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Report to the Chairman, Subcommittee on Regulation, Business Opportunities, and Technology, Committee on Small Business, House of Representatives

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MEDICARE PART B

Regional Variation in Denial Rates for Medical Necessity

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Program Evaluation and
Methodology Division

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The Honorable Ron Wyden
Chairman, Subcommittee on
Regulation, Business Opportunities,
and Technology
Committee on Small Business
House of Representatives

Dear Mr. Chairman:

You asked us to assess whether there are significant differences among carriers in denial rates for lack of medical necessity for Medicare Part B claims and to identify factors that contribute to intercarrier variations. Carrier differences in the treatment of claims denied for reason of medical necessity is an important issue, one that has implications for the appropriate management of Medicare program expenditures as well as the consistency of treatment of providers and beneficiaries.

In response to your request, we analyzed 1992 and 1993 Medicare Part B data on claims processed by six Medicare carriers for 74 services that were either expensive or heavily utilized. We computed denial rates for services that carriers determined to be not medically necessary. This report presents the results of our analysis of these denial rates and identifies and examines five factors that contributed to the observed rate differentials among the six carriers.

Results in Brief

Although denial rates for lack of medical necessity for 74 expensive or heavily utilized services were generally low, there were substantial variations across the six carriers we examined.[1] Moreover, these variations were persistent for most services from 1992 to 1993, even though the denial rates for some specific services may have increased or decreased.[2] Five factors help explain carrier variations in denial rates. For one, they stemmed primarily from carriers' differing prepayment screens—that is, some carriers screened specific services while others did not, and those that screened the same service used different criteria. For

[1]The following six carriers were included in this study: California Blue Shield (jurisdiction: Northern California), Transamerica Occidental Life Insurance (jurisdiction: Southern California), Connecticut General Life Insurance Company (jurisdiction: North Carolina), South Carolina Blue Shield, Illinois Blue Cross and Blue Shield, and Wisconsin Physicians' Service.

[2]See U.S. General Accounting Office, Medicare Part B: Inconsistent Denial Rates for Medical Necessity Across Six Carriers, GAO/T-PEMD-94-17 (Washington, D.C.: March 29, 1994).

another, only 5 percent of providers accounted for 50 percent of the denied claims. Three other factors were the varying interpretation of certain national coverage standards across carriers, differences in the way carriers treated claims with missing information, and reporting inconsistencies.

Medicare Coverage Criteria

In accordance with section 1842 (42 U.S.C. 1395u) of the Social Security Act, the Health Care Financing Administration (HCFA) contracts with 32 insurance carriers to process and issue benefit payments on claims submitted under Medicare Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1993, carriers processed about 576 million Part B claims submitted by about 780,000 physicians and 136,000 suppliers.

Section 1842 of the Social Security Act provides that carriers pay only for services that are covered and that they reject a claim if they determine that the service was not medically necessary. In fiscal year 1993, carriers denied 112 million Part B claims in whole or in part (19 percent of all claims processed) for a total of $17 billion in denied claims (which represented 18 percent of all billed charges, a figure unchanged from the previous year). Services deemed not medically necessary constituted about 9 percent of the dollar amount denied by carriers. A claimant (provider or beneficiary) who is dissatisfied with a carrier's claims decision has the right to appeal.

Although most claim denials are the result of routine administrative checks made during claims processing (for example, denials for duplicate claim submissions or ineligible claimants), a significant portion of denials are the result of coverage determinations. Coverage under Medicare is determined by three criteria: Medicare law, national coverage standards developed by HCFA, and local coverage standards developed by individual carriers.

According to section 1832 (42 U.S.C. 1395k) of the Social Security Act, Medicare Part B covers a wide range of health services, such as physician services, outpatient hospital services, the purchase of durable medical equipment, prosthetic devices, and laboratory tests. At the same time, the act limits or excludes certain services: It places limits on podiatric, chiropractic, and dental services and specifically excludes some categories of service, such as routine physical checkups and cosmetic surgery. Medicare law is best viewed as a framework for making coverage

determinations: It is not, as HCFA has observed, "an all-inclusive list of specific items, services, treatments, procedures or technologies covered by Medicare."[3]

Recognizing that the law could not anticipate all possible coverage issues, the Congress provided the following guidance to HCFA for making decisions:

"Notwithstanding any other provisions of this title, no payment may be made under part A or part B . . . for any expenses incurred or items of services . . . which . . . are not reasonable and necessary for the diagnosis or treatment or illness or injury or to improve the functioning of a malformed body member."[4]

For a service to be covered, it must meet

"a test of whether the service in question is 'safe' and 'effective' and not 'experimental'; that is, whether the service has been proven safe and effective based on authoritative evidence, or alternatively, whether the service is generally accepted in the medical community as safe and effective for the condition for which it is used."[5]

Although carriers make most coverage decisions, HCFA has set national coverage standards for some specific services, the guidelines of which are found in the Medicare Carriers Manual, the Medicare Coverage Issues Manual, and other program publications.[6] Where HCFA has issued a national coverage decision, carriers are expected to enforce it. Although national coverage standards are for the most part straightforward, some standards may require clarification or interpretation. In such instances, carriers are advised to consult with a HCFA regional office, which may in turn ask the HCFA central office for guidance.

In the absence of national coverage standards, HCFA has, consistent with Medicare law, given carriers the discretion to develop and apply their own medical policies based on local standards of medical practice. Since national coverage standards have been issued for only a small portion of all services, carriers often "must decide whether the service in question

[3]54 Fed. Reg. 4304. (Preamble to proposed rules that, although not yet final, are generally looked to for guidance.)

[4]Title XVII of Social Security Act, sec. 1862(a)(1)(A)[42 U.S.C. 1395y (a)(1)(A)].

[5]54 Fed. Reg. 4304.

[6]For a general description of how HCFA makes coverage decisions on new medical technologies, see U.S. General Accounting Office, Technology Assessment and Medical Coverage Decisions, GAO/HEHS-94-195FS (Washington, D.C.: July 1994).

appears to be reasonable and necessary and therefore covered by Medicare."[7] HCFA has given carriers broad latitude in this area—that is, it has given them primary responsibility for defining the criteria that are used to assess the medical necessity of services. Such local medical policies allow carriers to target specific services that may need greater scrutiny. For example, local medical policies may be developed in response to excessive utilization of a service or inappropriate billing patterns.

To implement medical policies, carriers develop prepayment screens that suspend a subset of claims for manual review. Screens are computer algorithms that use certain claim information (such as diagnostic code or frequency of services performed) to channel certain types of claims to examiners for further review. The criteria used to flag claims for medical review are less exhaustive than the criteria used in making the final determination.

For example, a screen for chiropractic treatment may suspend claims of beneficiaries who have received more than 12 treatments within the past year. At this point, the suspended claims are reviewed by claims examiners, who make a determination based on medical policy. A carrier's medical policy defines the conditions under which chiropractic treatments beyond the threshold are medically necessary. It is, however, important to note that the proportion of claims that carriers review for medical necessity is determined by the amount of money available to HCFA for allotment to carriers for the purpose of medical review. In fiscal year 1994, HCFA allotted enough funds for 5 percent of claims to be medically reviewed.

Despite the importance of carrier vigilance over Medicare claims, budgetary constraints have led to a decrease in program safeguard activities such as prepayment screening of claims for medical necessity. The proportion of claims that are reviewed for medical necessity has decreased from 20 percent of all claims in 1989 to 5 percent in 1994. Because carriers now have fewer resources to review the appropriateness of claims, it is essential that carriers use what resources they do have in the most effective way possible. Yet, we found that HCFA has not compiled information, nor does it have a systematic method that would allow it to assess the adequacy of current carrier safeguard controls.[8]

[7]54 Fed. Reg. 4304.

[8]U.S. General Accounting Office, Medicare: Funding and Management Problems Result in Unnecessary Expenditures, GAO/T-HRD-93-4 (Washington, D.C.: February 1993).

We conducted our study between April and November 1994 in accordance with generally accepted government auditing standards. See appendix I for a description of our analytical methodology.

Analysis of Denial Rates

This section presents the results of our analysis of 1992-93 medical necessity denial rates for six carriers across 74 expensive or heavily utilized services. We examined the (1) magnitude, (2) variability across carriers, and (3) annual changes of denial rates for 2 consecutive years.

Denial Rates Were Generally Low

Table 1 summarizes 1993 denial rate information from appendix III (appendix II gives 1992 data) and shows the frequency distribution of denial rates for the 74 services across six carriers. This table shows that within this group of 74 services, denial rates were generally low—a finding that was consistent across all carriers. For example, the Northern California carrier had 47 services with a denial rate of zero, 19 services with a denial rate of between 1 and 10, 6 services with a rate of between 11 and 100, and 2 services with a denial rate of over 100 per 1,000 services allowed.[9] Furthermore, the Southern California carrier, which had the largest number of services with denial rates over 10 per 1,000 allowed, still had a majority of services (46 of 74) with denial rates of less than 10 per 1,000 services allowed.

Table 1: Distribution of Top 74 Services by Denial Rate and Carrier, 1993

	Number of services						
Denial rate per 1,000 services allowed[a]	**Northern California**	**Southern California**	**North Carolina**	**South Carolina**	**Illinois**	**Wisconsin**	**Total**
0	47	8	15	52	38	36	196
1 to 10	19	38	48	22	20	28	175
11 to 100	6	23	7	0	14	9	59
100+	2	5	4	0	2	1	14
Total	**74**	**74**	**74**	**74**	**74**	**74**	**444**

[a]We classified three codes with no allowed services as 0 for the purpose of this tabulation. Denial rates were rounded to the nearest whole number.

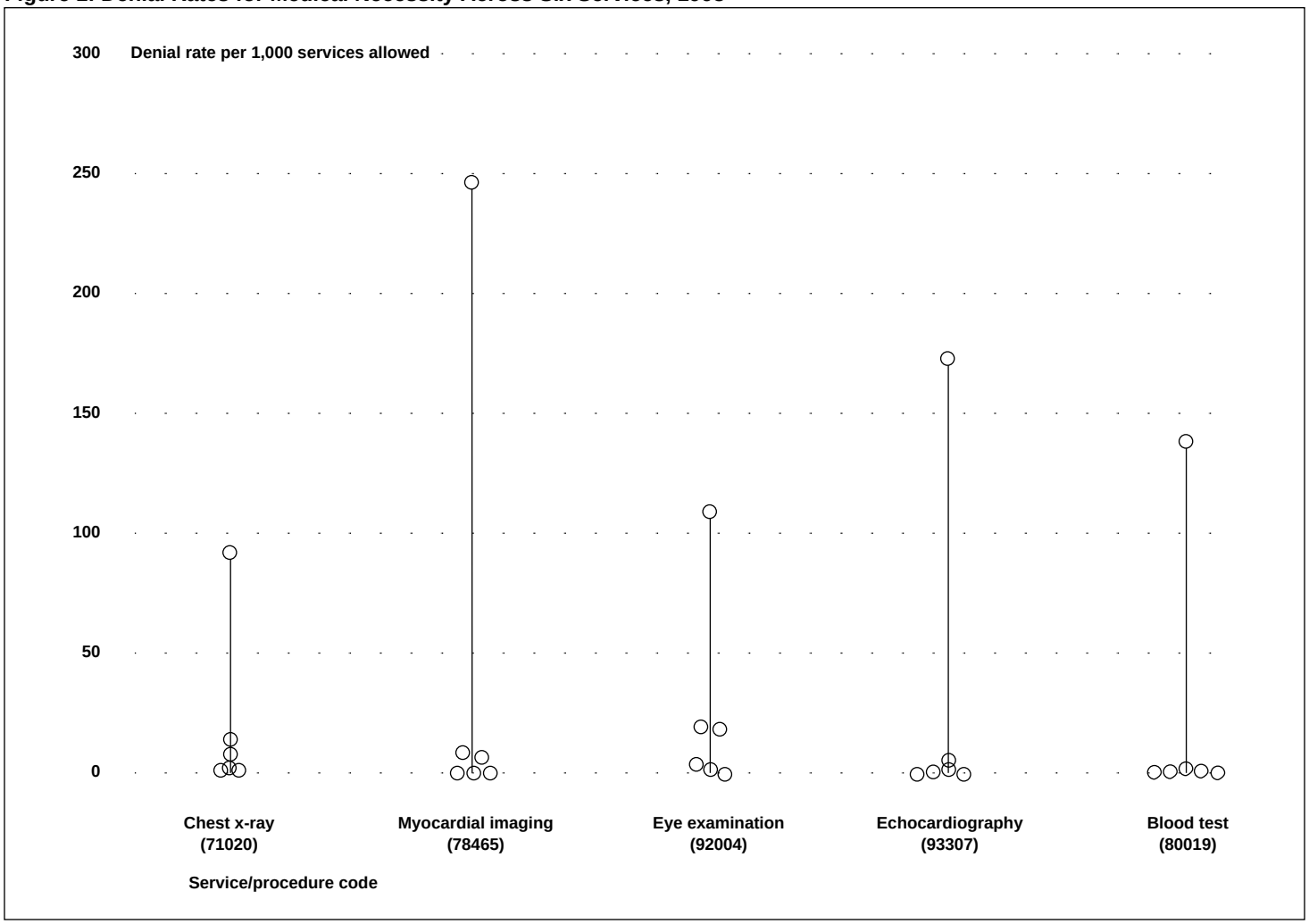
[9]Services that exhibited high denial rates included those of the following types: ambulance service, eye examination, chiropractic treatments, myocardial perfusion imaging, percutaneous transluminal coronary balloon angioplasty, and duplex scan of extracranial arteries. Services that exhibited minimal variation in the range of denial rates across carriers were those that pertained to digestive procedures (endoscopy and colonoscopy); nursing facility services; office and outpatient visits; and cardiovascular, musculoskeletal, anesthesia, and urinary procedures.

