiaries did not receive. Each notice encourages a beneficiary to contact the carrier immediately if the beneficiary believes Medicare paid for a service he or she did not receive.

Benefit Notices Do Not Clearly Communicate Claims Decisions

At the three carriers we visited, we reviewed a sample of benefit notices and found that beneficiaries can have difficulty understanding them. When the notices do not clearly present information concerning the decision made on a claim, a beneficiary may ask the carrier for clarification. Beneficiaries made about 19 million inquiries to carriers—either by telephone, by mail, or in person—during fiscal year 1989; confusion about the information presented on the notices, several carriers said, was one reason for these inquiries. Further, this lack of clarity, as well as the fact that some carriers do not send notices in all instances, reduces the usefulness of the notices as an internal control against fraud or error.

Unclear Service Descriptions and Provider Names Make Comparing Information Difficult

Our primary concern about the notices is that service descriptions and provider names can be vague and general, making it difficult for a beneficiary to identify the services involved. Such difficulty also creates problems for beneficiaries in (1) understanding the action taken and (2) determining whether Medicare has paid for the services received; in addition, such difficulty greatly reduces the value of the benefit notice as a deterrent to provider fraud.

Chapter 3
Benefit Notices Sent to Beneficiaries Need to
Be More Clear

A benefit notice contains general descriptions of the services beneficiaries received instead of descriptions of the actual, specific services (treatments or procedures). Even though there are approximately 7,000 medical procedures in HCFA's common procedure coding system, HCFA limits its notice descriptions to 21 service categories—such as office service, inpatient visit, nursing facility, independent lab, and durable equipment. The term “office service,” for example, may represent a brief office visit, a chiropractic manipulation of the spine, or one of numerous other services. These general service descriptions can make it difficult for beneficiaries to identify the actual services that Medicare pays. An example of a benefit notice is shown in figure 3.1; item A was intended to describe two office services—one an office visit, the other an immunization; both, however, are described as “office service.”

Chapter 3
Benefit Notices Sent to Beneficiaries Need to
Be More Clear

Figure 3.1: First Example of a Benefit Notice

YOUR EXPLANATION OF MEDICARE BENEFITS
READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS 363*****77
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION Jan 10, 1989 **EOMB COPY**
 Need help? Contact:
 TRANSAMERICA OCCIDENTAL LIFE INSURANCE
 1149 South Broadway
 P.O. Box 30540
 Los Angeles, CA 90030-0540
 Phone: 213 Area: 748-2311
 Other Areas: 1-800-252-9020

[D] Participating doctors and suppliers always accept assignment of Medicare claims. See the back of this notice for an explanation of assignment. Write or call us for the name of a participating doctor or supplier or for a free list of participating doctors and suppliers.

Your doctor or supplier did not accept assignment of your claim(s) totalling \$42.00. (See item 4 on back.)

		Billed	Approved
[B] ESCONDIDO			
1 Office Service	Dec 15, 1988	\$ 30.00	\$ 30.00
[A] 1 Office Service	Nov 03, 1988	\$ 12.00	\$ 0.00
Medicare does not pay for immunizations or other routine and preventive services except for a pneumococcal pneumonia vaccination.			
Total approved amount.		\$30.00	
Medicare payment (80% of the approved amount).			\$24.00

Payment for a total of \$24.00 was made to you on check number: 533575201. If you have other insurance, it may help with the part Medicare did not pay.

You are responsible for a total of \$18.00, the difference between the Billed amount and the Medicare payment (this includes services that Medicare does not cover - shown as '\$0.00' in the approved column).

[C] You could have avoided paying \$0.00, the difference between the Billed and Approved amounts for all covered services, if the claim had been assigned.

(You have met the deductible for 1988)

If you need to call, may we suggest that you avoid the peak hours from 11:00 a.m. through 1:30 p.m..

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Jul 10, 1989. (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. Claim Control No. 8355 477 460

Note: This example has been reduced in size to fit on this page.

We believe that for common services, specific descriptions could be used, but we recognize that it would neither be practical nor useful (because of the technical nature of many procedures) to always furnish procedure code descriptions on the notices. For example, HCFA data show that in 1987, allowed charges for the top 20 types of physician services accounted for nearly 45 percent of all allowed physician charges. Of the top 20 types, the 4 accounting for the greatest percentage of allowed charges were office visits, hospital visits, cataract surgery, and electrocardiograms. None of these, however, were specifically identified as one of HCFA's 21 service categories that carriers are required to use on notices.

The provider name appearing on a notice also may not be specific enough to permit identification. To determine the provider name for the notice, carriers use the provider identification number. These numbers may be issued either to an individual provider or to a physician group; for a group, the name of the physician who performed the services would generally not appear on the notice. In figure 3.1, a member of the "Escondido Family Practice Medical Group" treated the beneficiary; because of apparent space limitations, the name was abbreviated (item B) to "Escondido"—which is also the name of the town in which the practice is located. Accordingly, on this notice, the name of the physician or the physician group that provided the service is not shown. HCFA recently required carriers to assign a unique identifier number to each physician. We believe that carriers could use this number instead of the provider number as a means to identify and show the name of the specific physician furnishing services. HCFA currently has no plans, however, to use the identifier numbers for this purpose.

When services and charges are identical, a carrier will group these services on the notice. But beneficiaries are not informed of this action. Under such circumstances, the notice sent to the beneficiary does not (1) show the unit cost per service or (2) explain that the billed amount is the total for multiple services. Conversely, a carrier sometimes splits services on a notice if part of a billed service is not covered by Medicare. Again, a carrier may not tell the beneficiary that it has done so. For example, a physician billed Medicare \$63 for a comprehensive eye examination. The carrier split the claim, approving \$50.40 for an "office service," but disapproving \$12.60 for an "office service." Medicare does not pay for routine eye examinations, the notice stated, but contained no further explanation.

