

***Mining Medicare Claims:
A Medicare Contractor in Operation***

Bruce Quinn MD
Contractor Medical Director
California Medicare Part B
NHIC, Corp.

Overview

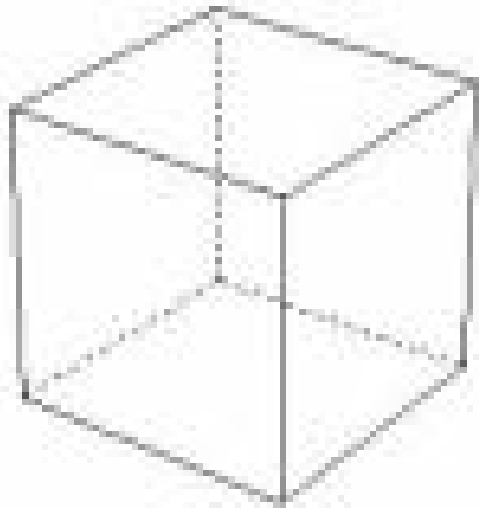
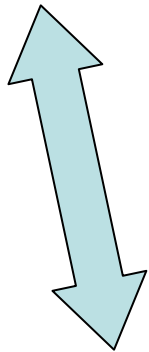
- **Medicare is complex**
- Claims data allows rule-based payment or denial
- Claims analysis is principally for abuse or fraud
- Footnote: A scholar's view of medical coding

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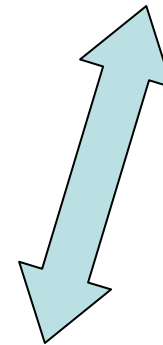
- **Medicare is complex** **WHERE ?**
- Claims data allows rule-based payment or denial **WHAT ?**
- Claims analysis is principally for abuse or fraud **WHY ?**
- Footnote: A scholar's view of medical coding