Denial Rates for Medical Necessity Varied Across Carriers

The denial rates for 1992 and 1993 show notable variability across six carriers. Figure 1, which displays 1993 carrier denial rates for 5 different services, illustrates this point. For example, the range of denial rates across carriers for a chest x-ray varied between 0.1 and 90.2 (per 1,000 services allowed).[10]

[10]The formula for calculating denial rates is as follows: denial rate = (number of services denied for reason of medical necessity) / (number of services allowed) * 1,000. We used the number of allowed services in the denominator rather than the number of submitted services because the latter includes services denied for other reasons (for example, duplicate line item) and thus would add spurious variation to our estimate.

Figure 1: Denial Rates for Medical Necessity Across Six Services, 1993



Carrier Denial Rates for 1992 and 1993 Were Stable for Most Services

The denial rates for at least two thirds of each carrier's services did not significantly change between 1992 and 1993. In general, the magnitude of carrier denial rates was persistent for 2 consecutive years. Services that had high denial rates in 1992 also tended to have high rates in 1993.

Conversely, services with low denial rates in 1992 also were generally low in 1993.[11] (See table 2.)

Table 2: Change in Denial Rates for the Top 74 Services by Carrier, 1992-93

Change in denial rate[a]	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin	Total
Increased	12	14	18	2	14	2	62
Decreased	4	7	1	5	3	20	40
No change	58	53	55	67	57	52	342
Total	**74**	**74**	**74**	**74**	**74**	**74**	**444**

[a]A chi-square test of statistical significance was used to test whether 1992 rates differed from 1993 rates. Rate differences significant at $p < 0.01$ were considered to have changed between years.

For two jurisdictions—South Carolina and Wisconsin—the number of services that had decreased denial rates in 1993 exceeded the number of services for which rates increased. Conversely, four carriers—Northern California, Southern California, North Carolina, and Illinois—had more services whose denial rates significantly increased than decreased. For Northern California, Southern California, and Illinois, the difference in the number of services with higher denial rates in 1993 was slight, from 7 to 11 services. However, denial rates for the North Carolina carrier significantly increased between 1992 and 1993 for 18 services; the denial rate was significantly decreased for only 1 service.

Factors That Contributed to Intercarrier Variation in Denial Rates

The significant differences in denial rates for medical necessity across carriers give rise to the following question: What accounts for the variations in denial rates? To address this question, we met with carrier representatives and HCFA officials, who identified five factors that could help explain the variation in denial rates across carriers.

Carriers Differed in How They Implemented Prepayment Screens

The Medicare program has since its inception acknowledged the existence of regional variations in medical practice standards and has sought to accommodate these differences in adjudicating claims. One practical

[11]For example, Southern California had a denial rate of 83.2 for nonemergency ambulance service (code A0150) in 1992 and a rate of 81.2 in 1993. The difference between denial rates for these 2 years is 2 and is not statistically significant. In other words, the Southern California carrier's denial rate for this ambulance code did not decrease significantly in 1993, and the difference between these 2 years is likely to be due to chance variation. We used a chi-square test of statistical significance to test whether 1992 rates differed from 1993 rates. Rate differences significant at $p < 0.01$ were considered to have changed between years.

consequence of this policy is that HCFA has delegated to carriers the authority to determine whether a rendered service was medically necessary. Making such determinations requires that carriers first develop a local medical policy. Computer screens are used to suspend a subset of claims, which are then reviewed by claims examiners, who in turn follow local medical policy in making their determinations.[12]

Utilization and diagnostic screens are two of the more common types of screens.[13] Utilization screens measure the number of times a service has been performed against a standard (for example, services per year), and diagnostic screens compare the diagnosis listed on a claim with a defined set of diagnoses that would usually warrant performance of that service.[14]

Differences in the way that carriers use screens can affect the variability of denial rates in two ways. First, in the absence of an applicable local medical policy or a coverage directive from HCFA to assess the validity of a claim, carriers usually assume that a claim is valid and thus should be approved. It follows that, given comparable billing patterns, a carrier with a screen in place for a specific medical service will deny more claims than a carrier without such a screen in place.[15] Carriers differ in the number of services they screen; we reported earlier that the total number of local

[12]We did not examine whether differences in the criteria used in carrier medical policies affect denial rates. However, HCFA has acknowledged the need to promote consistency in medical policy across carriers and has undertaken the following initiatives to promote consistency: (1) developing a database that allows carriers to share information on medical policies, (2) establishing a technical advisory committee for each carrier that informs the carrier of current issues and technological developments in the medical community, and (3) distributing copies of model medical policy and encouraging carriers to use this model as a guide for developing their own policies.

[13]Carriers have a limited number of autoadjudicating computer screens. Such screens do not suspend claims for manual review but, rather, make the final determination of medical necessity. That is, claims not meeting certain criteria are automatically denied without being manually reviewed by claims examiners.

[14]For example, with regard to utilization screens, if a carrier's medical policy stated that only one office visit for eye exam per year is medically necessary, the carrier might construct a screen that would suspend a beneficiary's claims for eye examinations that exceed this limit. Diagnostic screens compare the diagnosis listed by the provider on a claim with a set of diagnoses determined by the carrier to indicate the medical necessity of performing a service.

[15]A recent demonstration project sponsored by HCFA underscored this point. Additional funds were allocated to four carriers for the purpose of improving their systems of medical review. Participating carriers used these funds to upgrade their computer systems, develop additional medical policies, and conduct more medical reviews. These improvements led to significant Medicare savings, in part caused by the carriers' appropriately denying a greater number of billed services. This project showed that savings in Medicare expenditures could be achieved by improving and expanding medical review activities. See U.S. General Accounting Office, Medicare: Greater Investment in Claims Review Would Save Millions, GAO/HEHS-94-35 (Washington D.C.: March 1994).

screens carriers used in 1988 ranged from 5 to 177.[16] Second, different carriers screening the same service may use different criteria to suspend claims. Thus, although two carriers may screen the same service for medical necessity, their respective criteria may result in differing denial rates.

To gauge the effect of medical necessity screens on carrier denial rates, we asked the carrier with the highest denial rate for medical necessity for 5 selected services to identify the specific reason for denial for a small sample of 15 to 20 claims denied for lack of medical necessity.[17] In this way, we were able to identify the key screens that most directly caused denial. We selected the 5 services because carrier denial rates for each one exhibited significant variation. For each service, we selected the carrier with the highest denial rate and determined the reason for the denial: x-ray and multichannel blood test (Illinois), myocardial perfusion imaging and echocardiography (Southern California), and opthalmologic exam (Wisconsin).

For example, for the automated multichannel blood test, the Illinois carrier had a denial rate of 138.9 per 1,000 services allowed in 1993, while the other carriers had negligible denial rates of 0, 0.1, 0.5, 1.4, and 1.7. After examining a sample of claims, the Illinois carrier concluded that the majority of its denials for reason of medical necessity resulted from a joint utilization and diagnostic screen. That is, a provider in the Illinois carrier's jurisdiction could order this type of blood test for a patient up to two times per year with no condition attached. On the third and subsequent tests, however, the carrier checked the appropriateness of the test against a set of diagnostic codes specified by its local medical policy. If the diagnostic codes on the claim matched codes on this list, the service was approved. Conversely, if a diagnosis was not provided or did not match the accepted codes, the claim was denied and returned to the provider. The provider could then resubmit the claim with a different diagnostic code if appropriate.

We then asked the other carriers (Northern California, Southern California, North Carolina, South Carolina, and Wisconsin) if they had similar utilization and diagnostic checks to assess the medical necessity of multichannel blood tests. Their responses indicated that two carriers used

[16]U.S. General Accounting Office, Medicare: Improving Quality of Care Assessment and Assurance, GAO/PEMD-88-10 (Washington, D.C.: May 1988), p. 119.

[17]Because the computer systems of most carriers can retrieve claim records for only the preceding 12 to 18 months, we sampled claims from the last quarter of 1993.

only a diagnostic screen and the remaining three did not have either a utilization or a diagnostic screen for this service. The carriers' responses for this service, as well as for the 4 other services selected for analysis, are summarized in table 3.

Table 3: Pattern of Carrier Screen Use and Denial Rates, by Selected Services, 1993[a]

Service and procedure code	Northern California		Southern California	
	Screen	Denial rate	Screen	Denial rate
Echocardiography (93307)	None	1.7	Diagnostic[b]	173.3
Myocardial perfusion imaging (78465)	None	0	Diagnostic[b]	248.4
Chest x-ray (71020)	Diagnostic[a]	7.6	Diagnostic[b]	14.6
Multichannel blood test (80019)	None	0.1	None	1.7
Ophthalmologic exam (92004)	Diagnostic[a]	19.2	Diagnostic	4.2

North Carolina		South Carolina		Illinois		Wisconsin	
Screen	Denial rate	Screen	Denial rate	Screen	Denial rate	Screen	Denial rate
None[c]	1.1	None[d]	4.4	None	0	None	0
None	6.4	None[d]	6.0	None	0	None	0
Diagnostic	1.2	None	0.2	Diagnostic[b]	90.2	Diagnostic[b]	0.1
Utilization	0.5	Utilization	1.4	Utilization + diagnostic[b]	138.9	Diagnostic[b]	0
Diagnostic	1.2	None	0	Utilization + diagnostic[b]	19.6	Diagnostic[b]	108.4

[a]Services that were not screened by carriers could have denial rates greater than zero because of postpayment review or other reasons. Edits for bundling and duplicate line items are not considered to be utilization screens in this table.

[b]The screen autoadjudicates.

[c]Carrier requires diagnostic code but does not require a specific one.

[d]South Carolina also reported screens for codes 93307 and 78465; however, they were implemented on December 13, 1993, and November 18, 1994, respectively.

Variation From the Presence of a Prepayment Screen

We found that the types of services screened for medical necessity varied across carriers. For example, as shown in table 3, only one of the six carriers (Southern California) screened echocardiography and myocardial perfusion imaging services. Similarly, while four carriers screened multichannel blood test services, the types of screens they used varied. For example, the North Carolina carrier used a utilization screen, the Wisconsin carrier used a diagnostic screen, and the Illinois carrier used both.

Table 3 also provides evidence that carrier denial rates were associated with the presence or absence of a screen. For two services, echocardiography and myocardial perfusion imaging, the only carrier (Southern California) that had screens in place had much higher denial rates. While denial rates greater than zero do not always imply the presence of a medical necessity screen (some medical necessity denials may stem from postpayment review activities), denial rates are higher when a carrier has a screen.

For the 3 other services—chest x-ray, multichannel blood test, and opthalmologic exam—the relationship between screening and carrier denial rates was less clear cut. With respect to multichannel blood test, it is possible that the reason the Illinois carrier had the highest denial rate stemmed from the fact that it used two types of screens, consisting of both a utilization and a diagnostic check, while the other carriers either had no screen (Northern California, Southern California, and South Carolina) or had only a diagnostic check (North Carolina and Wisconsin). This explanation, however, is less satisfactory when attempting to account for carrier variation in denial rates for chest x-rays and ophthalmologic exams. In sum, although the presence or absence of a screen was not sufficient to account for all variation in denial rates across carriers, it is important to note that the highest denial rates were invariably associated with screens.

Variations From Differences in the Stringency of the Screen Criteria

Beyond the simple presence or absence of a screen, the stringency of the screen criteria can also contribute to variation in denial rates across carriers by suspending a greater or lesser number of claims that are then subject to a medical review. We found that, even when screening the same service, carriers used different criteria for suspending claims. For example, the first 12 visits to a chiropractor for spinal manipulation to correct a subluxation must meet certain basic HCFA coverage criteria, such as the following: An x-ray demonstrating the spinal problem must be available, signs and symptoms must be stated, and the precise level of subluxation must be reported. The six carriers had all incorporated these criteria into their medical policies for chiropractic spinal manipulation. HCFA requires that carriers assess the necessity of visits in excess of 12 per year, but carriers diverged in how they assessed such treatments. One carrier stated that, after 12 visits, additional documentation on medical necessity would be required. Another carrier based the number of additional visits allowed on the injured area of the spine. When that number of additional visits was reached, this carrier required additional documentation from the provider. Still another carrier stated that, while it reviewed visits beyond 12, it usually did not require additional documentation until the 30-visit mark.

Carriers Differed in How They Interpreted Certain National Coverage Standards

While we anticipated variation in denial rates on account of differences in carriers' implementation of screens, we expected less variation to result from carriers' differing interpretations of national coverage standards. However, we learned that carriers interpreted and applied the same

standards in different ways because some standards leave key elements of the policy undefined.

In 1993, Transamerica Occidental Life, in coordination with HCFA, studied claims that it had processed for 17 different services for which Transamerica showed variation in denial rates in 1992 among the six carriers.[18] The following discussion highlights some problem areas uncovered by the Transamerica study that relate to the implementation of national coverage standards.

Although national coverage standards allow Medicare carriers to pay for diagnostic tests, these standards significantly restrict particular tests for routine screening. Hence, in determining whether a claim should be paid by Medicare, carriers must judge whether the tests were performed for diagnostic or screening purposes. Making such judgments is often difficult, especially for certain types of tests.[19] Transamerica, for example, found differences across carriers in how they assessed chest x-ray and mammography claims. With regard to chest x-rays, the Transamerica study reported the following:

"There is a continued trend toward diagnostic screening for asymptomatic patients which we feel necessitates a formal policy. There is also wide variation among carriers as to the necessity for pre-operative diagnostic testing, and whether it falls within the 'medical necessity' coverage of the program. Review of various carriers' policy indicates that some deny as 'routine physical examination,' and not as a medical necessity denial. HCFA needs to clarify their position on this issue so there is more consistency on a national basis."[20]

Similarly, the Transamerica study reported difficulty in implementing HCFA's coverage guidelines for mammographies:

[18]The services were ambulance service (A0010 and A0020), chiropractic (A2000), cataract removal (66984), chest x-ray (71020), mammography (76091), surgical pathology (88305), percutaneous transluminal coronary angioplasty (92982), echocardiography (93307), Doppler echocardiography (93320), duplex scan of extracranial arteries (93880), and hospital care (99222, 99231, 99233, 99238, 99283, and 99332). HCFA provided Transamerica with a sample of claim numbers drawn from the data set used in our preliminary analysis of denial rates. Claims were extracted from Transamerica's computer system and then examined to determine the reason why a claim was originally denied.