Information on Notices
Can Be Incomplete,
Confusing, or Unnecessary

Notices often do not present beneficiaries with all the information needed to understand the decisions made on claims. When a claim is denied, a notice may omit (1) the reason for denial or (2) the steps the beneficiary should take to seek payment. For example, two carriers denied claims covering clinical or diagnostic laboratory services (which Medicare pays only on assignment) because, in each instance, the provider did not indicate that assignment had been accepted. More than half of all beneficiaries, a Physician Payment Review Commission survey said, do not understand the term "assignment." In each instance, the notice stated that "Medicare can only pay for laboratory tests when assignment is accepted." But the notice did not indicate what additional steps the beneficiary could take to obtain payment. In denying payments on claims, all three carriers we visited use messages on the notices simply stating that "Medicare does not pay for these supplies or services" or "Medicare does not pay for the services provided by this physician (supplier)." These messages do not explain the specific reasons for denials and, therefore, give beneficiaries little basis to challenge denials or avoid similar denials on future claims.

The notices that we reviewed also contained messages that are confusing and difficult to follow. For example, in explaining to the beneficiary how it determined the amount Medicare paid, one carrier used the message "minus your deductible remaining for this year" (see fig. 3.2, item A), indicating that the deductible remaining for the year was \$68. The approved amount, \$68.00, was not the deductible remaining for the year. Actually, the carrier applied the \$68 towards the \$75 deductible for the year.

Chapter 3
Benefit Notices Sent to Beneficiaries Need to
Be More Clear

Figure 3.2: Second Example of a Benefit Notice

YOUR EXPLANATION OF MEDICARE BENEFITS
READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS 363****96
THIS IS NOT A BILL.

HEALTH CARE FINANCING ADMINISTRATION Jan 16, 1989 **EOMB COPY**
Need help? Contact:
 TRANSAMERICA OCCIDENTAL LIFE INSURANCE
 1149 South Broadway
 P.O. Box 30540
 Los Angeles, CA 90030-0540
 Phone: 213 Area: 748-2311
 Other Areas: 1-800-252-9020

Participating doctors and suppliers always accept assignment of Medicare claims. See the back of this notice for an explanation of assignment. Write or call us for the name of a participating doctor or supplier or for a free list of participating doctors and suppliers.

Your doctor or supplier did not accept assignment of your claim(s) totalling \$78.00. (See Item 4 on back.)

	Billed	Approved
DR JORDAN		
1 Office Service Nov 08, 1988	\$ 40.00	\$ 30.00
Approved amount limited by item 5b on back.		
1 Surgery Nov 08, 1988	\$ 38.00	\$ 38.00
Total approved amount.		\$68.00
[A] Minus your deductible remaining for this year.		\$68.00
Amount remaining after subtracting the deductible amount.		\$0.00
Medicare Payment (80% of the approved amount remaining).		\$0.00

No payment is being made to you because the total amount was applied toward your annual \$75.00 deductible. If you have other insurance, it may help with the part Medicare did not pay.

You are responsible for a total of \$78.00, the difference between the Billed amount and the Medicare payment. You could have avoided paying \$10.00, the difference between the Billed and Approved amounts, if the claim had been assigned.

(You have now met \$68.00 of the \$75.00 deductible for 1988)

If you need to call, may we suggest that you avoid the peak hours from 11:00 a.m. through 1:30 p.m..

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Jul 16, 1989. (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. Claim Control No. 8355 371 400

Note: This example has been reduced in size to fit on this page.

We also found instances in which notices included messages that were not necessary. For example, on a notice for a claim processed in January 1989, one carrier included the message "Effective October 1, 1982, inpatient radiology and pathology services are paid at 80 percent." Since Medicare pays 80 percent of the approved amount for most covered physician services, this message seems unnecessary 6 years after the change. In another instance, the three carriers we visited included this message on notices: "If you have other insurance, it may help with the part Medicare did not pay." The notices also included a second message, however, stating that the carriers had forwarded each claim to the beneficiary's supplemental insurer. Messages such as those in figure 3.1, item C, are unnecessary on unassigned claims; when the billed amount and the approved amount are the same, carriers describe the participating physician program and advise beneficiaries that they could have saved "\$0.00" if the claim had been assigned.

Notice Contains Messages That Make Locating Specific Claim Data More Difficult

The notice also contains messages about various topics beyond the services Medicare pays for, who provided the services, and how much Medicare is paying. The notice has become a vehicle to provide general program information in addition to claim specific information. Because of the educational messages on a notice, beneficiaries receive a full page of data for a relatively simple claim. The notice shown in figure 3.1, for example, is in response to a claim submitted by a beneficiary for a physician office visit and an immunization.

Some educational messages are required by recent legislation, which mandated that a message describing Medicare's Participating Physician and Supplier Program appear on all notices for unassigned claims. The program, however, is described in full in the Medicare handbook each beneficiary receives. The message appears at the top of the notice on each of the millions of unassigned claims processed annually; it also precedes messages describing the action taken on the claim (see figure 3.1, item D.)

Other messages have been included on the notice in response to the Gray Panthers' lawsuit.¹ These messages let beneficiaries know why Medicare did not approve the full amount the provider billed, giving the reason (1) "the approved amount (is) limited by item 5(b or c) on back" or (2)

¹In 1983, the Gray Panthers, an advocacy group for the elderly, filed suit against the Secretary of Health and Human Services concerning, among other things, the format and content of the benefit notice.