Four Different Sides of Medicare

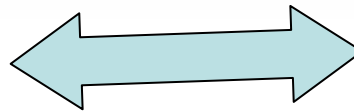
Operations



Organizations

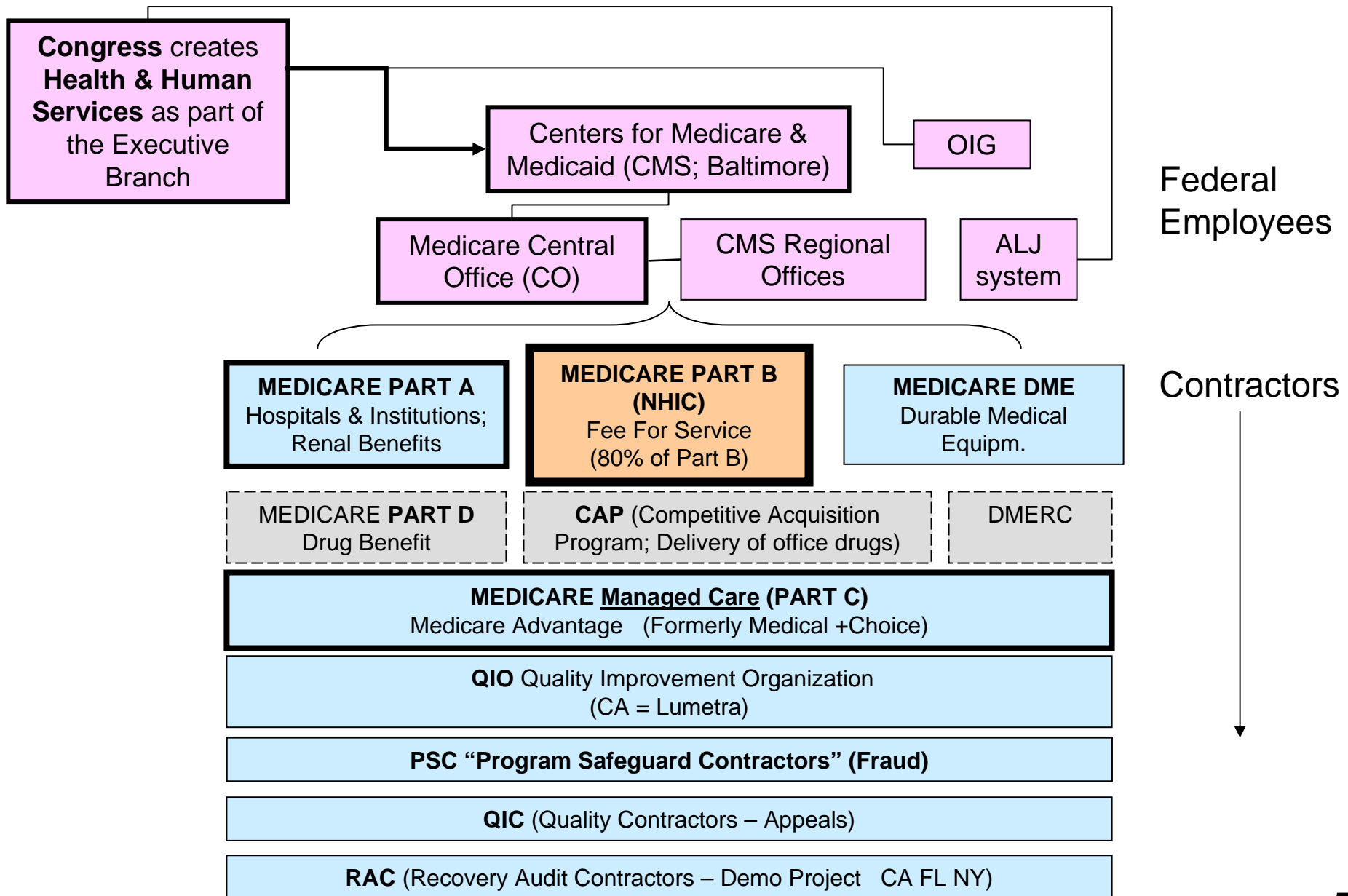


Contractors

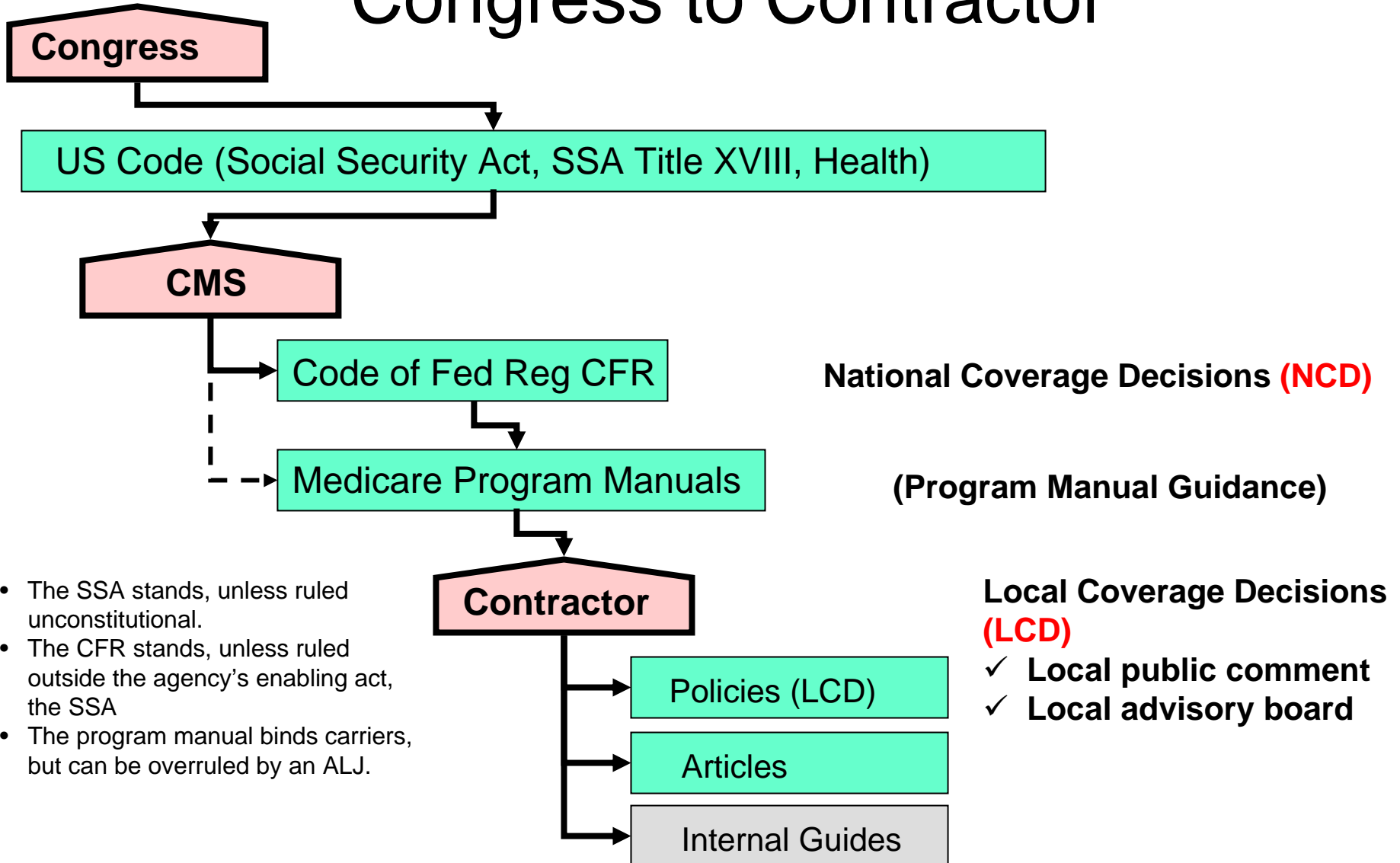


Regulatory
Cascade

Medicare has many organizations.

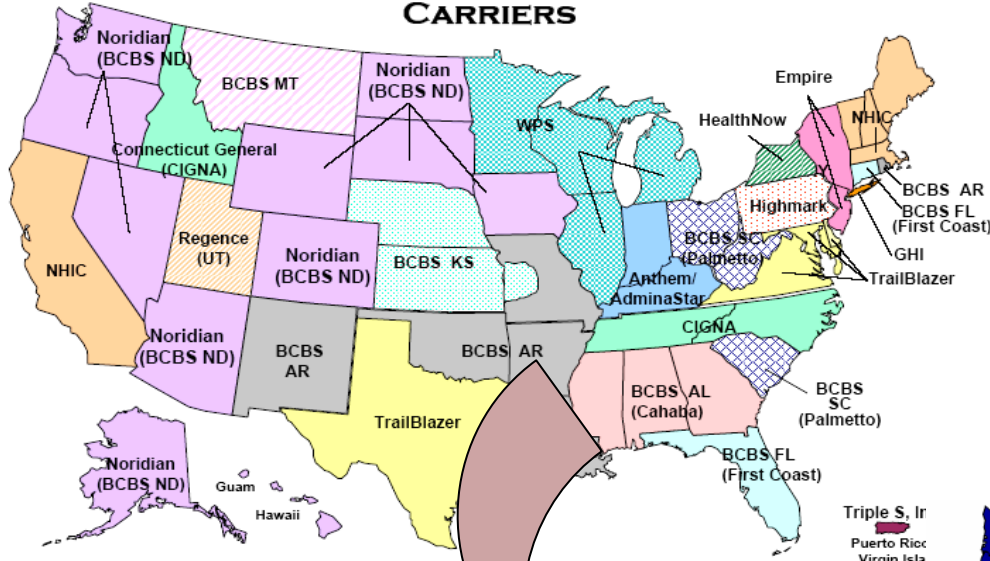


The “Regulatory Cascade” from Congress to Contractor

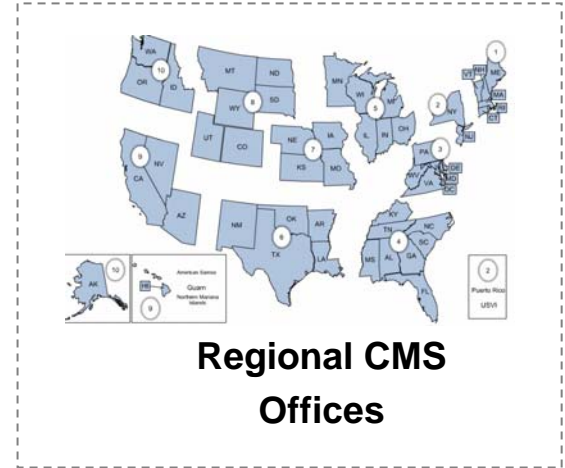


There are a lot of contractors -- but there will be many less.