[19]This issue also applies to carriers' determinations of when a test ceases to be experimental. A carrier representative told us that, prior to 1993, her company denied all claims submitted for prostate specific antigen (PSA) test, used for detecting cancer of the prostate. It was considered to be an experimental procedure with low reliability. However, following technical refinements to the test that improved its reliability, PSA gained greater acceptance among physicians as a diagnostic tool. As a consequence, this carrier changed its policy and now pays for PSA testing under certain conditions. Because such decisions are made carrier by carrier, denial rates for certain types of tests are likely to vary across carriers.

[20]Transamerica report to HCFA on denial rates (May 1994), p. 2.

"HCFA needs to re-evaluate its screening mammography billing and coverage requirements. Many screening services are being performed by nonscreening centers under the nonscreening procedure code. This may reflect a lack of, or inaccessibility to, screening mammography centers. There are also differences among carriers as to what constitutes a screening test. Some of the encounter codes used by HCFA as an indication for screening are also being used for diagnostic tests. Further clarification is needed."[21]

Findings from the Transamerica study suggest that, at least with respect to chest x-rays and mammographies, carriers found it difficult to distinguish whether these procedures were performed for screening or diagnostic purposes. It is likely that this difficulty may extend to other types of test procedures.

This example illustrates the fact that simply issuing a national coverage standard for a service is not sufficient to ensure consistency of application. While it is probably not feasible for HCFA to develop coverage standards that anticipate every conceivable circumstance under which a claim might be filed, we have identified a coverage issue for chest x-ray and mammography that appears to be in need of further clarification by HCFA.

Carriers Differed in How They Treated Incomplete Claims

The manner in which carriers treated claims with billing errors or missing information affected denial rates. For example, if a carrier's medical policy required that the provider indicate the diagnosis when submitting a claim for a particular type of service, and the claim lacked this information, the carrier had several options. The carrier could (1) return the claim to the provider, (2) "develop" the claim (that is, delay adjudication and try to obtain the required information by contacting the provider), or (3) deny the claim.

If the first option was exercised and the claim was returned, it was as if the claim had never been submitted. If the second option was exercised and the carrier received the requisite claim information, then the claim was adjudicated. If the third option was selected and the carrier denied the claim, the provider had either to resubmit the claim or go through the appeal process to obtain payment for this service.[22] The resubmitted claims might well be paid, but the carrier's records would still show that the claim had been denied. (See table 4.)

[21]Transamerica, p. 2.

[22]Earlier this year, HCFA surveyed all carriers and concluded that there was significant variation in the way the carriers were treating missing information.

Table 4: Options Carriers Used to Process Incomplete Claims

Option	Description
Return, delete, reject	Return: Used for hardcopy claims screened in the mailroom. Rejected claims were never given an internal claim control number; they were physically returned to the provider or supplier. A message was sent to the provider informing it that the claim was not processed. For budgetary purposes, returned claims were not counted as part of the workload.
	Delete: Used for electronically submitted claims screened by computer. Deleted claims were not given an internal claim control number and a message was sent to the provider or supplier informing it that the claim was not processed. For budgetary purposes, deleted claims were not counted as part of carrier workload.
	Reject: Claims (both hardcopy and electronic) were assigned an internal claim control number. Claims were entered into the computer system and screened. When missing information was detected, the claim was rejected and a message was sent to the provider or supplier informing it that the claim was not processed. For budgetary purposes, rejected claims were counted as part of carrier workload.
Develop	Carriers suspended judgment on claims and requested missing information from physician or supplier. If requested information was not received within 30 to 45 days, the carrier denied the claim.
Deny	Claim was completely processed through the system and a Medicare explanation-of-benefits message was sent to the claimant (beneficiary or provider) that indicated the basis of the denial. Denied claims were given full appeal rights.

Source: HCFA.

Although carriers had several ways of processing incomplete claims, the option they selected for any given claim depended on such factors as the cost incurred to develop the claim, the capability of their computer system, and special instructions from HCFA. For example, a carrier might have developed incomplete claims involving surgical procedures while denying incomplete claims involving chiropractic treatments, or the carrier might have rejected claims missing beneficiary health insurance numbers while developing claims with missing provider identification numbers.

Because the preceding examples highlight only a handful of the numerous possible combinations that may have been used to process claims with incomplete information, it is difficult to characterize any one carrier's

approach, much less systematically compare differences. However, it is reasonable to infer that carriers that emphasized claim denial over claim development (or rejection) for incomplete claims had higher denial rates than carriers that did not.

HCFA has examined this issue and has asked its Office of the General Counsel for advice that would bring consistency to the way that carriers process claims lacking basic information. In brief, HCFA recommends eliminating the denial option for incomplete claims. Claims that lack the requisite information would be returned or deleted and the provider or supplier would be notified.

HCFA has noted that carriers have expressed concern over this proposal. Some carriers are against the elimination of the denial option because (1) it would negatively affect their administrative budgets (because deleted or returned claims do not count in their workload statistics), (2) the cost of returning claims can be high, and (3) physicians and suppliers learn how to bill correctly faster when a claim is denied rather than returned. HCFA has responded by asserting that "these costs will be more than offset by fewer denied claims, fewer beneficiary inquiries, and fewer unproductive and expensive appeals." Standardizing the handling of incomplete claims would also improve the accuracy of carrier workload statistics by making them more comparable across carriers.

Carriers Differed in How They Reported the Reason for a Claim Denial to HCFA's Central Database

Because carriers used different computer systems to process claims, their internal action codes—which indicate the reason for denying a service—were not identical. To facilitate comparisons, HCFA has required that each carrier translate its own set of internal action codes into 10 broad categories when transmitting data to HCFA's central database. (See table I.2.) However, because HCFA has given carriers little guidance in performing this task, carriers are uncertain as to how denials should be classified for reporting purposes. This, in turn, has affected the reliability of estimated denial rates.

Transamerica identified two service categories that carriers have tended to use interchangeably: "noncovered" and "medically unnecessary" care. Its study found that "medically unnecessary" was used to classify denials for 3 service codes (of 17 studied) that should have been classified as "noncovered" care. The misclassified codes related to evaluation and management, ambulance, and cataract services. With regard to ambulance

services reported to HCFA as denied for reason of medical necessity, the Transamerica study noted that

> "Changes were made to the reporting classification of messages as a result of our review of Medicare Carriers Manual (MCM) coverage criteria, shifting some of the denials from a medical necessity classification to a coverage classification. There is a great deal of variation among carriers as to whether certain types of ambulance denials are based on medical necessity or coverage. There needs to be more definitive information from HCFA as to how they want the denials to be classified."[23]

We collected and analyzed reporting protocols for the six carriers in this study, and our analysis of these data corroborates Transamerica's findings. (See appendix IV.) We found that while reported misclassifications of this type do not affect the actual outcome of claims, they can affect the reliability of estimated denial rates for certain services. For this reason, we calculated separate denial rates for "medical necessity" and "noncovered" care and the combined total (see appendixes II and III) and assessed the degree of intercarrier variability for each category of denial. We found significant intercarrier variability for all three types of denial categories. Reporting inconsistencies of this type affects HCFA's ability to accurately monitor program operation activities and is thus an area where additional guidance from HCFA could improve the quality of the data it collects.

A Few Providers Account for a Significant Proportion of the Variation in Carrier Denial Rates

HCFA officials advanced several hypotheses that might help explain variations in carrier denial rates. They focused on provider billing practices as they relate to (1) geographic differences in the level of fraud and abuse, (2) differences across carriers in provider education (that is, efforts aimed at increasing provider awareness of appropriate billing procedures), and (3) high denial rates caused by the aberrant billing practices of a minority of providers. HCFA has not systematically studied this issue and did not provide us with empirical evidence that would support any of these hypotheses. Using claims data, however, we were able to examine one of these hypotheses—whether the billing practices of a minority of providers were responsible for a disproportionate share of service denials.

[23]Transamerica report, section headed "Detail Analysis."

To test this hypothesis, we examined four services that exhibited wide variation in carrier denial rates for medical necessity.[24] Although HCFA did not specify the criteria for identifying providers with aberrant billing practices, we assumed that providers that submit claims that are denied at a high rate have aberrant billing practices. However, such providers may not submit enough claims to substantially affect a carrier's denial rate for that service. For this reason, we defined providers with aberrant billing practices in two ways: (1) those with the highest denial rates and (2) those with the largest number of denials. We then calculated a carrier's denial rate for a service excluding the contribution of the top 5 percent of providers (in terms of both rate and total) to determine whether variations in denial rates were still observable.

Table 5 shows that the top 5 percent of providers, in terms of the highest denial rates and highest number of services denied, contributed substantially to carrier denial rates for each of the 4 services. However, excluding these providers did not eliminate the variation across carriers. For example, the actual range of carrier denial rates for echocardiography was 0 to 173.3; excluding the Southern California providers with the highest denial rates, the range was 0 to 154.9; and excluding the Southern California providers with the largest number of services denied, the range was 0 to 63.1. Thus, under both definitions of aberrant billing practice, excluding aberrant practitioners reduced the variability in denial rates for a service but did not eliminate that variation. It is therefore likely that the billing practices of a few providers account for part of the intercarrier variation in denial rates.

[24]See table 3; we did not analyze provider billing practices with respect to multichannel blood tests because laboratories submitted most of the claims for this service, not the physicians who ordered the test.

Table 5: Carrier Denial Rates for Four Services, Excluding Aberrant Providers

		Denial rate per 1,000 services allowed		
			Top 5 percent of providers excluded	
Service and procedure code	Carrier	All providers	Based on denial rate[a]	Based on total number of denials[b]
Chest x-ray (71020)	Northern California	7.6		
	Southern California	14.6		
	North Carolina	1.2		
	South Carolina	0.2		
	Illinois	90.2	83.0	45.8
	Wisconsin	0.1		
Echocardiography (93307)	Northern California	1.7		
	Southern California	173.3	154.9	63.1
	North Carolina	1.1		
	South Carolina	4.4		
	Illinois	0		
	Wisconsin	0		
Myocardial imaging (78465)	Northern California	0		
	Southern California	248.4	181.7	148.8
	North Carolina	6.4		
	South Carolina	6.0		
	Illinois	0		
	Wisconsin	0		
Ophthalmologic exam (92004)	Northern California	19.2		
	Southern California	4.2		
	North Carolina	1.2		
	South Carolina	0		
	Illinois	19.6		
	Wisconsin	108.4	67.2	51.9

[a]Denial rate calculated after excluding the 5 percent of providers with the highest denial rates.

[b]Denial rate calculated after excluding the 5 percent of providers with the highest total number of denials.

To further examine provider denial rates for medical necessity, we analyzed the distribution of provider denials for 16 services that had denial rates exceeding 90 per 1,000 allowed. For each service, we calculated the percentage of providers (within a carrier) that accounted for 50 percent of all denials for that service, as well as the percentage of providers with at

least one denial. For example, only 6.9 percent of Northern California chiropractors accounted for 50 percent of all denials. Table 6 displays the result of these calculations.

Table 6: Provider Denial Rates for Medical Necessity, 1993[a]

Carrier	Services with denials exceeding 90 per 1,000 services allowed	Percent of providers with at least 1 medical necessity denial	Percent of providers receiving 50 percent of all medical necessity denials
Northern California	A0150	52.5	2.8
	A2000	65.4	6.9
Southern California	78465	58.7	7.9
	92982	19.5	2.3
	93307	53.0	1.5
	93320	49.1	3.0
	93880	52.6	3.1
North Carolina	A0010	73.4	5.6
	A0020	78.1	4.8
	A2000	85.5	10.6
	92982	38.0	6.5
	93549	40.8	6.1
Illinois	A2000	70.5	7.4
	71020	54.2	2.1
Wisconsin	A2000	56.2	6.4
	92004	47.5	4.4

[a]Excludes South Carolina because it does not have medical necessity denial rates greater than 90 per 1,000 services allowed. Excludes providers that did not submit a claim for a service. Percentages are based on a 100-percent sample of 1993 claims. The method used for determining the denial median was based on the total number of denials a provider received. The percentage of allowed services accounted for by providers with 50 percent of denials was as follows: Northern California, A0150 = 28.2, A2000 = 29.7; Southern California, 78465 = 31.5, 92982 = 3.8, 93307 = 8.7, 93320 = 11.8, 93880 = 19.6; North Carolina, A0010 = 20.8, A0020 = 8.4, A2000 = 29.3, 92982 = 9.9, 93549 = 12.3; Illinois, A2000 = 27.1, 71020 = 17.1; Wisconsin, A2000 = 20.5, 92004 = 16.6.

Our analysis suggests that a small minority of providers, between 1.5 and 10.6 percent, accounted for 50 percent of services denied for lack of medical necessity (and thus were responsible for the bulk of denials). Thus, the screens and medical policies these carriers used to determine the medical necessity of claims primarily affected a relatively small proportion of the provider community. Table 6 also shows that the proportion of providers that had at least one denial varied between 19.5 and 85.5 percent. The latter range suggests that some prepayment screens

used to identify inappropriate billing patterns affected a smaller proportion of the provider population than did others.

While we cannot explain differing patterns of provider denials—for example, they may stem from unnecessary services being disproportionately offered by a few providers, differences in patient characteristics, variations in billing practices, or a number of other factors—further examination of the reasons for them is warranted given their potential to explain substantial amounts of variation in denial rates.