“a special method was used to set the customary or prevailing charge (see item 5b/5c on back). The number of claims processed for this service was not enough to set the charge in the usual manner.” These messages refer the beneficiary to other messages printed on the back of the notice; these messages explain why the amount Medicare approves may be less than the amount billed and defines the “customary” and “prevailing” charge levels that limit Medicare payments. How Medicare computes the approved amount, however, is explained in the Medicare handbook.

Although some of these messages are useful, other ways are available to give this information. If beneficiaries need to be reminded of information already provided in the Medicare handbook, periodic mailings or separate inserts, included with the notice, could be used. Such alternatives should ease understanding and decrease confusion and frustration, but they may increase paperwork.

Use of Notices to Deter Fraud Has Been Hampered

In addition to showing beneficiaries the actions taken by carriers on their claims, the notices also serve as the only opportunity for beneficiaries to verify that services billed on assigned claims were actually provided. Thus, the notice is an important internal control mechanism to detect and deter fraud in the Medicare program. Two factors undermine its effectiveness in this role. First, as discussed earlier, the general descriptions of beneficiary services received and the frequent lack of specific provider names make it difficult for beneficiaries to compare the services shown on the notices with their records. Second, we found that many carriers do not send notices to beneficiaries under certain conditions, denying them the opportunity to verify that they have received the services paid by Medicare.

With one exception,² HCFA directs carriers to send notices to beneficiaries for all claims. Of the 31 carriers that responded to our inquiry, however, only 6 comply with HCFA’s guidance. The other 25 have adopted different policies on when to withhold notices. For example, 9 carriers do not send beneficiaries notices when the claims are assigned and the beneficiaries are Medicaid recipients; 4 carriers do not send notices when the beneficiaries have met the deductibles and the claims have been sent to supplemental insurers. Of the 31 carriers, 9 reported that they always send notices to the beneficiaries, even when HCFA directs them not to.

²The one exception involves claims for clinical diagnostic laboratory services that have been paid in full, are based on a fee schedule and do not involve a deductible or coinsurance.

Carriers and Beneficiary Organizations Agree That Notices Are Confusing

Carriers and beneficiary organizations have expressed concerns about the notices; these concerns are similar to the problems we identified in our review. Problems with the content or readability of the notices, representatives of 23 carriers and 10 beneficiary organizations said, include

- services that are vaguely described, and provider names that are inaccurate or incomplete, make verification of information difficult;
- mathematical calculations and explanations of beneficiary liability that are difficult to understand;
- reasons for service denial that are not precise or are difficult to understand; and
- messages that are wordy, confusing, or unnecessary.

In 1988, the American Association of Retired Persons commissioned a study of how to improve the benefit notice. This study contained comments on benefit notice problems from about 50 Medicare advocacy counselors who were community based. The principal concerns these counselors expressed were these: (1) Nonspecific descriptions of services prevented beneficiaries from comparing notices with providers' bills. (2) Abbreviating provider names or using corporate names on notices made it difficult for beneficiaries to identify the provider of services.

HCFA Has Not Adequately Addressed Notice Problems

HCFA either develops individual notice messages or approves carrier-developed messages. HCFA, however, does not review completed notices to determine if messages are relevant or used in the proper context. In addition, HCFA staff do not determine if notices are understandable or whether they confuse the reader with unnecessary information.³ HCFA officials do not, they said, routinely solicit or receive feedback from beneficiaries concerning the clarity of the notices or individual messages. Occasionally, from groups such as the American Association of Retired Persons, HCFA will solicit feedback on how clear a new message is, but this is not done for all new messages. In addition, these groups have not been asked to comment on the overall clarity of notices. Notice problems are not a HCFA priority; therefore, HCFA has not devoted resources to addressing them, although it agrees that notice messages could be improved.

³Although HCFA does not review notices to determine if they are clear and contain only necessary information, HCFA does examine benefit notices for accuracy during its evaluation of carrier operations.

In contrast to HCFA, the Social Security Administration implemented a Clear Notices Project in 1984 so as to improve its service to the public. Recognizing that unclear notices may confuse and frustrate clients, as well as result in additional calls and visits by clients to its offices, Social Security field tests proposed notice language using actual and potential notice recipients.

Conclusions

The Medicare benefit notice sent to beneficiaries (1) notifies them of claims decisions and (2) serves as an internal control against provider fraud or error. To accomplish these tasks, the notices should clearly show the services Medicare is paying for, who provided the services, and how much Medicare is paying.

Benefit notices often do not clearly identify the services Medicare is paying for or who provided the services. Unclear service descriptions and provider names (1) make it difficult for beneficiaries to compare the notices with providers' bills and (2) limit the usefulness of the notice as a deterrent to provider fraud. In addition, often because of legal requirements, notices contain confusing and unnecessary information that makes it difficult for beneficiaries to locate claim-specific information. Many carriers further reduce the notice's effectiveness as an internal control by not sending notices when Medicare payment has been approved and HCFA instructions require that a notice be sent.

HCFA acknowledges that the benefit notice could be improved, but, it stated, HCFA does not consider notice problems a priority. HCFA does not (1) solicit feedback from beneficiaries and others on how well they understand notices and (2) review the clarity of notices carriers prepare. We believe that given the potential to reduce the burden and frustration among Medicare beneficiaries and to improve internal controls, HCFA should establish notice improvement as a priority.