CURRENT CONTRACTING ENVIRONMENT: CARRIERS

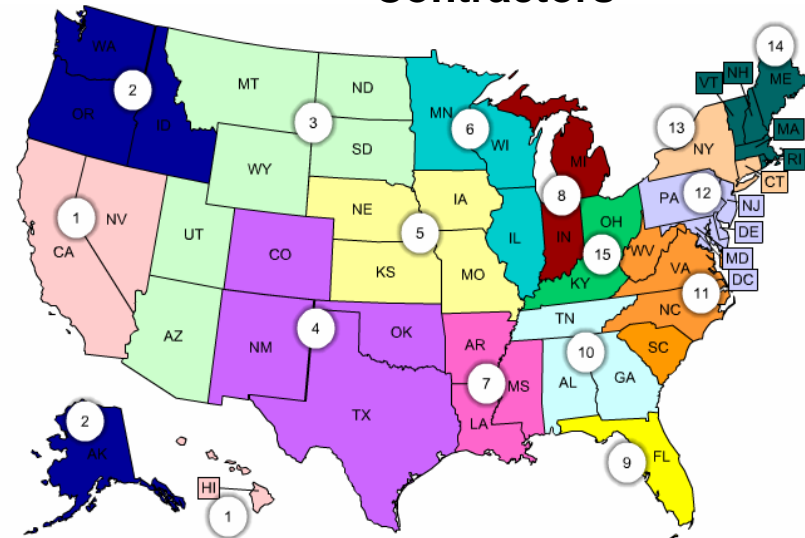


Today's Part B
Contractors



Regional CMS
Offices

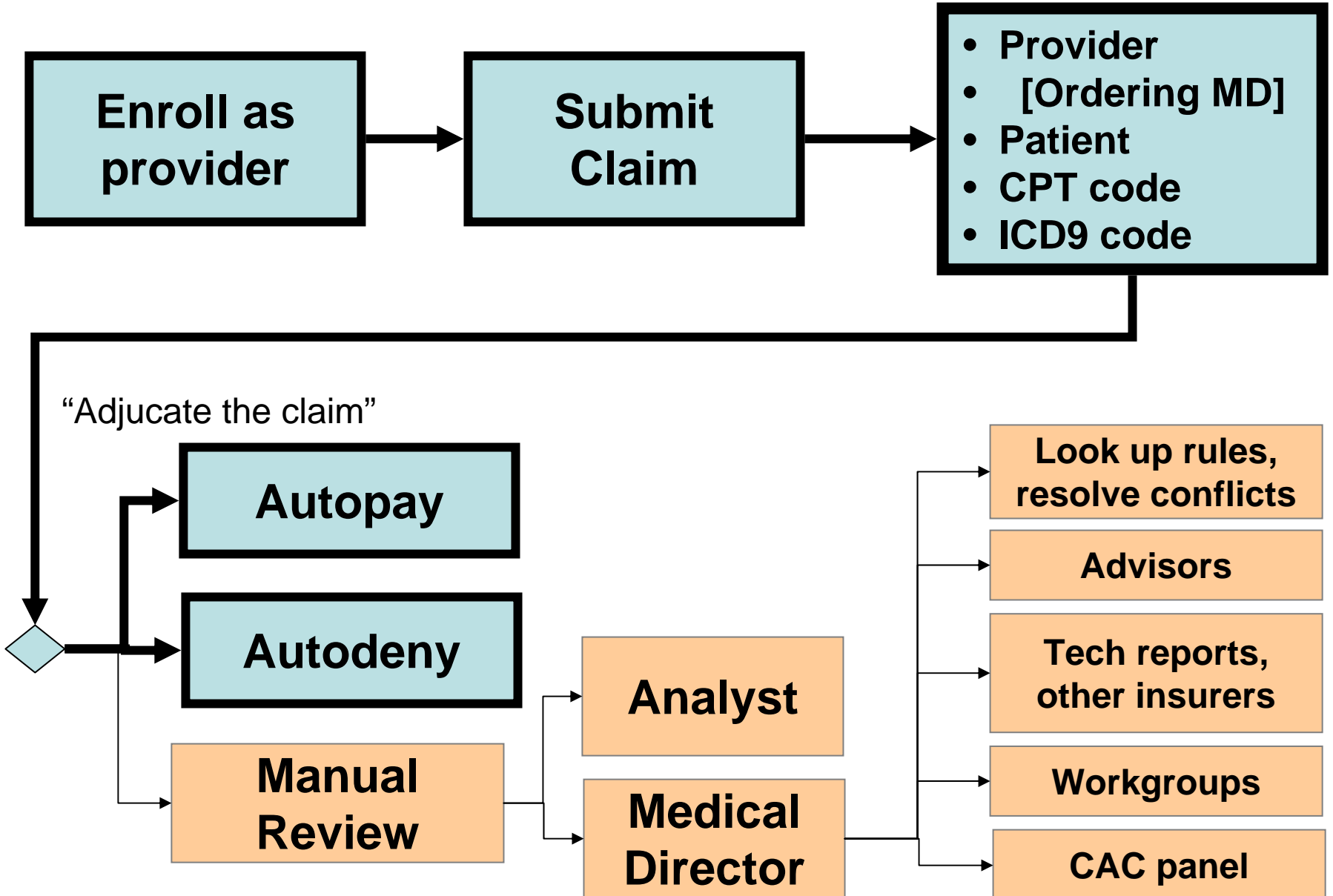
2008 "A-B MAC" Contractors



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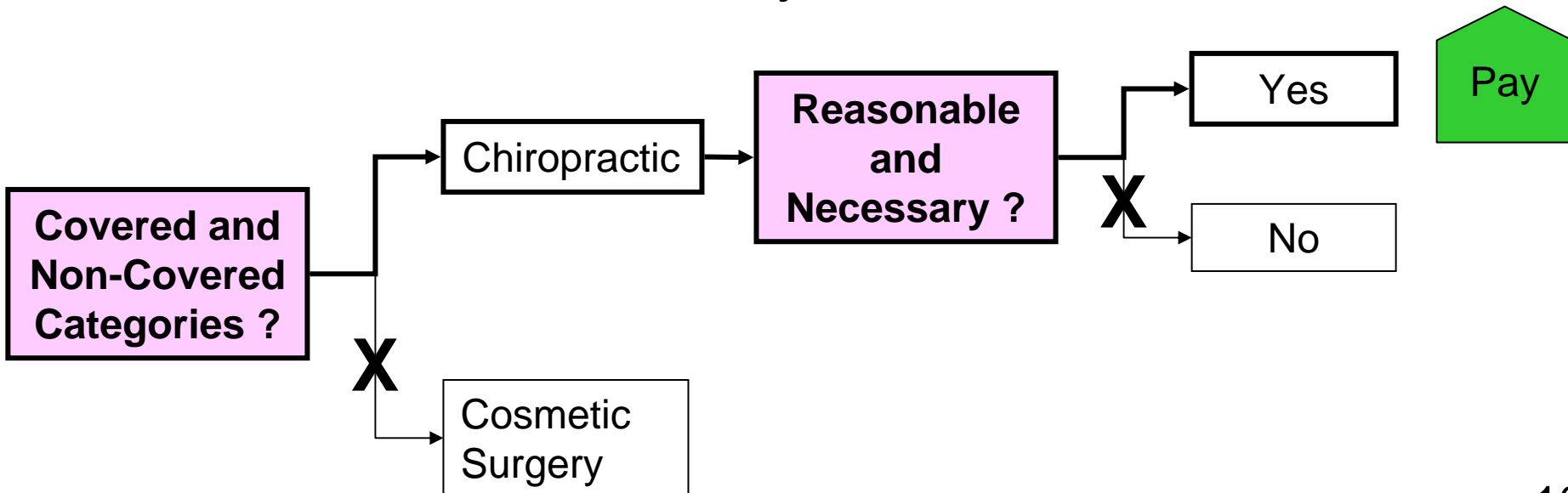
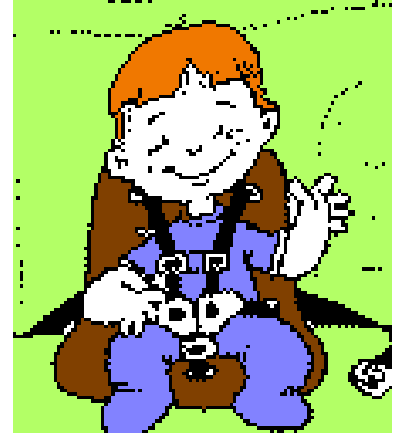


Medicare has Two Questions

Like a child in the back seat, we ask the same questions over and over.