Conclusions

The magnitude of carrier denial rates was generally low and persistent for 2 consecutive years, although rates for some services shifted across years. Medical necessity denial rates for 74 services across six carriers varied substantially. The primary reason for variation in carrier denial rates was that certain carriers used screens for specific services while others did not. Thus, carriers' selecting the services to be screened and their determining the stringency of the screen criteria probably account for a significant proportion of the variability. Further, a small proportion of the providers accounted for 50 percent of the denied claims. To a lesser degree, the varying interpretation of certain national coverage standards across carriers, differences in the way carriers treated claims with missing information, and reporting inconsistencies helped explain variation in carrier denial rates.

We did not attempt to assess whether low or high medical necessity denial rates for individual carriers were appropriate. Low denial rates are desirable from the standpoint that they imply less annoyance and inconvenience for providers and beneficiaries. However, low denial rates are desirable only insofar as providers do not bill for medically unnecessary services.

What is clear from our work is that further analysis of denial rates can provide useful insight into how effectively Medicare carriers are managing program dollars and serving beneficiaries and providers. Since funding constraints limit the number of claims carriers can examine on a prepayment basis, it is important that they use the most effective and appropriate screens.

We believe that HCFA could improve its oversight capabilities by actively monitoring data on carrier denial rates and improving the reliability of the data that it collects. Data on denial rates are useful for identifying

inconsistencies in the way that carriers assess claims for medical necessity. This information, in turn, could be used to identify the services that certain carriers have found to have billing problems. In addition, for services that are more uniformly screened by carriers, variation in denial rates could indicate that carriers are using different screen criteria, which raises issues of appropriateness and effectiveness. Finally, data on denial rates could be used to construct a profile of the subpopulation of providers that have a disproportionately large number of denials, which might suggest a solution to this problem.

Recommendations

We recommend that, to improve its oversight of the Medicare Part B program, HCFA

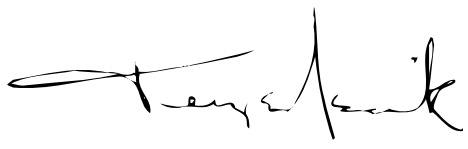
- issue instructions to carriers on how to classify the reason for denial when reporting this information;
- analyze intercarrier screen usage (including the stringency of screen criteria), identify effective screens, and disseminate this information to all carriers; and
- direct carriers to profile the subpopulation of providers responsible for a disproportionate share of medical necessity denials in order to devise a strategy for addressing this problem.

Agency Comments

At your request, we did not obtain agency comments on a draft of this report.

If you or your staff have any questions about this report or would like additional information, please call me at (202) 512-2900 or Kwai-Cheung Chan, Director for Program Evaluation in Physical Systems Areas, at (202) 512-3092. Major contributors to this report are listed in appendix V.

Sincerely yours,



Terry E. Hedrick
Assistant Comptroller General

Contents

Figures

Abbreviations

CWF	Common Working File
HCFA	Health Care Financing Administration
MCM	Medicare Carriers Manual
NCH	National Claims History
PSA	Prostate specific antigen

Objectives, Scope, and Methodology

Objectives

We had two objectives in this report. Our first was to determine the extent of carrier variability in denial rates for lack of medical necessity. Our second was to identify and examine factors that contributed to intercarrier variation in denial rates.

Scope

To develop the information on denial rates, we analyzed a 5-percent sample of 1992 and 1993 claims for the top 74 medical services processed by six carriers (based on their national ranking in terms of total allowed charges in 1992).[1] We also interviewed HCFA officials and representatives of the following six carriers: California Blue Shield (jurisdiction: Northern California), Transamerica Occidental Life Insurance (jurisdiction: Southern California), Connecticut General Life Insurance Company (jurisdiction: North Carolina), Blue Shield of South Carolina, Illinois Blue Cross and Blue Shield, and Wisconsin Physicians' Service.

In selecting carriers for our analysis, we considered geographic location and the number of claims processed. Our sample included two carriers each from of the Southeast, the Midwest, and the West. We sought to maximize the geographic distance between regions while retaining the potential for examining intraregional variation in claims adjudication. With regard to the number of claims processed, we attempted to obtain a mix of large and small carriers.[2] Table I.1 lists the carriers we visited and the number of claims they processed in fiscal year 1992.

Table I.1: Claims Processed by Selected Medicare Part B Carriers in 1992

Carrier	Geographic location	Number of claims processed (in millions)
California Blue Shield	West	24
Transamerica-Occidental	West	25
Illinois Blue Cross and Blue Shield	Midwest	22
Wisconsin Physicians' Service	Midwest	10
Connecticut General (North Carolina)	Southeast	18
South Carolina Blue Shield	Southeast	8

[1]We abstracted claim information from the physician and supplier portion of the National Claims History database, which serves as a repository for all Medicare claims.

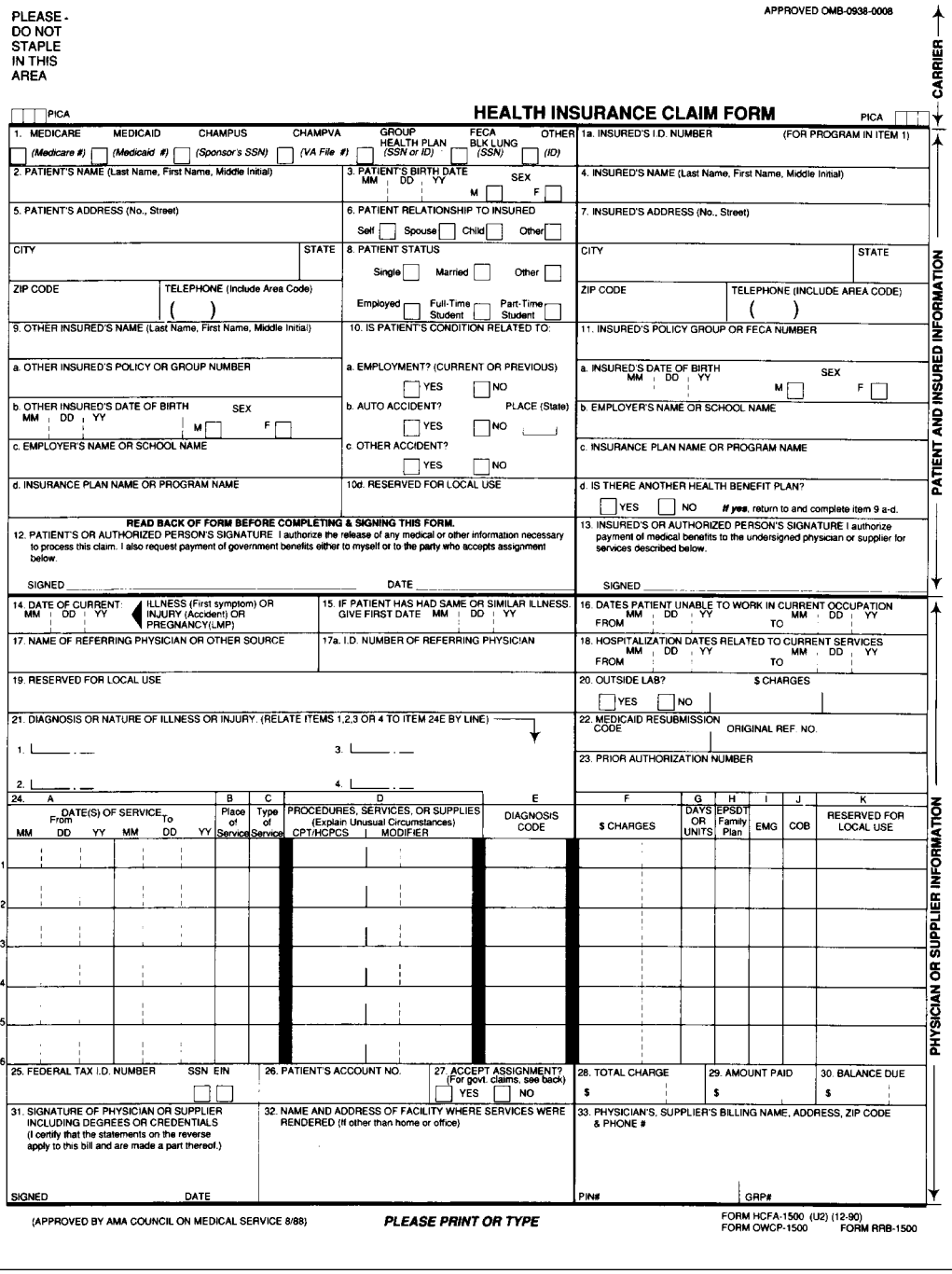
[2]The frequency distribution of number of claims processed by the Medicare carriers is essentially bimodal. That is, there are two large clusters of carriers: those that annually process between 2 and 13 million claims and those that process between 18 and 29 million claims (two carriers processed over 46 million claims each). Our sample includes two carriers from the former cluster and four from the latter.

Taken together, these six carriers processed about 19 percent of all Part B claims in fiscal year 1992. It should be noted, however, that the judgmental method used to select carriers for this report does not allow us to generalize our findings to the universe of carriers.

Methodology

We obtained data on denial rates from the National Claims History File, a database maintained by HCFA. It contains a wide variety of claim information, including type of medical service billed and type of action carriers take as a result of the claim adjudication process. On the Medicare claim form, each billed service, or line item, appears as a separate charge with a corresponding five-digit service code that describes the type of service provided. (See figure I.1.) For example, code 71020 refers to a chest x-ray. It is important to note that a Medicare claim can contain submitted charges for more than one service. A claim for a physician's office visit, for example, may also include the charges for laboratory tests performed during the visit. The denial rates presented in this report are based on specific services, not on claims.

Figure I.1: Medicare Part B Claim Form



PLEASE - DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500

Each service, or line item, listed on a claim is subject to the carrier's approval or denial. For each service processed, the carrier must indicate whether the claim for service was approved or denied and, if denied, the specific reason for denial. Table I.2 shows the categories of denial that are reported to HCFA's central database.

Table I.2: Reported Reasons for Denying a Medicare Service Claim

Reason	Description
Medically unnecessary	Service denied because it was determined that service was not medically necessary
Noncovered care	Service denied because it was administered under conditions that are not covered by Medicare
Benefits exhausted	Service denied because beneficiary exhausted all Part B benefits or reached the maximum limit of services: the three types of services subject to limitations under Medicare are psychiatric services, occupational therapy, and physical therapy
Invalid data	Claim contained invalid data; for example, the day and month of the service date were transposed, as in 15/9/94. This type of claim should be resubmitted
Multiple submittal	Service denied because submitted charge was duplicated on claim form
Medicare secondary payer	Service denied because Medicare was not the primary payer
Clinical Laboratory Improvement Act	Service denied because it was performed by a noncertified laboratory
Physician ownership denial	Service denied because the physician (or physician's relative) has ownership in the laboratory that performed the service
Data match (Medicare secondary payer cost avoided)	Service denied because Medicare was not the primary payer, discovered through an Internal Revenue Service and Social Security Administration data match
Other	Denials that do not fit into the categories above

We analyzed services that were denied because they were "medically unnecessary." We focused on this type of denial because it reflects, to a greater degree, the effect of carrier discretion in claims assessment. That is, determining medical necessity quite often entails the application of a complicated set of decision rules and may ultimately require the individual judgment of a claims reviewer. In contrast, the other types of denial involve more straightforward criteria that can be applied by means of computerized programs (such as whether charges for the same service appear twice on a claim). We calculated denial rates by summing the number of services denied for medical necessity and dividing the total by

the number of services allowed for each of 74 services.[3] We excluded from the analysis services denied for reasons other than medical necessity.

Although Medicare covers more than 10,000 different medical services, relatively few services account for the bulk of Medicare costs. Our analysis was restricted to the top 74 services, based on their national ranking in terms of the total of allowed charges in 1992.[4] In 1992, the top 74 services constituted approximately 50 percent of all Medicare Part B allowed charges. Services that rank high in allowed charges are either frequently performed (for example, office visits) or costly (for example, angioplasty treatments).[5]

[3]The formula for calculating denial rates is as follows: denial rate = (number of services denied for reason of medical necessity) / (number of services allowed) * 1,000.

[4]The "allowed charge" for a service is set by HCFA. The amount HCFA actually pays is 80 percent of the allowed charge less deductible or co-payment.

[5]Because durable medical equipment and parenteral and enteral claims are currently processed at regional centers, we also excluded such services from our analysis.