Recommendations to the Secretary of Health and Human Services

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to initiate a concerted effort with carriers and beneficiaries to improve the quality of notices and messages. Specifically, HCFA should

- establish a formal mechanism to solicit feedback from carriers and beneficiaries on benefit notice problems and use the feedback to improve notices and messages;

-
- during annual carrier evaluations, examine the messages used on benefit notices to assure that information is clear and necessary; and
 - monitor carriers to ensure that notices are sent to beneficiaries in all required cases so that beneficiaries will have the opportunity to detect potential payment errors or fraudulent claims.

Agency Comments and Our Evaluation

HCFA agreed with our recommendations and has taken, or plans to take, a number of initiatives in this area. For instance, HCFA has convened a work group to redesign the beneficiary benefit notice. The work group will identify the changes needed to improve the notice, including its clarity and design. HCFA will also study ways to be more specific about service categories and develop explanatory language to increase beneficiary acceptance. HCFA reports that during the planning and assessment stages, the work group will obtain input from beneficiary focus groups, carriers, and HCFA regional officials.

HCFA acknowledged that benefit notices are not sent in certain cases where there is no beneficiary liability; the practice was initiated as a cost-saving measure. However, in light of concerns about program fraud and abuse, HCFA said it would reevaluate the need to send notices in all cases.

HCFA's actions, with respect to the design and clarity of benefit notices and the use of beneficiary focus groups to obtain input, should correct many of the weaknesses we found during our work.

Expanded Use of Electronic Technologies Could Streamline the Claims Process

To reduce Medicare paperwork and increase efficiency in the claims-processing system, HCFA could make greater use of electronic technologies to automate the process. Two ways in which we found that increased automation could be beneficial were

- making it easier for providers to file claims electronically rather than on paper claims forms and
- establishing electronic communication links between carriers and providers rather than relying on mail and telephone.

HCFA acknowledges that each of these technologies could offer advantages to providers but, apart from requiring carriers to be able to receive electronic claims, has taken few steps recently to facilitate electronic filing or encourage use of electronic links.

Increased Electronic Claims Filing Can Promote Efficiency

Filing claims electronically rather than on paper claims forms has been offered as an option to providers for several years. Carriers save on processing costs for each electronic claim; providers also save on purchasing and preparing paper claims forms.

OBRA of 1989 requires HCFA to encourage and develop a system that will provide expedited payment for electronic claims, which should encourage more electronic filing. We found that some carriers and commercial insurance firms have developed systems that can make electronic filing attractive even to small-volume providers.

Electronic Claims Filing Would Benefit Carriers and Providers

Instead of preparing and submitting paper claims forms, providers can file claims by (1) sending magnetic tapes or floppy disks to carriers or (2) using modems, which connect computers over normal telephone lines. HCFA requires that carriers be able to (1) accept claims on magnetic tape and (2), unless carriers can demonstrate this would not be cost-effective, receive claims through modems.

Filing claims electronically has significant advantages over paper filing, say HCFA officials. Electronic claims can be filed more easily, can be processed more quickly and economically, and generate less paper in the Medicare system. HCFA has estimated that electronic filing saves carriers an average of 35 cents per claim; each 1-percent increase in the number of electronic claims filed annually would save carriers about \$1.3 million in processing costs.

In addition to these advantages, providers who file claims electronically incur no postage costs for submissions, have less chance of carriers losing claims, and eliminate costs to purchase and prepare paper claims forms. Electronic claims also eliminate errors sometimes made by carrier personnel when entering data into carrier systems.

To reduce Medicare administrative costs, HCFA, for several years, has required carriers to offer providers the option of filing Medicare claims electronically. Until 1987, a national work group of HCFA central office and regional office officials had established annual goals for the percentage of electronic claims it expected each carrier to receive. During each annual evaluation, HCFA measured carrier performance against these goals. But this is no longer done. In responding to this report, HCFA told us that this group has identified incentives for providers to file electronic claims. HCFA has also established a work group of representatives from each carrier that will identify incentives for electronic claims submission.

During fiscal year 1989, the Medicare law prohibited carriers from paying claims earlier than 14 days after receipt; previously, electronic claims had been paid in as little as 4 days. This delay in payment, HCFA officials said, discouraged providers from filing electronically.¹

To encourage physicians to file claims electronically, the Congress, in OBRA 1989, directed HCFA to encourage the development of a system that will provide expedited payment for electronic claims. In addition, the Congress directed HCFA to make available to physicians the technical information needed to enable them to file claims electronically.

Insurers See Potential to Increase Electronic Filing

Although the national average for claims filed electronically is 36 percent, some carriers have been considerably more successful than others in encouraging providers to file claims electronically. During the quarter ending June 30, 1989, Alabama Blue Shield received about 65 percent of claims electronically; four other carriers received more than 50 percent electronically. Some HCFA regional offices have placed more emphasis on electronic claim filing than others, HCFA officials said, and, therefore, the carriers in these regions receive a higher percentage of electronic claims.

¹This provision, effective for a 12-month period beginning October 1, 1988, was adopted in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203)

Many providers appear to have already acquired computer hardware, despite the fact that the investment in the hardware required to file electronic claims can be substantial. A survey taken by the Physician Payment Review Commission found that about half of the 2,800 physicians surveyed maintain office billing records electronically. Providers that already own personal computers would only require (1) modems, communications software, and data entry software to format claims data in order to meet carrier requirements and (2) some staff training to file electronic claims.