Our two questions are:

- Is this a covered benefit?
- Is it reasonable and necessary?



The Limitations: R&N

Congress 1862(a)(1)

- **Broad definition** of coverage categories (labs, **dx tests**, chiro, etc), the **entitlement**
- **Broad exclusions** (cosmetic surgery, normal foot care, glasses)
- **“No payment for care which is not reasonable and necessary to dx & treat disease”** (1862(a)(1))

HCFA Ruling 95-1

- **Services not meeting locally accepted stds of practice would be denied**
 - **Published medical literature**
 - Well-recognized peer-reviewed medical journals
 - **A consensus of expert medical opinion**
 - BCBSA, Amer Coll. Physicians, etc

Program Manual (PIM Ch 13)

- **Safe and effective**
- **Not experimental** or investigational
- **Appropriate**
 - Duration, frequency
 - Accepted practice
 - Meets but does not exceed need
- **At least as beneficial** as an existing, available, and appropriate alternative

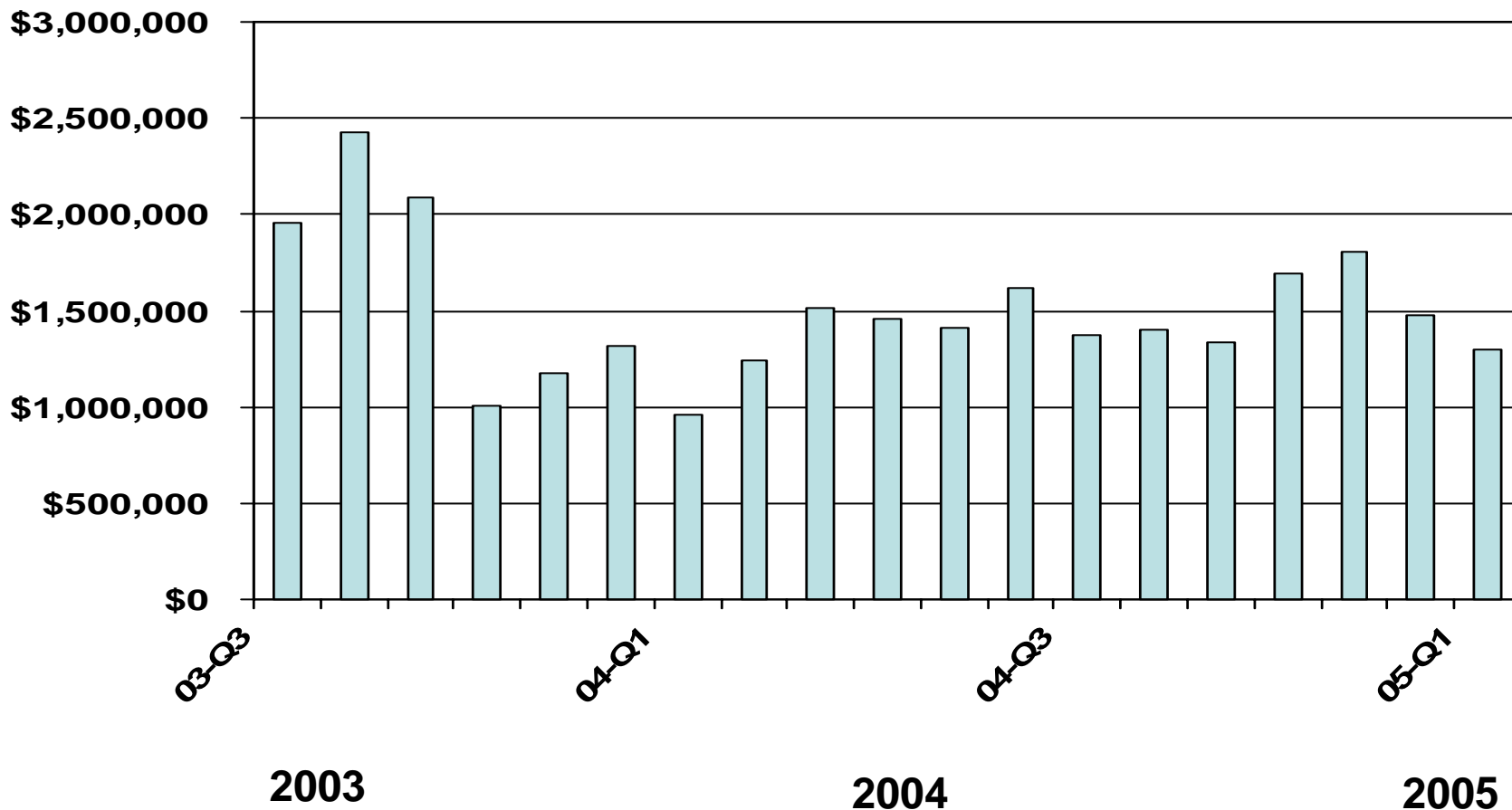
Claims editing rules

- Edits may be based on:
 - Program manual guidance
 - National Coverage Determinations
 - Local Coverage Determinations
 - “Correct Coding Edits”
 - Bundling. E.g. there is a code for stitching & closing a wound, but it is not billable with a surgery.
 - Anti-fraud edits (currently regional)