1992 Denial Rates (Per 1,000 Services Allowed) for Medical Necessity and Noncovered Care by Carrier

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Anesthesia							
00142	Anesthesia for procedure on eye, lens surgery	Med.	0.0	1.3	5.7	0.0	0.0	17.8
		Cov.	1.2	10.9	5.7	0.8	0.0	18.6
		Total	1.2	12.1	11.4	0.8	0.0	36.4
00562	Anesthesia, procedure on heart, pericardium and great vessels of chest; oxygenator with pump	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	2.4	3.4	11.4	0.0	0.0	17.8
		Total	2.4	3.4	11.4	0.0	0.0	17.8
	Muscloskeletal							
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement, with or without allograft	Med.	0.0	4.7	0.0	0.0	0.0	0.0
		Cov.	0.0	9.3	0.0	0.0	0.0	12.0
		Total	0.0	14.0	0.0	0.0	0.0	12.0
27236	Open treatment of closed or open femoral fracture	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	3.7	24.0	0.0	0.0	16.8
		Total	0.0	3.7	24.0	0.0	0.0	16.8
27244	Open treatment of closed or open intertrochanteric	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	16.3	31.4	0.0	0.0	21.9
		Total	0.0	16.3	31.4	0.0	0.0	21.9
27447	Arthroplasty, knee, condyle, and plateau; medical and lateral compartments, with or without patella resurfacing	Med.	0.0	2.9	0.0	0.0	0.0	0.0
		Cov.	0.0	2.9	43.5	0.0	0.0	14.2
		Total	0.0	5.8	43.5	0.0	0.0	14.2
	Cardiovascular							
33512	Coronary artery bypass, 3 coronary venous grafts	Med.	14.6	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	4.5	6.3	0.0	15.2	54.5
		Total	14.6	4.5	6.3	0.0	15.2	54.5
33513	Coronary artery bypass, 4 coronary venous grafts	Med.	3.9	0.0	0.0	0.0	0.0	0.0
		Cov.	0.0	32.7	30.3	0.0	13.2	35.7
		Total	3.9	32.7	30.3	0.0	13.2	35.7
36415	Routine venipuncture, collection of specimen	Med.	0.2	0.2	0.9	0.2	0.0	0.1
		Cov.	17.8	6.0	15.6	2.5	4.2	10.2
		Total	18.0	9.2	16.6	2.7	4.2	10.3
	Digestive							
43235	Upper gastrointestinal endoscopy, including esophagus, stomach, duodenum, or jejunum; complex diagnostic	Med.	0.0	0.9	1.1	0.0	1.8	0.0
		Cov.	0.9	10.2	14.2	2.3	1.8	10.2
		Total	0.9	11.1	15.3	2.3	3.6	10.2

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
43239	Upper gastrointestinal endoscopy, including esophagus, stomach, and either duodenum or jejunum; for biopsy or collections by brushing	Med.	0.0	1.6	3.7	0.0	2.2	0.0
		Cov.	0.9	6.4	24.9	0.0	0.0	12.8
		Total	0.9	8.0	28.6	0.0	2.2	12.8
45378	Colonoscopy, fiberoptic, beyond splenic flexure, diagnostic, with or without colon decompression	Med.	0.0	0.9	0.0	0.0	0.8	0.0
		Cov.	1.8	6.0	20.3	0.0	1.7	6.2
		Total	1.8	6.8	20.3	0.0	2.5	6.2
45385	Colonoscopy, fiberoptic, beyond splenic flexure, same as above, with removal of polypoid lesions	Med.	0.0	3.7	0.0	0.0	0.0	0.0
		Cov.	1.2	7.5	12.2	0.0	0.0	10.3
		Total	1.2	11.2	12.2	0.0	0.0	10.3
	Urinary							
52000	Cystourethroscopy (separate procedure)	Med.	1.3	2.1	0.0	0.0	3.2	0.0
		Cov.	1.3	8.9	5.8	0.0	2.4	17.0
		Total	2.6	11.0	5.8	0.0	5.6	17.0
52601	Transuretheral resection of prostate, including control of post-op bleeding, complete	Med.	9.0	3.2	0.0	0.0	0.0	0.0
		Cov.	6.0	0.0	21.4	7.8	0.0	12.9
		Total	15.0	3.2	21.4	7.8	0.0	12.9
	Eye and ocular adenxa							
65855	Trabeculoplasty by laser surgery, one or more sessions	Med.	0.0	2.3	0.0	0.0	0.0	0.0
		Cov.	3.8	75.9	9.6	0.0	0.0	74.1
		Total	3.8	78.2	9.6	0.0	0.0	74.1
66821	Discussion of secondary membranous cataract	Med.	0.0	1.0	1.1	0.0	0.0	0.0
		Cov.	0.0	35.3	27.6	0.0	0.5	5.9
		Total	0.0	36.3	28.7	0.0	0.5	5.9
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis	Med.	0.2	10.8	5.5	0.0	1.1	0.0
		Cov.	0.0	31.1	14.1	1.7	0.5	0.7
		Total	0.2	42.0	19.7	1.7	1.6	0.7
	Radiology							
71010	Radiological exam, chest, single view, frontal	Med.	0.5	16.0	4.4	1.0	80.5	1.0
		Cov.	0.5	13.0	12.5	4.2	0.3	17.4
		Total	1.0	29.0	16.8	5.2	80.9	18.4
71020	Radiological exam, chest, 2 views, frontal and lateral	Med.	0.4	12.4	0.9	0.2	103.2	0.9
		Cov.	1.2	7.0	14.2	11.9	1.3	19.1
		Total	1.6	19.3	15.0	12.2	104.5	20.0
76091	Mammography, bilateral	Med.	0.3	54.0	0.3	0.0	0.0	0.4
		Cov.	1.3	11.9	124.3	28.8	0.2	129.3
		Total	1.5	65.9	124.6	28.8	0.2	129.7

(continued)

Appendix II
1992 Denial Rates (Per 1,000 Services Allowed) for Medical Necessity and Noncovered Care by Carrier

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
77430	Weekly radiation therapy management, complex	Med.	0.0	1.2	0.0	0.0	0.0	1.6
		Cov.	0.0	5.5	35.6	1.6	75.3	8.2
		Total	0.0	6.7	35.6	1.6	75.3	9.9
78465	Myocardial perfusion imaging	Med.	0.0	261.4	1.5	15.1	0.0	0.0
		Cov.	2.0	4.9	17.0	0.0	0.0	5.9
		Total	2.0	266.3	18.5	15.1	0.0	5.9
	Path/lab							
80019	Automated multichannel test, 19 or more clinical chemistry tests	Med.	1.1	3.5	0.2	2.8	93.8	0.0
		Cov.	28.7	4.7	3.7	8.4	0.0	14.2
		Total	29.8	8.2	3.9	11.2	93.8	14.2
84443	Thyroid stimulating hormone	Med.	0.6	3.4	0.3	4.4	0.0	0.0
		Cov.	26.5	4.6	1.6	5.8	0.1	14.3
		Total	27.1	8.0	2.0	10.2	0.1	14.3
85025	Blood count; hemogram and platelet count, automated and CBC	Med.	0.9	5.2	0.2	0.0	0.0	0.3
		Cov.	27.8	3.7	3.2	7.7	0.0	9.7
		Total	28.7	8.9	3.3	7.7	0.0	10.0
86316	Immunoassay for tumor antigen (for example, prostate specific antigen)	Med.	0.3	3.2	0.4	0.0	0.0	0.0
		Cov.	30.6	4.1	8.2	4.1	0.0	6.5
		Total	30.8	7.3	8.6	4.1	0.0	6.5
88305	Level IV—surgical pathology, gross and microscopic exam	Med.	0.1	19.9	1.5	0.5	0.0	0.7
		Cov.	1.1	19.6	22.7	1.9	0.3	18.4
		Total	1.1	39.5	24.2	2.4	0.3	19.1
	Medicine							
90843	Individual medical psychotherapy by a physician, approximately 20-30 minutes	Med.	0.1	14.7	1.6	0.0	0.0	1.0
		Cov.	2.9	12.7	26.4	6.3	7.8	26.4
		Total	3.0	27.4	28.0	6.3	7.8	27.3
90844	Individual medical psychotherapy by a physician, approximately 45-50 minutes	Med.	0.2	9.9	1.0	0.0	0.0	0.7
		Cov.	0.6	15.7	23.4	0.0	35.5	182.1
		Total	0.8	25.6	24.4	0.0	35.5	182.8
92004	Opthalmologic services: medical examination and evaluation	Med.	0.2	5.2	0.4	0.0	1.4	102.2
		Cov.	3.4	11.7	61.6	16.7	3.1	4.7
		Total	3.7	16.9	62.0	16.7	4.5	106.9
92012	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	0.0	1.8	0.5	0.0	1.6	51.5
		Cov.	1.1	22.9	37.6	6.6	8.1	4.2
		Total	1.1	24.7	38.1	6.6	9.7	55.7

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
92014	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	0.0	2.8	0.9	0.0	2.5	83.5
		Cov.	1.1	12.7	49.0	22.6	4.1	5.6
		Total	1.1	15.6	50.0	22.6	6.6	89.1
92982	Percutaneous transluminal coronary balloon angioplasty, single vessel	Med.	0.0	182.4	29.2	0.0	0.0	33.3
		Cov.	256.3	19.5	58.5	0.0	175.0	0.0
		Total	256.3	202.0	87.7	0.0	175.0	33.3
93005	Electrocardiogram, routine, with at least 12 leads; tracing only, without interpretation and report	Med.	1.0	8.5	0.6	0.0	0.1	0.8
		Cov.	36.8	11.3	42.0	2.8	3.1	21.4
		Total	37.7	19.8	42.6	2.8	3.3	22.2
93307	Echocardiography, real-time with image documentation (2D), with or without M-mode recording, complete	Med.	4.1	140.0	1.2	0.0	0.0	1.5
		Cov.	0.9	41.4	39.3	1.2	0.0	5.2
		Total	5.0	181.4	40.5	1.2	0.0	6.7
93320	Doppler echocardiography, pulsed wave or continuous wave with spectral display, complete	Med.	0.4	88.8	8.1	0.0	0.0	4.8
		Cov.	0.7	31.9	40.2	0.7	5.1	6.2
		Total	1.1	120.7	48.3	0.7	5.1	11.0
93547	Combined left heart catheterization, selective coronary angiography, 1 or more coronary arteries, and selective left ventricular angiography	Med.	0.0	3.0	1.5	0.0	0.0	0.0
		Cov.	0.0	78.2	5.9	0.0	66.4	3.6
		Total	0.0	81.2	7.4	0.0	66.4	3.6
93549	Combined right and left heart catheterization, selective coronary angiography, 1 or more coronary arteries	Med.	0.0	0.0	198.6	0.0	0.0	0.0
		Cov.	0.0	79.1	41.1	0.0	88.5	5.3
		Total	0.0	79.1	239.7	0.0	88.5	5.3
93880	Duplex scan of extracranial arteries; complete bilateral study	Med.	0.0	124.9	13.6	0.0	0.0	0.0
		Cov.	1.9	15.4	55.9	0.0	1.8	7.2
		Total	1.9	140.2	69.6	0.0	1.8	7.2
	Office or other outpatient services							
99202	Office or other outpatient visit for the evaluation	Med.	0.2	15.9	0.4	0.0	2.7	0.4
		Cov.	10.8	12.6	26.6	5.7	15.0	65.7
		Total	11.0	28.4	27.0	5.7	17.7	66.0
99203	Office or other outpatient visit	Med.	0.7	10.4	0.2	0.0	3.6	1.3
		Cov.	6.8	11.9	30.7	7.6	12.7	87.7
		Total	7.4	22.3	30.9	7.6	16.3	89.0
99204	Office or other outpatient visit	Med.	0.0	8.6	0.0	0.0	4.1	0.0
		Cov.	3.2	9.5	20.5	2.5	13.0	66.5
		Total	3.2	18.1	20.5	2.5	17.1	66.5

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
99205	Office or other outpatient visit	Med.	0.3	7.0	0.7	0.0	9.3	0.0
		Cov.	1.3	9.4	23.8	3.5	26.6	40.7
		Total	1.6	16.4	24.5	3.5	35.9	40.7
99211	Office or other outpatient visit for the evaluation	Med.	1.2	17.4	0.3	0.0	6.2	20.2
		Cov.	9.3	25.8	25.6	1.1	15.7	31.8
		Total	10.5	43.3	26.0	1.1	21.9	52.0
99212	Office or other outpatient visit	Med.	0.6	7.9	0.5	0.0	5.5	18.4
		Cov.	2.6	27.2	20.3	2.0	8.1	10.8
		Total	3.2	35.1	20.8	2.0	13.6	29.3
99213	Office or other outpatient visit	Med.	0.4	3.7	0.3	0.0	3.7	9.7
		Cov.	1.2	15.7	12.2	1.5	5.2	9.3
		Total	1.6	19.4	12.5	1.5	8.9	19.0
99214	Office or other outpatient visit	Med.	0.2	4.4	0.3	0.3	3.8	8.2
		Cov.	0.5	14.6	16.0	3.3	5.3	15.3
		Total	0.7	19.1	16.2	3.6	9.2	23.5
99215	Office or other outpatient visit	Med.	0.1	6.3	1.0	0.0	5.6	6.2
		Cov.	1.0	19.1	28.4	5.6	7.1	19.6
		Total	1.1	25.4	29.4	5.6	12.6	25.8
	Hospital inpatient services							
99222	Initial hospital care, per day	Med.	0.6	11.3	1.5	3.1	9.8	2.5
		Cov.	0.0	30.6	28.9	3.1	8.7	7.7
		Total	0.6	41.9	30.4	6.3	18.5	10.2
99223	Initial hospital care, per day	Med.	0.3	9.4	2.6	1.2	7.8	6.6
		Cov.	0.3	17.9	24.2	0.0	6.9	7.9
		Total	0.5	27.4	26.8	1.2	14.7	14.5
99231	Subsequent hospital care, per day	Med.	0.3	12.4	0.3	2.2	13.4	21.5
		Cov.	0.1	16.8	22.4	1.1	6.2	9.5
		Total	0.4	29.3	22.8	3.3	19.6	31.0
99232	Subsequent hospital care, per day	Med.	0.9	13.7	0.4	1.7	11.9	17.1
		Cov.	0.2	11.4	16.7	1.6	5.2	8.7
		Total	1.1	25.1	17.1	3.3	17.1	25.7
99233	Subsequent hospital care, per day	Med.	0.8	22.9	0.3	2.1	9.1	20.4
		Cov.	0.1	13.8	26.4	1.6	6.5	13.7
		Total	0.9	36.7	26.7	3.7	15.6	34.1