We identified privately developed initiatives allowing providers to file claims using a standard record format rather than a unique format for each insurer. This would simplify electronic filing for providers that have purchased computer hardware. For example, the National Electronic Information Corporation (NEIC) acts as an electronic claims clearing house: it accepts claims from providers in a standard electronic format and then reformats the claims to meet the unique requirements of each participating insurer.² Similarly, one carrier allows providers to submit magnetic tapes containing claims for both Medicare and the carrier's commercial insurance business and forwards the claims to the appropriate department—Medicare or commercial—for processing. Providers may not be able to justify the start-up costs of electronic filing, officials familiar with these initiatives explained, on the basis of their claims volume for any one insurance program. A common claims format for several insurance programs, however, may make these start-up costs easier to justify.

Commercial insurers are also developing technology that could encourage the use of electronic filing by smaller providers that cannot justify the acquisition of computer hardware for billing and claim filing. To enter claim information, three commercial insurers are testing a system that uses a device resembling a telephone keyboard with a message screen. This device will be substantially less costly than typical office computer systems.

HCFA needs to once again encourage carriers to increase the number of claims they receive electronically. OBRA 1989 offers providers an incentive to file claims electronically; HCFA needs to identify and disseminate information on those techniques that permit more providers, even those with a comparatively low number of claims, to file electronically.

²NEIC is owned by a group of over 30 commercial insurance companies that, said NEIC officials, account for about 90 percent of commercial insurance claims dollars paid out annually

HCFA Has Not Encouraged Electronic Links Between Carriers and Providers

In addition to increasing electronic claims filing, HCFA could establish electronic communications links between carriers and providers to reduce the current volume of mail and telephone communications. This has been endorsed by both carriers and provider organizations. But offering electronic links, HCFA officials stated, would be too costly for HCFA. Some carriers and commercial insurers, however, have already automated some aspects of provider communications.

How Carriers Communicate With Providers

In addition to filing claims and receiving payment, providers communicate with carriers in other ways that generate substantial paperwork. Carriers mail providers summary vouchers explaining actions taken on claims, as well as requests for additional claim information. HCFA also requires carriers to send providers newsletters at least every 3 months to inform them of changes in Medicare policy and procedures; one carrier we visited generally mailed at least one planned bulletin and one special bulletin to providers each month. Providers initiate inquiries—in writing, by telephone, or in person—to obtain information about program coverage, the status of claims, or payments. In fiscal year 1989, providers initiated 3.3 million written inquiries and 5.2 million telephone inquiries. Carriers believe that responding to these inquiries is costly.

When providers are frustrated by their inability to readily obtain information by inquiries about unpaid claims, some may simply resubmit claims. During fiscal year 1989, carriers denied payment (in whole or in part) for about 72 million claims, or about 17.5 percent of all claims processed; about one-third of the payments denied involved duplicate claims. In addition, about 8.4 percent of the payments denied were for claims for ineligible claimants. By giving providers ready access to up-to-date information on the status of claims and beneficiary eligibility, we believe carriers could reduce the number of such denials.

Carriers and Providers Support Electronic Communication Links

Carriers and provider organizations support electronic communication links as a useful alternative to current methods of communication between providers and carriers. An electronic mail system—through which providers would receive program bulletins, payment notices, and requests for additional information—could reduce program administrative costs and speed up and simplify communications. In particular, an electronic link, allowing providers to obtain accurate and current information on claims status, could improve one of the more frustrating aspects of communications between carriers and providers.

Of the 31 carriers we contacted, 20 favored the use of electronic mail for delivering payment notices and educational materials to providers; 1 also mentioned the possibility of using electronic mail to request additional information from providers. Of the 19 provider organizations, 5 advocated using electronic mail. The American Society of Internal Medicine recently passed a resolution asking HCFA to offer an electronic mail service to providers.

Of the 31 carriers we contacted, 21 favored developing a system to allow providers to determine the status of their claims through electronic links; such a system, several carriers stated, could reduce the number of provider inquiries and lower the cost of responding to these inquiries. Of the 19 provider organizations, 13 favored such a system; 7 said that electronic inquiry would speed communications with carrier officials; 5 said electronic inquiry would make it less frustrating for providers to obtain information about their claims.

Electronic mail would have to be offered as an option for providers, although carriers and providers generally endorse it. The cost to implement such an option is a primary concern to carriers and provider organizations; the cost of equipment needed to implement an electronic mail system, several noted, could be prohibitive for some providers.

HCFA Considers Electronic Communication Links Costly but Insurers Are Implementing Them

HCFA agrees that the technology is available to electronically transmit benefit notices and educational materials to providers. Requiring all carriers to offer electronic mail, HCFA officials believe, would be costly for HCFA, and the necessary resources are not available. Electronic links to respond to provider inquiries on the status of claims are feasible, HCFA officials agree, and could result in fewer written inquiries. But a system of electronic links, these officials say, is a costly service, and officials are unwilling to invest in it. The system (1) may not significantly reduce the number of telephone, as opposed to written, inquiries and (2) may provide only general information, as existing systems do, rather than specific reasons why a claim has not been processed. Further, HCFA is concerned about safeguards to limit provider access to assigned claims only.

In our contacts with carriers, we found that several had implemented some form of electronic communication link for Medicare providers on their own initiative. The most common, reported by eight carriers, was use of electronic mail to deliver payment notices to providers. For example, Blue Cross and Blue Shield of Alabama reported that since 1980, it

had offered electronic payment notices to providers who file claims electronically. Other carriers that offer this service report that providers can use the electronic payment notices to automatically record Medicare payments in their accounts receivable records, saving substantial clerical effort.