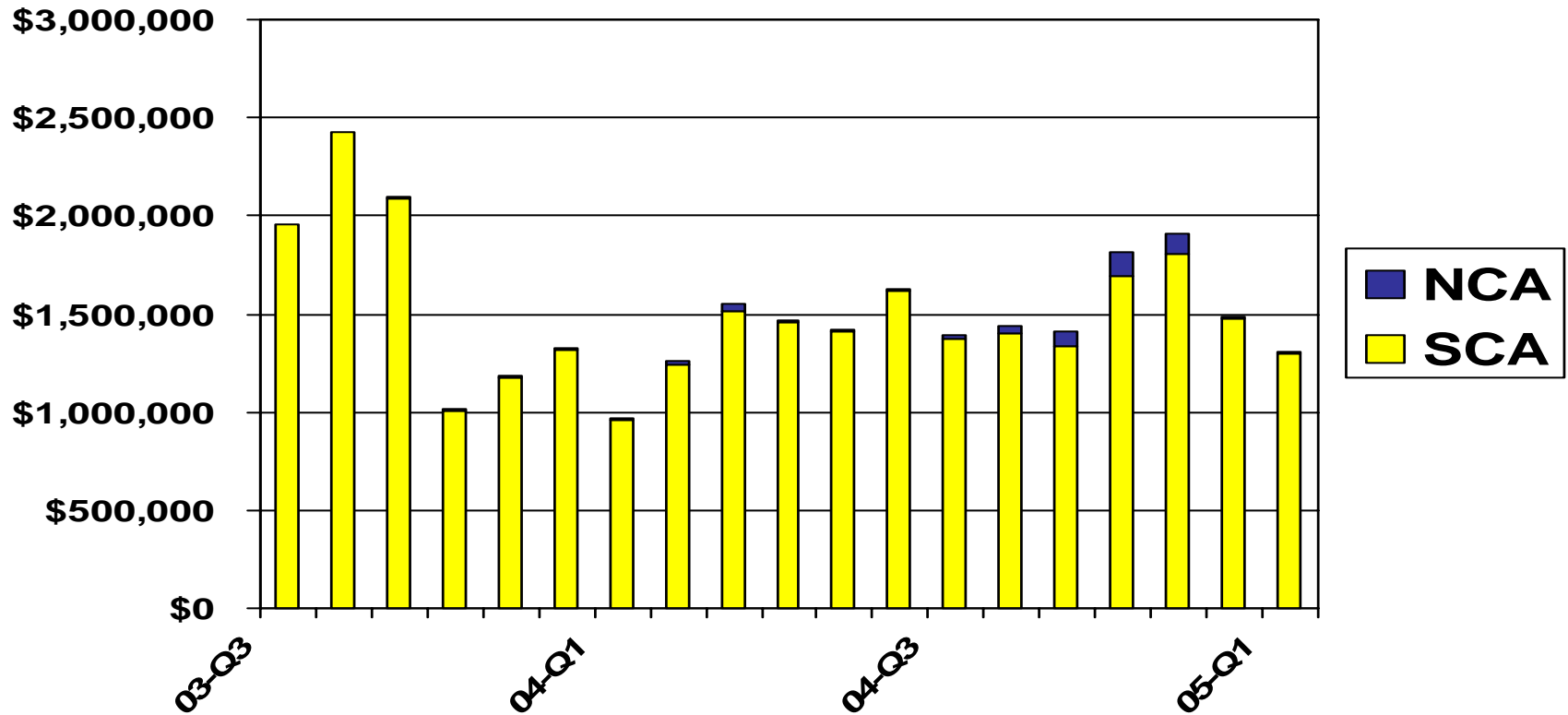
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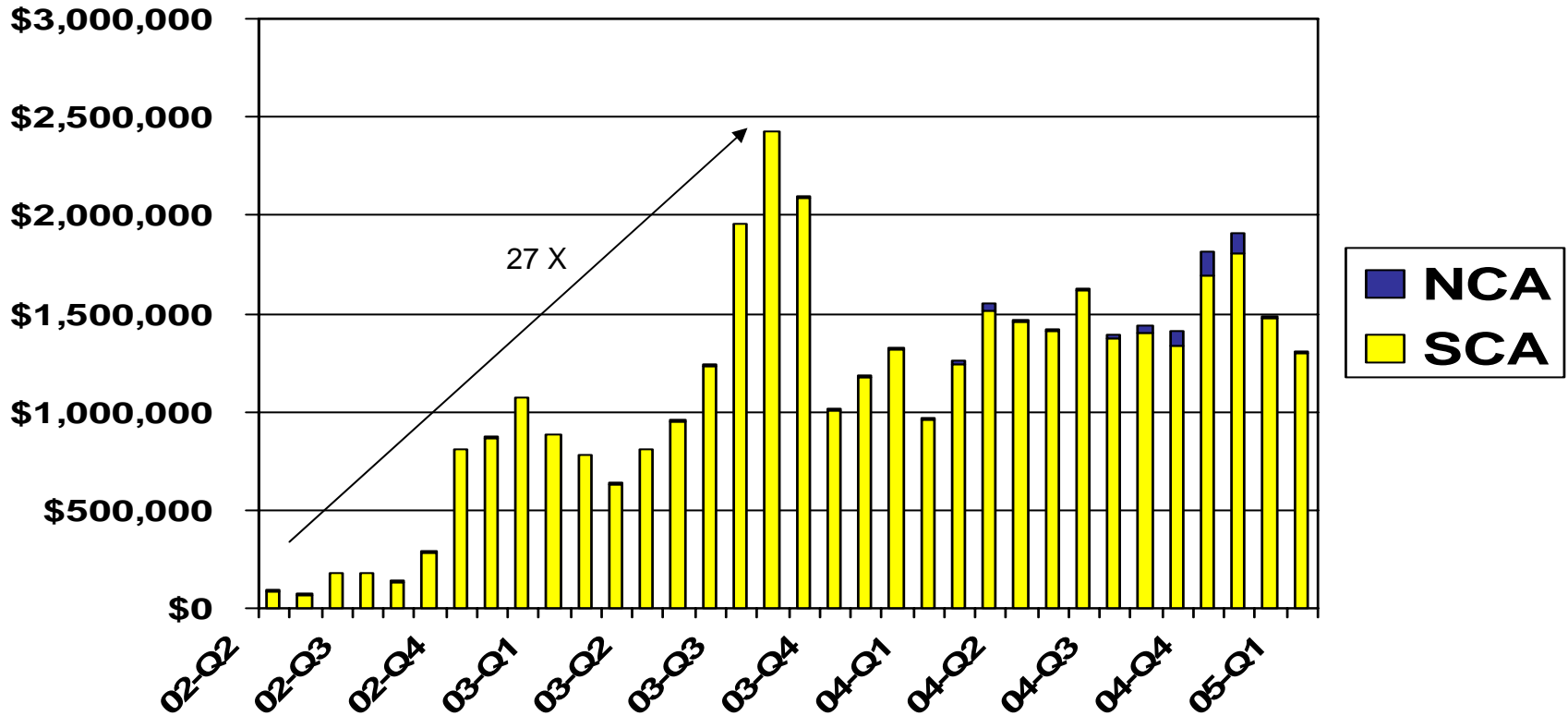
Anal Manometry (CPT 91122)



Anal Manometry is popular in Southern California.