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
99238	Hospital discharge day management	Med.	0.5	12.2	0.4	0.3	10.3	13.7
		Cov.	0.1	15.6	17.2	0.6	6.2	6.2
		Total	0.6	27.8	17.6	0.9	16.6	19.9
	Consultations							
99243	Office consultation, new or established patient	Med.	0.0	3.2	0.6	0.0	0.0	6.8
		Cov.	0.6	18.1	57.4	1.4	0.4	13.6
		Total	0.6	21.4	57.9	1.4	0.4	20.4
99244	Office consultation, new or established patient	Med.	0.0	3.0	0.0	0.0	0.0	3.6
		Cov.	0.7	12.9	65.6	2.1	1.0	10.9
		Total	0.7	15.9	65.6	2.1	1.0	14.5
99245	Office consultation, new or established patient	Med.	0.0	2.4	0.0	0.0	0.0	12.8
		Cov.	1.4	10.3	53.8	0.0	1.0	11.2
		Total	1.4	12.7	53.8	0.0	1.0	24.1
99253	Initial inpatient consultation, new or established patient	Med.	0.5	2.6	2.2	0.0	0.0	1.1
		Cov.	0.0	15.3	61.3	0.0	4.1	15.5
		Total	0.5	17.9	63.5	0.0	4.1	16.6
99254	Initial inpatient consultation, new or established patient	Med.	0.2	2.3	0.4	0.8	0.0	0.5
		Cov.	0.4	15.2	61.7	0.0	2.2	18.1
		Total	0.6	17.5	62.1	0.8	2.2	18.6
99255	Initial inpatient consultation, new or established patient	Med.	0.4	2.6	0.0	0.0	0.0	0.0
		Cov.	0.0	10.3	59.2	1.3	4.2	9.3
		Total	0.4	12.9	59.2	1.3	4.2	9.3
99262	Follow-up inpatient consultation for an established patient	Med.	0.0	10.5	1.6	0.0	0.0	33.0
		Cov.	0.0	14.6	79.7	8.6	5.3	26.2
		Total	0.0	25.1	81.3	8.6	5.3	59.3
	Emergency department services							
99283	Emergency department visit	Med.	0.1	12.5	1.0	0.8	0.0	14.7
		Cov.	0.0	4.3	16.3	2.9	3.9	8.1
		Total	0.1	16.8	17.2	3.7	3.9	22.8
99284	Emergency department visit	Med.	0.2	8.5	1.7	0.0	0.0	4.8
		Cov.	0.0	8.7	10.0	1.2	2.8	15.1
		Total	0.2	17.1	11.7	1.2	2.8	19.9
99285	Emergency department visit	Med.	0.0	30.6	2.9	0.9	0.0	8.3
		Cov.	0.0	7.2	22.9	0.9	2.2	16.0
		Total	0.0	37.8	25.8	1.9	2.2	24.3

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Critical care services							
99291	Critical care, including diagnostic and therapeutic services, first hour	Med.	0.3	6.9	1.8	4.2	13.8	27.7
		Cov.	0.8	6.7	43.2	0.0	30.5	10.0
		Total	1.0	13.6	45.0	4.2	44.3	37.7
	Nursing facility services							
99311	Subsequent nursing facility care, per day	Med.	0.0	2.6	0.8	0.0	4.1	5.0
		Cov.	0.1	9.9	14.2	0.2	1.3	12.8
		Total	0.1	12.6	14.9	0.2	5.3	17.8
99312	Subsequent nursing facility care, per day	Med.	0.2	4.3	0.3	0.0	3.6	3.1
		Cov.	0.1	12.0	17.2	0.0	0.8	11.1
		Total	0.2	16.3	17.5	0.0	4.4	14.2
	HCPCS							
A0010	Ambulance service, basic life support	Med.	0.3	20.4	1.2	48.6	0.0	42.4
		Cov.	0.3	18.9	270.3	5.6	0.8	52.2
		Total	0.6	39.3	271.5	54.2	0.8	94.5
A0020	Ambulance service, (BLS) per mile, transport, one way	Med.	6.2	74.3	1.4	18.4	0.1	49.5
		Cov.	1.6	35.1	459.9	1.0	1.7	49.8
		Total	7.8	109.4	461.2	19.4	1.8	99.4
A0150	Ambulance, nonemergency transport, base rate, one way	Med.	302.5	83.2	1.9	13.0	[b]	[b]
		Cov.	11.1	38.7	264.9	0.0	[b]	[b]
		Total	313.5	122.0	266.8	13.0		
A0220	Ambulance service, advanced life support, all-inclusive services	Med.	0.4	10.8	0.0	47.2	0.0	[b]
		Cov.	0.7	17.2	100.8	27.6	0.0	[b]
		Total	1.1	28.1	100.8	74.8	0.0	
A2000	Manipulation of the spine by chiropractor	Med.	77.1	72.2	173.9	116.5	142.8	18.3
		Cov.	0.7	41.1	89.5	77.4	4.5	145.8
		Total	77.8	113.4	263.4	194.0	147.2	164.1
J9217	Leuprolide acetate, for depot suspension, 7.5 mg	Med.	0.0	0.9	17.1	0.0	0.0	2.7
		Cov.	0.0	8.2	21.0	6.8	0.0	2.7
		Total	0.0	9.1	38.1	6.8	0.0	5.4

[a]Categories are Med. = medical necessity denial rate; Cov. = noncovered care denial rate; Total = medical necessity + noncovered care. (The "Total" category may not always be equal to the sum of the "Med." and "Cov." categories because it was independently rounded.)

[b]No allowed services were found for this code.

1993 Denial Rates (Per 1,000 Services Allowed) for Medical Necessity and Noncovered Care by Carrier

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Anesthesia							
00142	Anesthesia for procedure on eye, lens surgery	Med.	0.0	1.0	4.5	0.0	1.6	4.8
		Cov.	17.3	5.8	37.9	0.0	0.9	10.6
		Total	17.3	6.8	42.5	0.0	2.5	15.4
00562	Anesthesia, procedure on heart, pericardium and great vessels of chest; oxygenator with pump	Med.	0.0	0.0	13.3	0.0	0.0	0.0
		Cov.	11.6	3.5	17.7	0.0	0.0	0.0
		Total	11.6	3.5	31.0	0.0	0.0	0.0
	Musculoskeletal							
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement, with or without allograft	Med.	0.0	4.0	6.3	0.0	4.8	0.0
		Cov.	0.0	12.0	25.3	0.0	0.0	6.3
		Total	0.0	15.9	31.6	0.0	4.8	6.3
27236	Open treatment of closed or open femoral fracture	Med.	0.0	0.0	0.0	0.0	5.0	0.0
		Cov.	0.0	16.5	40.7	0.0	0.0	36.7
		Total	0.0	16.5	40.7	0.0	5.0	36.7
27244	Open treatment of closed or open intertrochanteric	Med.	0.0	5.2	0.0	0.0	0.0	0.0
		Cov.	0.0	15.6	58.8	0.0	3.8	7.2
		Total	0.0	20.8	58.8	0.0	3.8	7.2
27447	Arthroplasty, knee, condyle, and plateau; medical and lateral compartments, with or without patella resurfacing	Med.	0.0	11.2	3.9	0.0	2.8	0.0
		Cov.	0.0	8.4	85.6	0.0	0.0	11.6
		Total	0.0	19.7	89.5	0.0	2.8	11.6
	Cardiovascular							
33512	Coronary artery bypass, 3 coronary venous grafts	Med.	0.0	0.0	0.0	0.0	11.8	0.0
		Cov.	0.0	8.4	32.3	0.0	0.0	0.0
		Total	0.0	8.4	32.3	0.0	11.8	0.0
33513	Coronary artery bypass, 4 coronary venous grafts	Med.	9.4	0.0	0.0	0.0	11.2	0.0
		Cov.	0.0	0.0	0.0	0.0	0.0	0.0
		Total	9.4	0.0	0.0	0.0	11.2	0.0
36415	Routine venipuncture, collection of specimen	Med.	0.2	9.5	1.8	0.4	0.2	0.0
		Cov.	3.7	5.8	28.3	1.3	5.4	13.0
		Total	3.9	15.3	30.1	1.7	5.5	13.0

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
	Digestive							
43235	Upper gastrointestinal endoscopy, including esophagus, stomach, duodenum, or jejunum; complex diagnostic	Med.	0.0	0.9	0.0	0.0	0.9	0.0
		Cov.	1.0	6.3	33.5	0.0	1.9	7.7
		Total	1.0	7.2	33.5	0.0	2.8	7.7
43239	Upper gastrointestinal endoscopy, including esophagus, stomach, duodenum, or jejunum; for biopsy or collections by brushing	Med.	0.0	1.3	1.2	0.0	0.0	0.0
		Cov.	5.0	10.4	20.4	8.0	11.0	11.2
		Total	5.0	11.7	21.6	8.0	11.0	11.2
45378	Colonoscopy, fiberoptic, beyond splenic flexure, diagnostic, with or without colon decompression	Med.	0.0	0.8	0.0	0.0	0.0	0.0
		Cov.	0.9	5.0	20.7	2.2	2.7	1.9
		Total	0.9	5.8	20.7	2.2	2.7	1.9
45385	Colonoscopy, fiberoptic, beyond splenic flexure, same as above, with removal of polypoid lesions	Med.	0.0	0.0	0.0	0.0	0.0	0.0
		Cov.	2.2	5.7	27.2	0.0	28.3	4.6
		Total	2.2	5.7	27.2	0.0	28.3	4.6
	Urinary							
52000	Cystourethroscopy (separate procedure)	Med.	1.3	0.0	1.0	0.0	0.0	0.0
		Cov.	0.7	1.5	21.3	0.0	0.0	19.9
		Total	2.0	1.5	22.3	0.0	0.0	19.9
52601	Transuretheral resection of prostate, including control of post-op bleeding, complete	Med.	16.6	14.3	12.1	0.0	0.0	0.0
		Cov.	0.0	0.0	30.3	0.0	0.0	5.9
		Total	16.6	14.3	42.4	0.0	0.0	5.9
	Eye and ocular adenxa							
65855	Trabeculoplasty by laser surgery, one or more sessions	Med.	0.0	0.0	9.0	0.0	0.0	0.0
		Cov.	0.0	36.3	45.0	0.0	0.0	96.5
		Total	0.0	36.3	54.1	0.0	0.0	96.5
66821	Discussion of secondary membranous cataract (opacified posterior)	Med.	0.0	0.6	1.0	0.0	0.0	0.0
		Cov.	3.1	4.0	31.4	0.0	1.2	2.0
		Total	3.1	4.5	32.4	0.0	1.2	2.0
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis	Med.	0.3	1.8	12.9	1.0	0.0	1.5
		Cov.	6.7	7.2	23.5	0.0	2.3	3.1
		Total	6.9	9.1	36.4	1.0	2.3	4.6
	Radiology							
71010	Radiologic exam, chest, single view, frontal	Med.	5.1	17.3	7.0	0.4	57.5	0.1
		Cov.	0.6	12.1	18.6	0.7	0.4	10.4
		Total	5.6	29.4	25.6	1.1	58.0	10.5

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
71020	Radiologic exam, chest, 2 views, frontal and lateral	Med.	7.6	14.6	1.2	0.2	90.2	0.1
		Cov.	0.3	5.8	24.9	5.0	3.6	13.4
		Total	7.9	20.4	26.1	5.2	93.8	13.5
76091	Mammography, bilateral	Med.	47.0	63.5	0.0	2.6	0.0	0.0
		Cov.	0.0	16.0	128.5	82.8	0.0	147.3
		Total	47.0	79.5	128.5	85.4	0.0	147.3
77430	Weekly radiation therapy management, complex	Med.	0.0	4.5	0.0	0.0	0.0	0.0
		Cov.	0.0	0.0	61.5	0.0	0.0	4.3
		Total	0.0	4.5	61.5	0.0	0.0	4.3
78465	Myocardial perfusion imaging	Med.	0.0	248.4	6.4	6.0	0.0	0.0
		Cov.	0.0	3.9	10.3	12.0	0.0	0.0
		Total	0.0	252.3	16.7	18.0	0.0	0.0
	Path/lab							
80019	Automated multichannel test, 19 or more clinical chemistry tests	Med.	0.1	1.7	0.5	1.4	138.9	0.0
		Cov.	1.0	7.4	10.1	1.8	0.0	12.6
		Total	1.1	9.0	10.6	3.2	138.9	12.6
84443	Thyroid stimulating hormone (TSH)	Med.	0.1	2.3	0.4	4.0	0.2	0.0
		Cov.	1.0	3.0	7.0	2.7	0.0	11.6
		Total	1.1	5.3	7.4	6.7	0.2	11.6
85025	Blood count, hemogram and platelet count, automated and CBC	Med.	0.1	1.7	0.6	0.9	0.0	0.0
		Cov.	0.4	4.9	8.2	0.5	0.0	8.3
		Total	0.5	6.7	8.8	1.4	0.0	8.3
86316	Immunoassay for tumor antigen (for example, prostate specific antigen)	Med.	0.2	3.8	0.6	1.2	0.4	6.1
		Cov.	1.5	6.1	16.6	0.0	0.0	15.8
		Total	1.7	9.9	17.2	1.2	0.4	21.9
88305	Level IV—surgical pathology, gross and microscopic exam	Med.	0.1	5.7	6.2	1.3	0.6	0.7
		Cov.	0.5	19.0	21.7	0.9	0.0	6.5
		Total	0.6	24.7	27.9	2.2	0.6	7.2
	Medicine							
90843	Individual medical psychotherapy by a physician, approximately 20-30 minutes	Med.	0.2	8.7	5.3	0.0	0.6	0.7
		Cov.	0.2	11.5	16.8	0.7	1.6	38.8
		Total	0.4	20.2	22.1	0.7	2.3	39.5
90844	Individual medical psychotherapy by a physician, approximately 45-50 minutes	Med.	0.0	6.3	2.9	0.0	1.4	1.6
		Cov.	0.1	18.4	23.2	0.0	0.3	178.0
		Total	0.1	24.7	26.1	0.0	1.7	179.6