Other types of electronic links were less common among Medicare carriers, but several carriers were considering or already offering them to Medicare providers. Three carriers reported offering Medicare providers an electronic link to determine the status of claims; one reported offering an electronic link with Medicare providers that would be a helpful tool for requesting additional information. One carrier reported that it was studying an electronic bulletin board system for Medicare providers; six reported they were studying electronic links as a way of allowing providers to find out the status of claims.

To determine whether commercial insurers considered electronic links with providers useful in reducing administrative costs, we contacted selected commercial insurance firms. One said that it uses a telephone system that provides eligibility and benefit information to providers within 60 seconds; this has reduced the number of claims rejected on the basis of eligibility. NEIC is working with two commercial insurers to develop an electronic format for payment notices; NEIC has already developed an electronic system to respond to inquiries about claims status that six commercial insurers currently use. This system (1) reduces phone calls to determine the status of claims, (2) provides verification that the insurer has received the claim, and (3) reduces duplicate claims.

Conclusions

Electronic technologies can reduce Medicare administrative costs and alleviate the paperwork burden on providers. Carriers can process claims more cheaply if they are filed electronically rather than on paper. Carriers and commercial insurers are developing systems that can (1) make electronic filing accessible to more providers and (2) take advantage of electronic technology to alleviate the paperwork burden for providers. In particular, carriers and commercial insurers are experimenting with systems that require little investment in hardware and would appeal to providers with a smaller claims volume.

HCFA, however, has done little recently to promote increased automation in the claims process. HCFA has not pursued electronic communication links with providers, believing that the costs make this technology too expensive for carriers to offer. Some carriers have offered electronic

links on their own initiative; we believe this indicates electronic links can be cost-effective.

Recommendations to the Secretary of Health and Human Services

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to assume a leadership role in further automating the claims process and specifically

- identify the innovations in electronic claims filing systems and electronic communications that Medicare carriers and commercial insurers have instituted and
- disseminate information on such innovations to carriers in order to facilitate their implementation throughout Medicare.

Agency Comments and Our Evaluation

HCFA disagrees with our conclusion that the agency has not been active in promoting automation of the claims process. HCFA states that its electronic claims work groups have suggested incentives to increase electronic filing and that it will publish revised formats for electronic claims, remittance notices, and status queries. HCFA also states that it is considering electronic mail and automatic response units to transmit beneficiary information. We believe these are positive first steps. In our report, we discuss carriers and private insurers that have implemented systems that allow (1) electronic filing without use of a computer and (2) automated communication between providers and carriers. We continue to believe HCFA should take a leadership role in identifying such systems and helping its carriers implement them throughout the Medicare program.

List of Congressional Requesters

U. S. House of Representatives

Chester G. Atkins
Helen Delich Bentley
Sherwood L. Boehlert
Robert A. Borski
Barbara Boxer
John Bryant
Ben Nighthorse Campbell
Jim Chapman
Peter A. DeFazio
E. (Kika) de la Garza
Butler Derrick
Julian C. Dixon
Bill Emerson
Lanc Evans
Walter E. Fauntroy
Edward F. Feighan
Jack Fields
Claude Harris
Charles A. Hayes
Clyde C. Holloway
Larry J. Hopkins
Frank Horton
William J. Hughes
Henry J. Hyde
Jim Jontz
Marcy Kaptur
Robert W. Kastenmeier
Joe Kolter
Robert J. Lagomarsino
H. Martin Lancaster
John Lewis
Thomas J. Manton
John P. Murtha
Stephen L. Neal
Mary Rose Oaker
James L. Oberstar
Major R. Owens
Timothy J. Penny
John Edward Porter
Don Ritter
Robert A. Roe
Martin Olav Sabo
Dan Schaefer

Appendix I
List of Congressional Requesters

Norman D. Shumway
David E. Skaggs
Louise M. Slaughter
Christopher H. Smith
Lawrence J. Smith
Olympia J. Snowe
Charles W. Stenholm
Gerry E. Studds
Robert Lindsay Thomas
James A. Traficant, Jr.
Fredrick S. Upton

United States Senate

Daniel K. Akaka
James M. Jeffords

Scope and Methodology

Scope

In addition to working at HCFA's headquarters in Baltimore and its regional offices in Boston, Chicago, and San Francisco, we did work at three Medicare carriers—Blue Shield of Massachusetts, Transamerica Occidental Life Insurance Company (which serves southern California), and Blue Cross and Blue Shield of Indiana. These three carriers, which processed about 11 percent of all part B claims during fiscal year 1989, were selected to obtain (1) different geographical locations, (2) both Blue Cross and Blue Shield organizations and private insurers, (3) carriers with different assignment rates, (4) carriers receiving different proportions of electronic claims, and (5) carriers using different types of computer-based systems to process claims.

We also met with officials of three commercial health insurance companies—Aetna Life and Casualty Company, the Travelers Insurance Company, and the John Hancock Mutual Life Insurance Company—to obtain information on services these companies offered their private customers that could be useful to Medicare beneficiaries or providers. We talked to officials of the Gray Panthers (see p. 24, fn. 1) to obtain information about their lawsuit against HCFA concerning the Medicare claims process. Finally, for the 31 Medicare carriers nationwide that we did not visit, we sent letters soliciting their views on certain aspects of the claims process; 28 of these responded to our letters. To obtain views on ways to clarify Medicare paperwork and simplify the claims process, we also spoke, by telephone, with 17 groups representing the elderly (beneficiary organizations) and 19 providers or groups representing providers (both referred to as provider organizations).