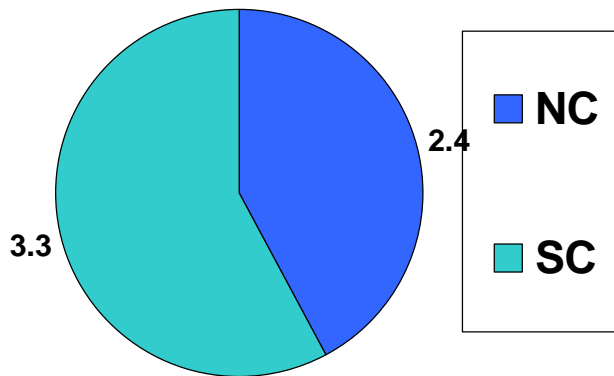
Anal Manometry ballooned in 2003



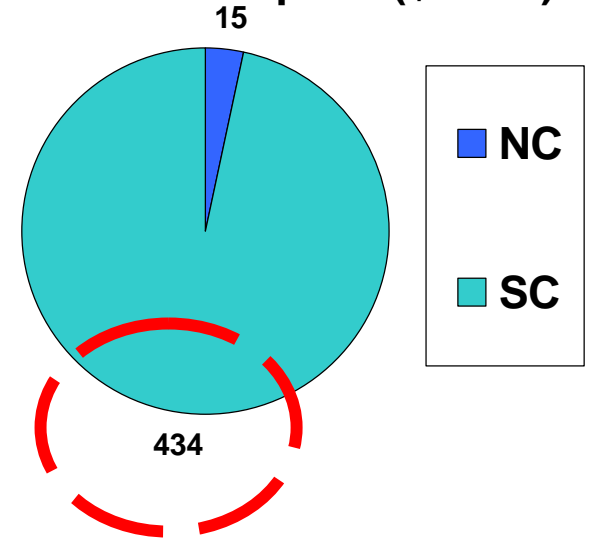
NCA ~ \$500,000
SCA ~ \$40,000,000

13% of **all** Southern California Part B dollars flowed into “anomalous code” services (\$434M)

Total Spend (\$6B)



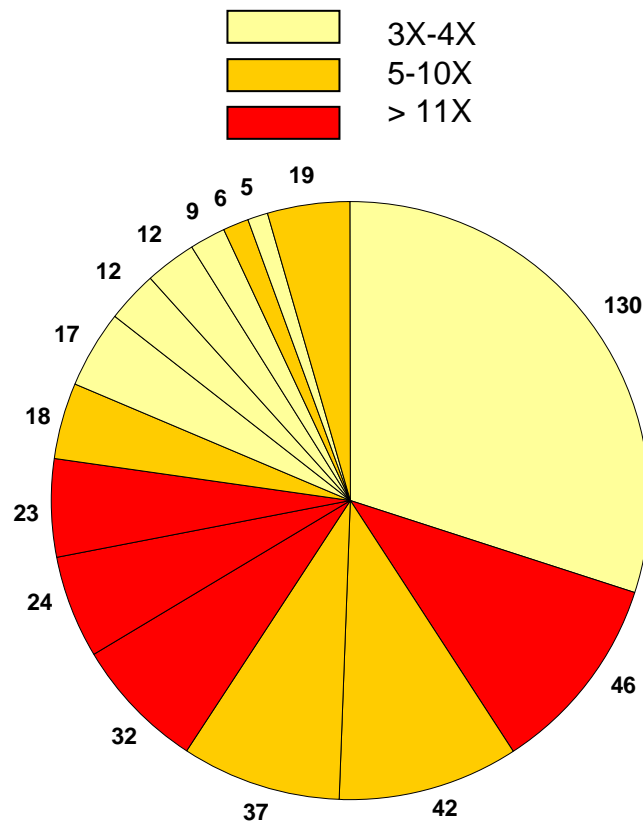
"Anomalous" Spend (\$450M)



"Anomalous Spend" as % Total Spend	
NC	SC
1.0%	13.2%

A table summarizing the percentage of total spend that is 'Anomalous' for each region. The SC value of 13.2% is highlighted with a red dashed circle.

In Southern California: **four services** were **over 10X!** national rate, totaling \$125M



\$434M/yr
 "Anomalous" SC Spend (\$M)

- SC PT (4X)
- SC Vestib (17X)** ←
- SC Lab (7X)
- SC Vasc U/S (6X)
- SC Anal (22X)** ←
- SC Pulm (15X)** ←
- SC Allerg (13X)** ←
- SC Skin (7X)
- SC Abd US (4X)
- SC Pain (4X)
- SC GI Upp (3X)
- SC Uro (3X)
- SC Eye (9X)
- SC Psy (4X)
- SC Oth (9X)

Anal Manometry is a magnet for extremely anomalous providers.

91122
 Anal Manometry
 SCA = 120X NCA
 \$40M / 2 yrs

Providers of 91122 in month of January 2005		
G4XXXX	Gen Pract	\$107,281
A3XXXX	Fam Pract	\$54,520
A7XXXX	Int Med	\$46,659
A3XXXX	Ophthalm	\$27,113
GFXXXX	Pediatric	\$20,077
A3XXXX	Emer Med	\$19,416

2004 Practice Profile – A3XX Ophthalmology		
91122,51784	Anal Testing	\$505,677
Pulm Fun Tests	Misc.	\$247,912
93307 & 20,25	Echocardiogr	\$200,987
93925 & 70	Duplex Veins	\$185,358
76700 & 70	U/S, Abd.	\$164,724
99204	New Patient (n=1,414)	\$118,752
51741	Uro Flow	\$46,151
76870	U/S Scrotum	\$19,886
Etc	etc	-----
	PAID 2004	\$1,624,946

This does not happen anymore.