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
92004	Opthalmologic services: medical examination and evaluation	Med.	19.2	4.2	1.2	0.0	19.6	108.4
		Cov.	1.2	13.8	65.3	0.8	35.5	9.0
		Total	20.4	18.0	66.5	0.8	55.1	117.4
92012	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	2.5	2.2	1.5	0.4	9.1	29.7
		Cov.	0.1	3.0	61.3	0.4	21.0	4.6
		Total	2.7	5.2	62.8	0.7	30.0	34.3
92014	Ophthalmologic services: medical exam and evaluation, with initiation or continuation of diagnostic and treatment program	Med.	7.0	1.4	0.6	0.0	13.8	80.1
		Cov.	1.3	6.6	56.6	0.3	24.2	7.0
		Total	8.3	8.0	57.3	0.3	38.0	87.1
92982	Percutaneous transluminal coronary balloon angioplasty, single vessel	Med.	46.3	100.3	125.0	0.0	12.7	0.0
		Cov.	78.4	3.5	125.0	54.9	237.3	0.0
		Total	124.8	103.8	250.0	54.9	250.0	0.0
93005	Electrocardiogram, routine, with at least 12 leads; tracing only, without interpretation and report	Med.	0.3	18.6	1.5	0.2	0.1	1.2
		Cov.	12.1	11.5	87.7	2.3	28.8	18.4
		Total	12.4	30.1	89.2	2.5	28.9	19.6
93307	Echocardiography, real-time with image documentation (2D), with or without M-mode recording, complete	Med.	1.7	173.3	1.1	4.4	0.0	0.0
		Cov.	0.5	25.1	36.3	0.0	0.0	3.1
		Total	2.2	198.5	37.3	4.4	0.0	3.1
93320	Doppler echocardiography, pulsed wave or continuous wave with spectral display, complete	Med.	0.0	129.1	3.3	4.3	0.0	4.9
		Cov.	0.6	22.3	26.9	0.0	0.0	4.4
		Total	0.6	151.4	30.3	4.3	0.0	9.3
93547	Combined left heart catheterization, selective coronary angiography, 1 or more coronary arteries, and selective left ventricular angiography	Med.	1.3	3.1	0.0	0.0	0.0	0.0
		Cov.	2.6	56.3	10.0	0.0	47.0	3.9
		Total	3.9	59.5	10.0	0.0	47.0	3.9
93549	Combined right and left heart catheterization, selective coronary angiography, 1 or more coronary arteries	Med.	3.8	3.9	180.6	0.0	0.0	0.0
		Cov.	5.7	46.7	12.9	0.0	63.9	3.5
		Total	9.5	50.6	193.5	0.0	63.9	3.5
93880	Duplex scan of extracranial arteries, complete bilateral study	Med.	0.0	209.9	1.2	0.0	0.0	0.0
		Cov.	0.4	13.2	29.9	31.4	0.0	7.7
		Total	0.4	223.1	31.1	31.4	0.0	7.7
	Office or other outpatient services							
99202	Office or other outpatient visit for the evaluation	Med.	0.3	23.9	0.8	0.5	2.7	0.4
		Cov.	21.5	6.5	58.5	18.9	26.3	107.7
		Total	21.8	30.4	59.3	19.4	28.9	108.0

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
99203	Office or other outpatient visit	Med.	0.1	14.7	0.7	0.0	4.5	0.0
		Cov.	11.9	8.0	85.3	12.2	29.2	109.7
		Total	12.1	22.7	86.0	12.2	33.8	109.7
99204	Office or other outpatient visit	Med.	0.2	7.2	1.3	0.0	1.9	0.0
		Cov.	4.0	5.9	55.4	7.4	22.6	65.5
		Total	4.2	13.1	56.7	7.4	24.5	65.5
99205	Office or other outpatient visit	Med.	0.0	5.7	1.5	0.0	4.5	0.0
		Cov.	3.4	13.9	63.4	2.6	45.6	66.8
		Total	3.4	19.7	64.8	2.6	50.2	66.8
99211	Office or other outpatient visit	Med.	0.6	36.6	0.2	0.0	7.2	12.0
		Cov.	27.7	4.9	52.3	13.8	22.0	55.6
		Total	28.3	41.6	52.6	13.8	29.2	67.6
99212	Office or other outpatient visit	Med.	0.7	15.7	0.7	0.0	6.2	6.9
		Cov.	4.1	6.2	46.7	7.0	2.2	27.6
		Total	4.8	21.8	47.4	7.1	8.4	34.5
99213	Office or other outpatient visit	Med.	0.3	5.6	0.5	0.0	4.4	3.0
		Cov.	1.5	4.5	26.9	1.0	1.8	17.3
		Total	1.8	10.2	27.5	1.0	6.2	20.3
99214	Office or other outpatient visit	Med.	0.3	5.2	0.3	0.0	3.7	2.0
		Cov.	0.8	4.4	38.1	2.0	3.0	24.9
		Total	1.1	9.6	38.5	2.0	6.7	27.0
99215	Office or other outpatient visit	Med.	0.0	6.0	1.0	0.0	3.6	1.8
		Cov.	1.6	5.9	43.1	4.8	7.5	33.4
		Total	1.6	11.9	44.0	4.8	11.1	35.3
	Hospital inpatient services							
99222	Initial hospital care, per day	Med.	0.4	8.7	2.8	2.6	16.9	0.7
		Cov.	0.2	18.2	73.0	0.5	2.4	3.3
		Total	0.6	26.9	75.8	3.1	19.3	4.0
99223	Initial hospital care, per day	Med.	0.8	7.2	2.6	2.8	12.2	3.6
		Cov.	0.3	16.4	64.8	0.0	4.2	4.0
		Total	1.1	23.6	67.4	2.8	16.5	7.6
99231	Subsequent hospital care, per day	Med.	7.7	20.7	5.8	3.2	17.6	10.1
		Cov.	0.4	11.8	35.2	0.0	6.1	8.8
		Total	8.1	32.5	41.0	3.2	23.7	18.9

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
99232	Subsequent hospital care, per day	Med.	8.7	20.8	4.7	4.1	17.8	9.8
		Cov.	0.3	10.6	39.5	0.0	4.5	11.6
		Total	9.0	31.3	44.2	4.1	22.3	21.4
99233	Subsequent hospital care, per day	Med.	11.4	24.8	4.1	5.7	17.1	12.0
		Cov.	0.1	7.4	53.6	1.4	7.0	17.8
		Total	11.4	32.2	57.7	7.1	24.2	29.8
99238	Hospital discharge day management	Med.	0.1	34.1	2.1	0.3	15.4	7.2
		Cov.	0.6	12.8	41.9	0.5	6.6	9.3
		Total	0.8	46.9	44.0	0.8	22.0	16.5
	Consultations							
99243	Office consultation, new or established patient	Med.	0.5	0.9	1.5	0.0	0.0	5.2
		Cov.	0.3	16.6	175.4	1.3	1.2	5.7
		Total	0.8	17.6	176.8	1.3	1.2	11.0
99244	Office consultation, new or established patient	Med.	0.3	2.2	0.9	0.0	0.0	1.1
		Cov.	0.3	16.9	143.9	0.0	1.9	9.1
		Total	0.6	19.1	144.7	0.0	1.9	10.3
99245	Office consultation, new or established patient	Med.	0.4	3.5	0.0	0.0	0.0	0.0
		Cov.	0.0	18.8	173.4	0.0	2.5	3.4
		Total	0.4	22.4	173.4	0.0	2.5	3.4
99253	Initial inpatient consultation, new or established patient	Med.	0.0	3.8	2.2	1.1	0.0	2.5
		Cov.	0.0	36.0	120.8	0.0	0.8	6.0
		Total	0.0	39.8	123.0	1.1	0.8	8.6
99254	Initial inpatient consultation, new or established patient	Med.	0.8	3.2	2.2	0.0	0.0	1.9
		Cov.	0.2	14.5	87.6	0.0	2.6	6.9
		Total	1.0	17.7	89.8	0.0	2.6	8.8
99255	Initial inpatient consultation, new or established patient	Med.	0.0	2.5	0.0	0.0	0.0	4.4
		Cov.	0.6	14.4	120.7	0.0	3.7	7.6
		Total	0.6	16.8	120.7	0.0	3.7	12.0
99262	Follow-up inpatient consultation for an established patient	Med.	0.0	33.3	1.9	0.0	0.0	4.5
		Cov.	0.7	10.9	198.1	0.0	9.6	23.8
		Total	0.7	44.2	200.0	0.0	9.6	28.3
	Emergency department services							
99283	Emergency department visit	Med.	0.3	17.1	6.0	0.0	0.0	1.1
		Cov.	0.0	5.4	20.3	0.0	3.4	4.9
		Total	0.3	22.6	26.3	0.0	3.4	6.0

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
99284	Emergency department visit	Med.	0.0	14.0	1.9	0.5	0.0	3.1
		Cov.	0.1	8.4	16.9	0.0	1.4	6.4
		Total	0.1	22.4	18.8	0.5	1.4	9.5
99285	Emergency department visit	Med.	0.0	79.6	2.1	0.7	0.0	4.5
		Cov.	0.0	9.8	33.4	0.7	1.5	7.2
		Total	0.0	89.4	35.5	1.4	1.5	11.7
	Critical care services							
99291	Critical care, including diagnostic and therapeutic services, first hour	Med.	12.0	6.7	3.9	1.8	12.9	12.5
		Cov.	0.7	6.7	164.2	0.0	15.0	60.4
		Total	12.7	13.5	168.1	1.8	27.9	72.8
	Nursing facility services							
99311	Subsequent nursing facility care, per day	Med.	0.0	3.8	0.5	0.0	6.8	1.3
		Cov.	0.1	18.8	22.8	0.2	0.5	8.0
		Total	0.1	22.6	23.3	0.2	7.2	9.2
99312	Subsequent nursing facility care, per day	Med.	0.1	4.2	2.0	0.0	4.2	1.6
		Cov.	0.1	20.2	18.8	0.7	1.4	5.8
		Total	0.1	24.4	20.8	0.7	5.6	7.4
	HCPCS							
A0010	Ambulance service, basic life support	Med.	1.4	13.7	114.0	0.8	0.0	31.1
		Cov.	0.0	21.6	299.1	0.8	2.2	90.8
		Total	1.4	35.3	413.2	1.5	2.2	121.9
A0020	Ambulance service, (BLS) per mile, transport, one way	Med.	3.1	64.3	98.0	0.0	0.0	38.4
		Cov.	0.0	79.5	664.6	0.0	1.9	92.0
		Total	3.1	143.7	762.6	0.0	1.9	130.4
A0150	Ambulance, nonemergency transport, base rate, one way	Med.	169.5	81.2	59.2	0.8	[b]	[b]
		Cov.	0.3	72.5	311.8	0.0	[b]	[b]
		Total	169.8	153.7	371.1	0.8		
A0220	Ambulance service, advanced life support, all-inclusive services	Med.	0.0	15.3	29.7	0.0	0.0	[b]
		Cov.	0.0	23.9	83.2	0.0	0.3	[b]
		Total	0.0	39.2	112.9	0.0	0.3	
A2000	Manipulation of the spine by chiropractor	Med.	145.0	66.2	236.5	0.0	133.8	94.0
		Cov.	0.9	67.6	106.3	14.0	12.5	111.9
		Total	145.9	133.8	342.8	14.0	146.2	205.9

(continued)

Code	Description	Type[a]	N. Calif.	S. Calif.	N.C.	S.C.	Ill.	Wis.
J9217	Leuprolide acetate, for depot suspension, 7.5 mg	Med.	0.8	0.0	21.1	0.0	0.0	11.9
		Cov.	0.8	7.3	7.0	0.0	0.0	5.9
		Total	1.5	7.3	28.2	0.0	0.0	17.8

[a]Categories are Med. = medical necessity denial rate; Cov. = noncovered care denial rate; Total = medical necessity + noncovered care. (The "Total" category may not always be equal to the sum of the "Med." and "Cov." categories because it was independently rounded.)

[b]No allowed services were found for this code.

Carrier Reporting of Service Denials

A carrier might not pay for a particular service for numerous reasons. And, because carriers must explain denials in writing to providers and beneficiaries, carriers must track the specific reason for a denial when processing a claim. This is accomplished by assigning a unique "action code" to each billed service on a claim. For example, code "AB" might indicate that the carrier denied a B-12 injection because the diagnostic code listed on the claim was, based on HCFA coverage parameters, not medically necessary. Similarly, "BB" might indicate that an office visit was denied because the claimant was ineligible for Medicare. While the reasons for denials are generally comparable across all carriers, the "action codes" that carriers use to record the reasons are not; hence, the code "AB" might not be used by all carriers or, if used, might mean something different for each.

Before transmitting information to the National Claims History (NCH) File, HCFA's central database for claims, HCFA requires that each carrier translate its set of action codes into 10 broad denial categories (see table I.2).[1] HCFA does not instruct carriers in how to make this classification. Thus, "AB" might be translated for NCH as "C" (for noncovered service) and "BB" as "O" (other denial). However, given that carriers have different sets of action codes to classify, the question naturally arises: Is the resulting NCH classification comparable across carriers? In other words, Does "noncovered service" or "medically unnecessary" mean the same thing to different carriers?

To answer this question, we made use of the fact that carrier action codes are connected to HCFA denial messages (a common set of messages that carriers are required to use in their written communications with beneficiaries). That is, while North Carolina and Wisconsin may use different internal action codes to record the reason for denying a service, they use the same set of HCFA messages to describe that reason to the beneficiary. By comparing the HCFA messages, rather than action codes, with NCH categories, it is possible to gain a sense of how similar different carriers' coding practices are. For illustrative purposes, table IV.1 displays a sample of carrier action codes, HCFA denial messages, and NCH categories for two carriers.[2]

[1]Before data reach NCH, they are compiled in an intermediate database called the Common Working File (CWF). The CWF is a repository for Medicare claims that carriers use to check patient history and verify claimant eligibility.