Methodology

To determine whether opportunities exist to help providers submit complete claims, we (1) reviewed HCFA guidance concerning when and how carriers should obtain additional information needed to process claims and (2) discussed HCFA monitoring of carrier information requests with HCFA officials. To ascertain what types of information carriers request and who the carriers ask (beneficiaries or providers) to furnish each type of information, we analyzed carrier reports on additional information carriers requested from beneficiaries and providers; we then discussed our analysis with carrier and HCFA officials (one of the carriers we visited, Blue Cross and Blue Shield of Indiana, did not prepare these reports). Finally, we reviewed carrier efforts to inform health care providers of the information the carriers needed to process claims. We solicited the views of carrier and HCFA officials on whether improved provider education could help reduce information requests.

To determine whether the notices sent to beneficiaries explained carrier claims decisions clearly, we (1) reviewed HCFA guidance to carriers concerning the notice and (2) discussed with HCFA officials the development and approval of notice messages and beneficiary feedback on the clarity of notices. To determine whether the messages on notices were relevant and clear, we reviewed, at each of the carriers we visited, a random sample of 50 notices for assigned claims and 50 for unassigned claims. We discussed our review with carrier and HCFA officials. Because these samples were small in comparison with the total volume of claims processed, the results of our analysis are not generalizable. Finally, we discussed ways to improve the notice with carrier and HCFA officials, as well as representatives of beneficiary organizations.

To determine whether electronic technologies—such as electronic mail—could reduce paperwork, we

- interviewed officials of selected health insurance companies to obtain information on (1) services they offered that facilitate the claims process and (2) their opinions on how Medicare could improve services for beneficiaries and providers;
- discussed, with HCFA and carrier officials, the feasibility and potential savings, as well as advantages and disadvantages, of additional carrier services for beneficiaries and providers; and
- discussed additional carrier services with selected provider and beneficiary organizations.

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 27 1990

Ms. Janet L. Shikles
Director for Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: HCFA Can Reduce Paperwork Burden for Physicians and Their Patients." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,


For Richard P. Kusserow
Inspector General

Enclosure

Appendix III
Comments From the Department of Health
and Human Services

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Medicare: HCFA Can Reduce Paperwork
Burden for Physicians and Their Patients"

Overview

We agree that reducing the paperwork burden for physicians and patients is a worthy objective. However, increasing legislative requirements within the Medicare program generate the need for even more information. Virtually all of these changes are aimed at protecting the liability of the Medicare Trust Funds and beneficiaries. We agree that further automation of the claims process by establishing electronic communications between carriers and providers to reduce telephone communications will reduce the paperwork burden for physicians.

GAO Recommendation

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to identify effective techniques for reducing the number of incomplete claims filed by providers and encourage carriers to adopt these techniques where appropriate.

Department Comment

We agree and are working to accomplish this goal. GAO emphasizes the need to improve provider claims submission to reduce the number of claims returned for incomplete information. GAO found that 45 million carrier claims, or 9 percent of the total, were returned for incomplete service information. According to GAO, a large percentage of claims lacked basic information required on the claim form. The above findings were based on the projection from a 3-month sample of several carriers.

We question both the percent of claims returned and the reasons associated with claims returned. Based on HCFA's Carrier Workload and Processing Time Report for FY 89, only 7 percent of all carrier claims were returned for development. This figure includes claims that were returned for non-basic information development associated with Medicare Secondary Payer first claims development. Data included all claims submitted by all Medicare carriers in FY 89.

In spite of the questionable data reported by GAO, we agree that more can be done to reduce the number of claims returned for development. For example, we will consider for implementation in FY 91, GAO's suggestion that we study "best carrier practices" for professional relations.

Appendix III
Comments From the Department of Health
and Human Services

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Concerning mandatory claims submissions, we agree that provider education is important. In fact, HCFA's Provider Education and Training initiative is a major component of the HCFA Physician Payment Reform implementation plan. The PET initiative will feature training of providers on the provisions of payment reform through special articles in carrier bulletins, carrier-sponsored workshops and seminars, formal liaison with State and local medical societies, and through participation in meetings with physicians sponsored by State and local medical societies.

Additionally, when funding for Professional Relations (PR) was restored to the FY 89 contractor budget, HCFA recommended in its budget guidelines that carriers develop a data-analysis capability to identify and target PR needs. Many carriers adopted this recommendation.

In our FY 91 budget guidelines, we have specifically directed carriers to identify and target problem providers in an effort to provide intensive training in submission of claims which are complete, well documented, and error free. This will no longer be an optional task.

Finally, we would also like to point out that HCFA is conducting a national study to determine whether there is a difference between the error rates of claims filed electronically versus the more usual paper claim. This study will compare a sample of claims filed in either mode with the billing entities' supporting documentation, such as medical records. The ultimate purpose for the study will be to point up any additional claims processing safeguards which may be necessary as the volume of electronically billed claims increases.

GAO Recommendation

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to initiate a concerted effort with carriers and the beneficiary community to improve the quality of Explanation of Medicare Benefits (EOMB) notices and messages. Specifically, HCFA should

- establish a formal mechanism to solicit feedback from carriers, beneficiaries, and other groups on EOMB problems and use the feedback to improve the notice and its individual messages;
- examine carrier compliance with its guidance concerning EOMB format and content during annual carrier evaluations; and
- monitor carriers to ensure that EOMBs are sent to beneficiaries in all required cases so that beneficiaries will have the opportunity to detect potential payment errors or fraudulent claims.

Department Comment

We agree with these recommendations and continue to conduct a number of initiatives in this area.

Regarding the seeming lack of clarity of the EOMB referenced on page 22, the language used to develop and enhance the EOMB was developed with the approval of the Gray Panthers and other senior citizen groups.