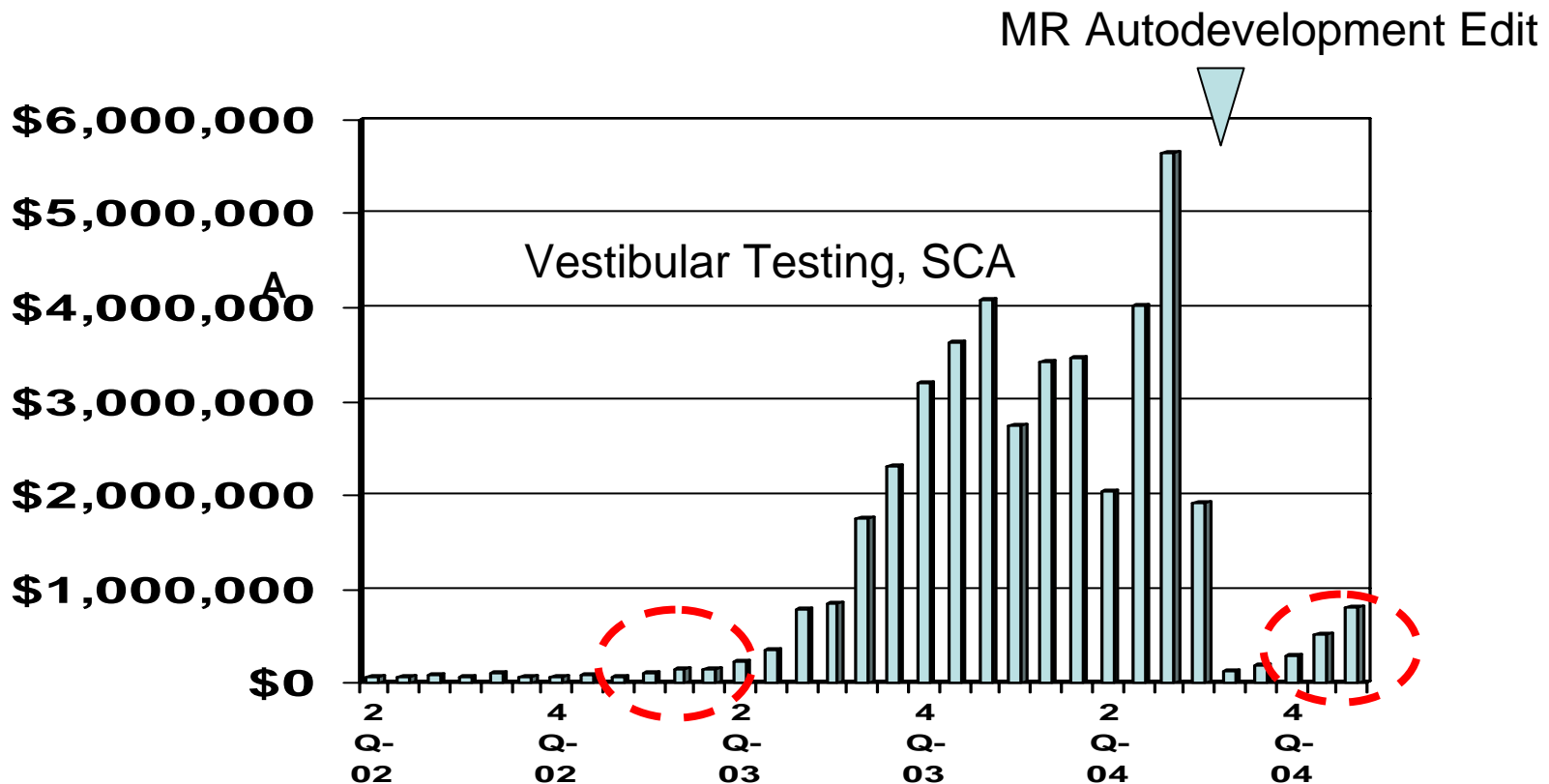
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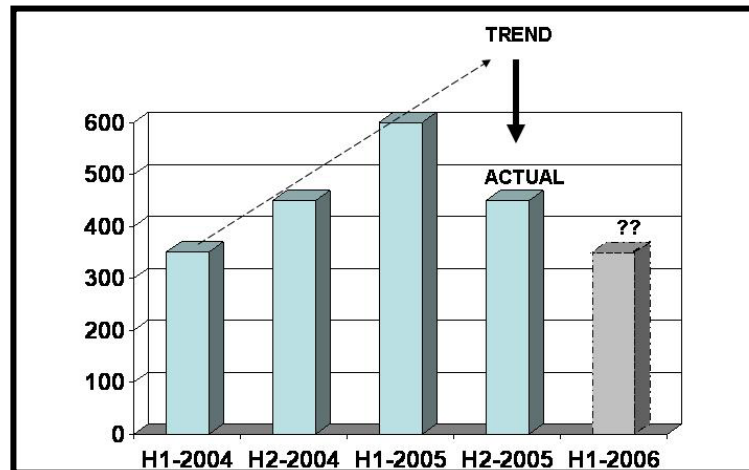
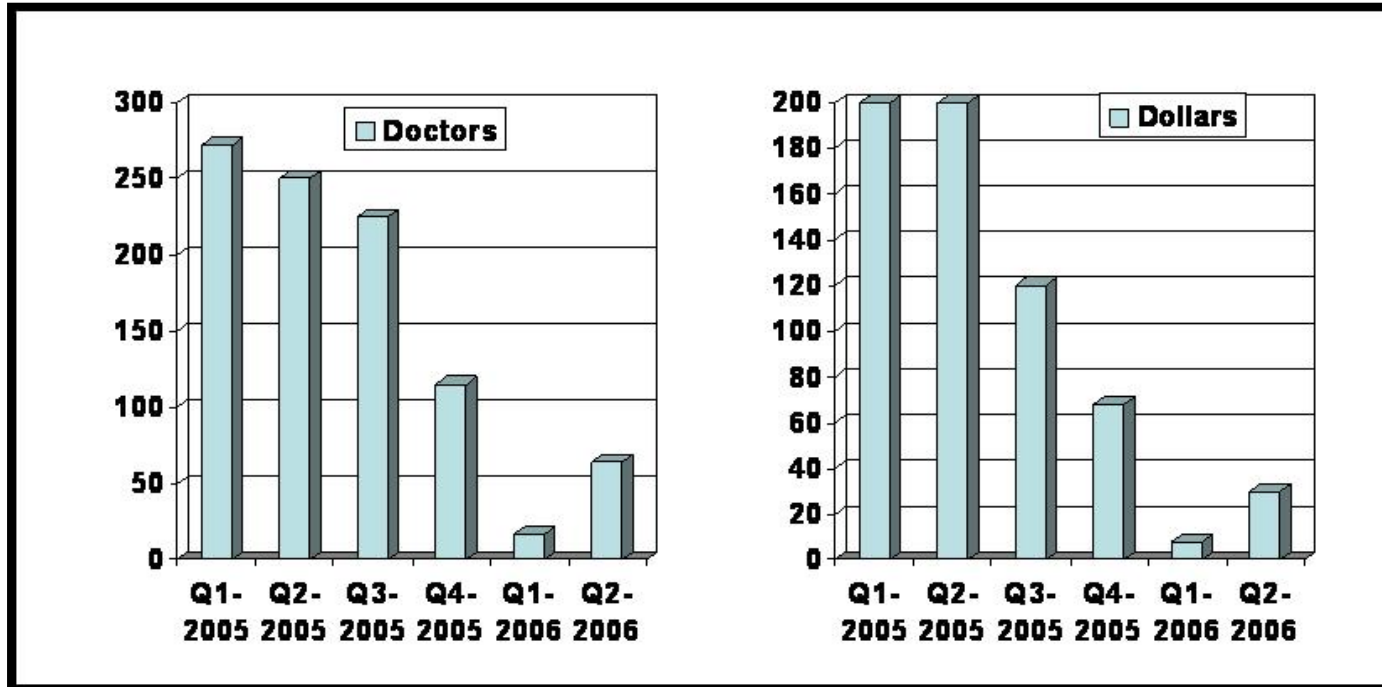
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Etc	etc	-----
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Medical Review Edits Deter Theft

- Medical review edits (July 04) can markedly impact high fraud/abuse codes
- \$25M saved (July-Dec 04).