[2]HCFA issues over 300 different standard messages that carriers are required to use when communicating with beneficiaries. Carriers are free to "pick and choose" from this universe messages that best suit the needs of their jurisdictions.

Table IV.1: Sample Translation Table for Two Carriers

Carrier action code	HCFA message number	NCH reason category
North Carolina		
AA	1.01	Noncovered care
II	14.13	Noncovered care
IJ	15.01	Medical necessity
IH	9.44	Noncovered care
VI	10.05	Noncovered care
Wisconsin		
30	1.01	Noncovered care
I1	14.13	Noncovered care
AR	15.01	Medical necessity
Not applicable	Not used	Not applicable
18	10.05	Medical necessity

Table IV.1 shows that when North Carolina uses "AA" and Wisconsin "30," both carriers send the beneficiary the same message: "Medicare pays for transportation to the closest hospital or skilled nursing facility that can provide the necessary care" (HCFA message 1.01). Similarly, when they transmit this information to NCH, both carriers report the denial as relating to "noncovered care." However, when North Carolina and Wisconsin send the beneficiary the message, "HCFA does not pay for routine foot care" (HCFA message 10.05), they report different reasons for denial to NCH. North Carolina reports this as a "noncovered" care denial while Wisconsin considers it a "medical necessity" denial. Reporting consistency among carriers varies by type of message. For example, table IV.1 shows that there is agreement for three actions and disagreement for one action and, in a third instance, one of the carriers uses a particular HCFA message that the other does not.

We collected translation tables, similar to table IV.1, for all six carriers in this study and compared HCFA message numbers with corresponding NCH categories. We restricted our comparison of HCFA messages to those that were (1) used for communicating denials, (2) used by at least three carriers, and (3) classified as a "medical necessity" denial by at least one carrier. Table IV.2 shows how carriers report the service denial reason to NCH when a particular HCFA message is sent to a beneficiary. Table IV.3 displays the actual messages that correspond to the HCFA message numbers. As table IV.2 demonstrates, carriers generally agree on how they classify HCFA messages for reporting purposes; instances of carrier

disagreement center primarily on the distinction between "medically unnecessary" and "noncovered care" and, to a lesser extent, on "other." For messages that HCFA has explicitly designated as pertaining to "medical necessity" (messages 15.01 through 15.33), we found the highest level of carrier agreement.

Table IV.2: CWF Categories by HCFA Message Number and Carrier[a]

HCFA message number	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin
1.01	N	C	C	C	C	C
1.03	O	C		C		N
1.05	N	C		C		C
1.10		N/O	N	N		N
1.11	N	N		N		N
1.12	N	N		N		C
3.01	N	N				C/N
3.02	N	C	C			C
3.03	N	C	N	C		N
3.04	N	C	N	C		O
4.01	O	C	C	C		N
4.02	C	O		C		C/N
4.04	N	C	C	C		
4.05	N	C	C	C		
4.06	N	C	C	C		
4.07	N	O	O	C	C	C
4.08	N	O	O	C	C	C/M
4.18	N	O	C	O	C	C
6.02		N	N	C		C
6.04	N	C	C			
9.01	O	O	C		C	C/I/N/O/S
9.16	N	O	C	O	C/O	O
9.18		N	O		C	
10.05	C		C	C		N
11.04	N	C	O		S	C/I/O
14.02	N	C	C	C		C
14.04	N	C		C		
15.01	N	N	N	N	N/O	N
15.07	N	N	N	N	C/N	I/N
15.09	N	N	N	N	C/N	C/N

(continued)

HCFA message number	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin
15.10	N	N		N		
15.11	N	N	N	N	N	C/N
15.12	N	N		N	C/N/O	N
15.13	N	N	N	N	N	C/N
15.14	N	N	N	N	C/N/O	C/N
15.15	N	N		N	N	
15.16	N	N/O	N	N		
15.17	N	N		N		N
15.18	N	N	N	N	N	
15.19		N	N	N		
15.21	N	N	N	N	C	
15.22	N				N/O	C
15.26	N		C	C		N
15.32	N	N	N	C		C
15.33	N	N	N	C		C
16.04	N	I	C	O	C/O	C
16.05	N	C	C	O		C/N
16.07	N	O	C	C	O	C
16.14	N	C/O	C/O	C	C/O	C
16.16	C	O	O	O	C/N/O	C
16.17	N	C	C		C/N	C
16.18	N	O	C	C	C	C
16.19	N	C		N	N	N
16.20	N	C	C	C		C
16.21	N	C	C	C	C	C
16.25	N		C	C		C
16.74	C	N	C	O		C
16.75	C	N	C	O	C	C
16.76	N	N	C	O	C	C
16.77	N	N	C	O		C
16.78	C	N	C	O	C	C/L
16.79		N	C	O	C/O	C/L
17.01	C	C	C	C		N
17.36		N	C	O		
18.01	C	C	C	C	C/N/O	C/N
18.03	N	C	C	C		C
18.05	N	O	C	C		C
18.06	N	O	C/O	C	C	C

(continued)

HCFA message number	Northern California	Southern California	North Carolina	South Carolina	Illinois	Wisconsin
18.07	N	O	O	C		
18.08	N	O	O	C	C/O	C
18.12	N		N			C
19.01	C	O	C	O		C/N
19.05	C	N	C	O	C	C
19.06	C	N	C	O		C
21.09	C	C/N/O	C	C	C/N/O	C
23.04		N/O	C	O	O	C/N
23.05	C	C	C		N	C
23.10		N/O	C	N		
23.14	N				C	C
26.01	C	C/O	C	C	C	C/N
26.04	N	C	C	C		N
26.05	N	C	O	C	C	N
26.06	N	C	C	C		C
29.11	N	C	O	S	S	C
33.02	N		O			C

[a]CWF categories are C = noncovered service; I = invalid care; L = Clinical Laboratory Improvement Act (that is, unapproved lab); N = medically unnecessary; O = other; P = physician ownership denial; S = secondary payer; X = Medicare secondary payer cost avoided; Y = IRS/SSA data match. Empty cells indicate that the carrier does not use that message.

Table IV.3: HCFA Messages for Denied Services

HCFA message number[a]	Narrative
1.01	Medicare pays for transportation to the closest hospital or skilled nursing facility that can provide the necessary care.
1.03	Medicare does not pay for separate charges by the mile.
1.05	Medicare does not pay for transportation in a wheelchair van.
1.10	The information we have in your case does not support the need for this ambulance service.
1.11	The information we have in your case does not support the need for this transportation. (NOTE: Use of transportation between places of medical care.)
1.12	The information we have in your case does not support the need for extra help in the ambulance.
3.01	Medicare pays for the services of a chiropractor only when “recent” x-rays support the need for the services. “Recent” means the x-rays were taken within the past 12 months.

(continued)

HCFA message number[a]	Narrative
3.02	Medicare pays for chiropractic services only to correct a subluxation of the spine.
3.03	Medicare does not pay for this because your x-ray does not support the need for the service.
3.04	Medicare does not pay for this because the x-ray was not taken near enough to the time treatment began.
4.01	Medicare does not pay for this because it is part of the total charge at the place of treatment.
4.02	Medicare does not pay for this because it is part of the monthly charge for dialysis.
4.04	Medicare does not pay for immunosuppressive drugs that are not approved by the Food and Drug Administration.
4.05	Medicare pays for this service up to 1 year after transplant and release from the hospital.
4.06	Each prescription for immunosuppressive drugs is limited to a 30-day nonrefillable supply.
4.07	Medicare can pay for this supply or equipment only if your supplier agrees to accept assignment.
4.08	Medicare can pay only one supplier each month for these supplies and equipment.
4.18	Medicare cannot pay more than $ — each month for these supplies. (NOTE: The limits for 1992 are $1,600 and $2,080 for CCPD. Update these figures when limits change.)
6.02	Medicare does not pay for drugs that have not been approved by the Food and Drug Administration.
6.04	Medicare pays for this drug only when Medicare pays for the transplant.
9.01	Medicare cannot pay for this because we have not received the information we requested. (NOTE: If assigned claim, add: "The assignment agreement remains in effect and will apply to the new claim.")
9.16	Medicare cannot pay for this because your provider used an invalid or incorrect procedure code and/or modifier for the service you received. Please ask your provider to resubmit the claim with the valid procedure code and/or modifier.
9.18	No certification of medical necessity was received for this equipment.
10.05	Medicare does not pay for routine foot care.
11.04	Another agency handles the bills for these services. We have sent the information to them. They will send you a notice. (Applies to RRB, United Mine Workers.)
14.02	Medicare does not pay for this because the laboratory is not approved for this type of test.

(continued)

HCFA message number[a]	Narrative
14.04	Medicare does not pay for laboratory procedures which have not been approved by the Food and Drug Administration.
15.01	The information we have in your case does not support the need for this many visits or treatments.
15.07	The information we have in your case does not support the need for this equipment.
15.09	The information we have in your case does not support the need for this service. (If the claim was reviewed by your Medical Staff, add: Your claim was reviewed by our Medical Staff.)
15.10	The information we have in your case does not support the need for this number of home visits per month.
15.11	The information we have in your case does not support the need for this injection.
15.12	The information we have in your case does not support the need for this many injections.
15.13	The information we have in your case does not support the need for similar services by more than one doctor during the same time period.
15.14	The information we have in your case does not support the need for this many services within this period of time.
15.15	The information we have in your case does not support the need for more than one visit a day.
15.16	The information we have in your case does not support the need for the level of service shown on the claim.
15.17	The information we have in your case does not support the need for similar services by more than one doctor of the same specialty.
15.18	The information we have in your case does not support the need for this laboratory test.
15.19	The information we have in your case does not support the need for the level of service shown on this claim. We have approved this service at a reduced level.
15.21	The information we have in your case does not support the need for this foot care.
15.22	The information we have in your case does not support the need for more than one screening PAP smear in three years.
15.26	Medicare does not pay for a surgical assistant for this kind of surgery. The doctor should not bill you for this service.
15.32	Medicare does not pay for two surgeons for this procedure.
15.33	Medicare does not pay for team surgeons for this procedure.

(continued)

HCFA message number[a]	Narrative
16.04	Medicare does not pay for this in the place or facility where you received it.
16.05	Medicare does not pay for this because the claim does not show that it was prescribed by your doctor.
16.07	Medicare cannot pay for this service because the claim did not show that the Peer Review Organization approved it.
16.14	Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.
16.16	Medicare does not pay for this service because it is part of another service that was performed at the same time.
16.17	Medicare does not pay for this item or service.
16.18	Medicare does not allow a separate charge for this because it is included as part of the primary service. The provider cannot bill you for this.
16.19	Medicare does not pay for this because it is a treatment that has yet to be proved effective.
16.20	Medicare does not pay for these services or supplies.
16.21	Medicare does not pay for drugs you can give yourself.
16.25	Medicare does not pay for discussions on the telephone with the doctor.
16.74	Medicare does not pay separately for a hospital admission and a visit or consultation on the same day. You should not be billed separately for this service. You do not have to pay this amount. (NOTE: Assigned claim.)
16.75	Medicare does not pay separately for a hospital admission and a visit or consultation on the same day. You do not have to pay this amount. (NOTE: Unassigned claim.)
16.76	Medicare will pay for only the nursing facility service when performed on the same day as another visit in a different site. You should not be billed separately for this service. You do not have to pay this amount. (NOTE: Assigned claim.)
16.77	Medicare will pay for only the nursing facility service when performed on the same day as another visit in a different site. You do not have to pay this amount. (NOTE: Unassigned claim.)
16.78	Medicare does not pay separately for this service. You should not be billed separately for this service. You do not have to pay this amount. (NOTE: Use for global denials for assigned claims.)
16.79	Medicare does not pay separately for this service. You do not have to pay this amount. (NOTE: Use for global denials for unassigned claims.)

(continued)

HCFA message number[a]	Narrative
17.01	Medicare does not pay for services performed by a private duty nurse.
17.36	Medicare cannot pay for this service as billed. (NOTE: Use when nonphysician practitioners do not separate professional and technical services on the claim.)
18.01	Medicare does not pay for routine examinations and related services.
18.03	Medicare does not pay for this screening examination for women under 35 years of age.
18.05	The place where you had this examination is not approved by Medicare.
18.06	Medicare does not pay for this examination because less than one year (two/three years) has (have) passed since your last examination of this kind.
18.07	Medicare will pay for this screening examination again in one year (two/three years).
18.08	Medicare pays for this examination only once for women age 35-39.
18.12	Medicare pays for screening pap smears only once every three years unless high risk factors are present.
19.01	Medicare does not pay for services of a hospital specialist unless there is an agreement between the hospital and the specialist on how to charge for the services.
19.05	Medicare will pay for only one hospital visit or consultation per physician per day. You do not have to pay this amount.
19.06	Medicare will pay for one hospital visit per day. You do not have to pay this amount.
21.09	Medicare does not pay for this service when performed, referred or ordered by this provider of care.
23.04	Medicare does not pay for these charges because the cost of the care before and after surgery is part of the approved amount for the surgery. (NOTE: Use for global denials.)
23.05	Medicare does not pay for cosmetic surgery and related services.
23.10	Medicare does not pay for a surgical assistant for this kind of surgery.
23.14	Medicare does not pay a doctor for assisting at this kind of surgery. The doctor cannot bill you for this service.
26.01	Medicare does not pay for routine eye examinations or eye refractions.
26.04	Medicare does not pay for eyeglasses or contact lenses except after cataract surgery or if the natural lens of your eye is missing.

(continued)

HCFA message number[a]	Narrative
26.05	Medicare pays for only one pair of glasses after cataract surgery with lens insertion.
26.06	Medicare does not pay the extra charge for deluxe frames.
33.02	Medicare does not pay for this service when it is performed in an ambulatory surgical center.

[a]For presentation in this table, HCFA message numbers with one decimal place were modified. For example, message 1.1 was changed to 1.01, message 1.3 to 1.03, and so on.

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