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This language is somewhat technical in order to protect beneficiary rights in the hearings and appeals process and to provide sufficient information for other insurers to process supplemental benefits.

In response to paragraph 2 of page 24 that EOMBs do not contain enough specific information, beneficiaries can match the medical services listed on their bills with their EOMBs to identify services. Carriers are required to specifically identify on the EOMB the name of the provider of services.

We note that the EOMB is not the only tool for detecting fraud and abuse in the Medicare program. Carriers monitor claims of participating physicians for evidence of violation of the participation agreement. Further, Congress enacted certain charge limits and provisions to protect Medicare beneficiaries treated by non-participating physicians. Carriers monitor the non-participating physicians to see that they adhere to these charge limits.

Additionally, we would like to point out that GAO's statement on pages 34 and 35 that HCFA ". . . does not review completed EOMBs to determine if messages are relevant or used in the proper context." is somewhat misleading. Under the Carrier Quality Assurance Program conducted at each carrier site and by each regional office, the quality of carrier claims processing is evaluated. This includes an examination of the EOMBs prepared and sent by carriers to determine their accuracy and appropriateness. Failure to follow the specific instructions issued by HCFA relative to the format and content of these notices will result in the assessment of processing errors. Likewise, an error will be charged if HCFA required that an EOMB be sent but the carrier did not do so. Compliance with claims processing requirements is one of the areas considered in determining whether or not to renew a carrier's contract to process Medicare claims.

GAO makes reference that carriers should send an EOMB to beneficiaries for each claim processed. It is true that when Medicare pays 100 percent of the approved amount to the physician on an assigned claim and the deductible has been met, EOMBs are not sent to beneficiaries. In this situation, there is no beneficiary liability. This practice was initiated as a cost saving measure. In light of the GAO's concerns and the desire to reduce program fraud and abuse, we are reevaluating the need to send EOMBs in all cases.

Finally, a workgroup has been convened within HCFA to re-design the EOMB. This effort will coincide with the implementation of physician payment reform mandated by OBRA '89. The workgroup has the following objectives: (1) to determine changes necessary to improve the EOMB, such as for added clarity; (2) to study improvement in EOMB design; (3) to examine the possibility of using descriptor language which explains CPT-4 procedure codes on EOMBs; and (4) to develop explanatory language for more widespread beneficiary acceptance. During the planning and assessment stages, the workgroup will secure input from beneficiary focus groups, carriers and regional offices.

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GAO Recommendation

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to assume a leadership role in further automating the claims process and specifically:

-- identify the innovations in electronic claims filing systems and electronic communications that Medicare carriers and commercial insurers have instituted; and

-- disseminate information on such innovations to carriers in order to facilitate their implementation throughout Medicare.

Department Comment

Deleted.

We do not believe, as the last paragraph on page 38 suggests, that only larger-volume providers will file their claims electronically. In fact, a high proportion of Electronic Media Claims (EMC) for low-volume providers now come through billing services or organizations which specifically do EMC billings.

Now on p. 30.

On page 40, mention is made that the HCFA EMC workgroup had not proposed incentives for electronic claims submission at the time this report was issued. To present a balanced report, mention should be made that the HCFA EMC workgroup has suggested incentives for EMC. HCFA will publish revised EMC formats in 1990 which will meet the needs of HCFA and other insurers. These formats were developed by HCFA carriers and representatives of Medical Group Management Association, the Blue Shield Association, and National Electronic Information Corporation. HCFA's leadership in EMC billing is acknowledged by the commercial and Blue Shield plans. The revised specifications will include electronic remittance notices and status queries. HCFA is also considering electronic mail and the pilot testing of automatic response units to send and receive beneficiary information. The issue of beneficiary privacy, however, is sensitive. Information on beneficiaries is protected by the Privacy Act. Any initiatives undertaken must be considered within this context.

Now on p. 34.

On page 47, GAO concludes that HCFA has not been active in promoting automation in the claims process. GAO states that HCFA believes that increases in electronic claims filing will be limited because of the high cost of computer systems needed to support this initiative. GAO's perception of HCFA's attitude and approach to expanding EMC is incorrect. We believe EMC receipts can be substantially increased. As evidenced by our response to this report, we are currently working to promote EMC and will continue to do so.

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Technical Comments

Part B claims are processed by both carriers and fiscal intermediaries. The process described on page 10 is the carrier process only.

The quotation in paragraph 1 on page 12 is anecdotal. Carriers may not return beneficiary-submitted claims.

The bottom of page 12 refers to a 1987 survey by the American Society of Internal Medicine that comments upon the difficulty physicians have in obtaining information from carriers by telephone or in writing. Since that time, Medicare has greatly increased its funding of, and requirements for carriers in the area of, professional relations. These requirements include timely responses to provider inquiries.

On page 38, GAO states that the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) now requires HCFA to pay electronic claims faster. This reference should be changed to indicate that OBRA '89 actually requires HCFA to encourage and develop a system which will provide for expedited payment for electronically-submitted claims.

Now on p. 8.

Deleted.

Now on p 11

Now on p 29.

Major Contributors to This Report

Human Resources Division, Boston

Nicholas White, Assistant Director, (617) 565-7558
Monty Peters, Assignment Manager

Boston Regional Office

Robert Dee, Health Issue Area Manager
Roland A. Poirier, Evaluator-in-Charge
Julia C. Svendsen, Evaluator
Pamela L. Milligan, Evaluator
P. Taylor McNeil, Evaluator
Georgia O. Rowell, Evaluator
John Ficociello, Reports Analyst

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