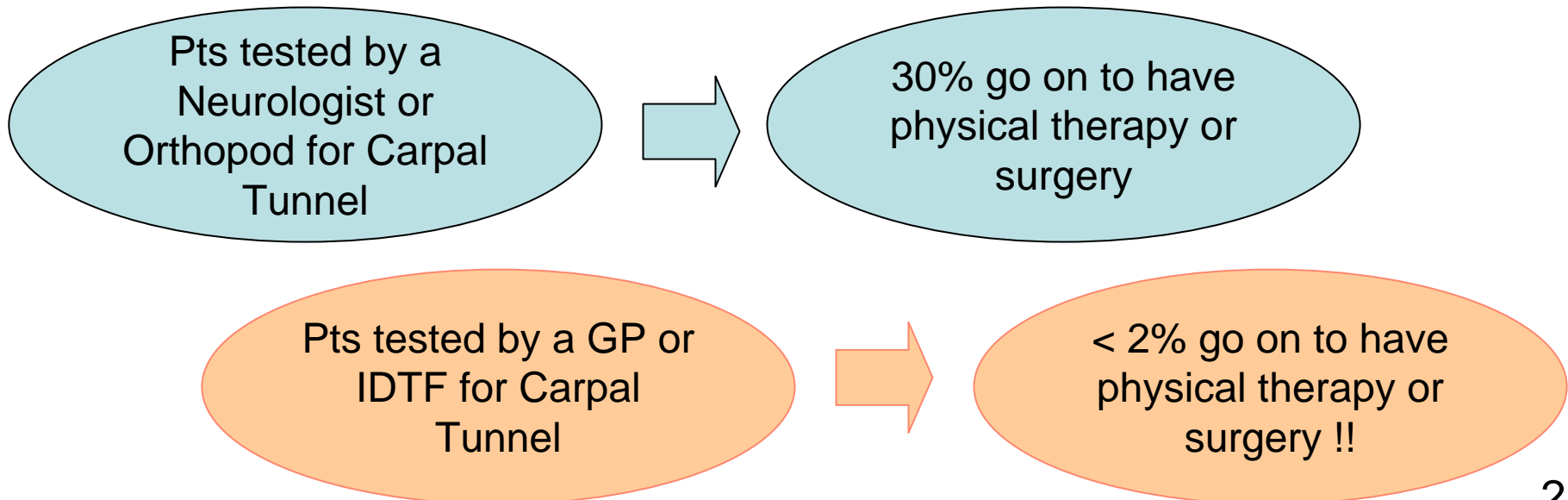
Dramatic advances in one year



We used a “serial technique” recently for Nerve Conduction Studies (NCS).

http://www.medicarenhic.com/cal_prov/articles/nrvcond_compbill_0906.htm

NE (1.5M pts)	SoCal (1.5M pts)
NCS for diabetic neuropathy	
300	22,000
NCS for “skin disturbance”	
2000	220,000



Claims data utilized at the national level

- Major studies of Medicare services are conducted using primarily claims data
 - Dartmouth Center for Evaluative Clinical Sciences



Health Affairs (2004)
Web Exclusive, 10/7/2004
www.healthaffairs.org

- CMS recently introduced “coverage with evidence development” – typically adding a registry to supplement raw claims data of CPT + ICD-9
 - National Oncologic PET registry (NOPR)
 - <http://www.cancerpetregistry.org/>
- Disease Management pilot projects
 - (10 year history of these)
 - <http://www.cbo.gov/showdoc.cfm?index=3776&sequence=0>

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Sorting Things Out

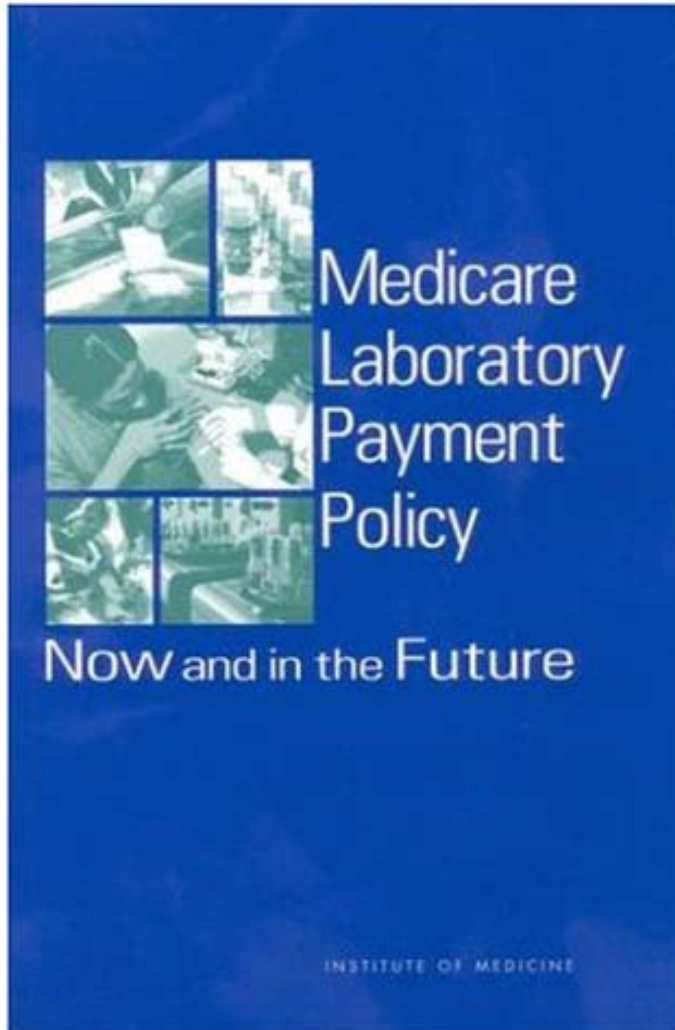


- Bowker & Leigh have written an illuminating history of the ICD – development, arguments, users, and uses.
- Cited therein:
 - Geist (1992) Negotiating the Crisis: DRGs and Hospitals.

Bowker GC & Star SL (2000) Sorting things out. MIT.

Geist P & Hardesty M (1992) Negotiating the crisis: DRGs and the transformation of hospitals. Erlbaum.

IOM on ICD-9s and Medicare



HCFA should discontinue use of International Classification of Diseases, Ninth Revision (ICD-9) diagnosis codes as the basis for determining the medical necessity of clinical laboratory tests...

Determinations of medical necessity based on diagnosis codes were instituted to improve the appropriateness of testing and, in part, to discourage fraud and abuse....**experience has shown that the use of ICD-9 codes is not a sound basis for making judgments regarding the medical necessity of particular laboratory tests in specific patients.**

One of the fundamental problems with the approach that...in many circumstances, it is likely to give the wrong answer.

Moreover, the current system is easily gamed, is administratively burdensome, and does not place sufficient responsibility on the physician.

Q&A