



May 2013

MEDICARE PROGRAM INTEGRITY

Few Payments in 2011
Exceeded Limits
under One Kind of
Prepayment Control,
but Reassessing Limits
Could Be Helpful

GAO Highlights

Highlights of [GAO-13-430](#), a report to congressional requesters

Why GAO Did This Study

CMS has estimated improper Medicare fee-for-service payments of \$29.6 billion in fiscal year 2012. To help prevent improper payments, CMS has implemented national MUEs, which limit the amount of a service that is paid when billed by a provider for a beneficiary on the same day. The limits for certain services that have been fraudulently or abusively billed are unpublished to deter providers from billing up to the maximum allowable limit.

GAO was asked to review issues related to MUEs. This report examines the extent to which CMS has (1) paid for services that exceeded the unpublished MUE limits and (2) examined billing from providers that exceeded unpublished MUE limits. GAO analyzed Medicare claims related to these limits in 2011, and interviewed CMS officials and selected contractors in states with high improper payments.

What GAO Recommends

GAO recommends that CMS examine contractor edits to determine if any national unpublished MUE limits should be revised; and consider reviewing claims to identify providers that exceed the unpublished MUE limits, and determine whether their billing was proper. In its written comments, HHS concurred with both our recommendations.

View [GAO-13-430](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

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Few Payments in 2011 Exceeded Limits under One Kind of Prepayment Control, but Reassessing Limits Could Be Helpful

What GAO Found

Less than 0.1 percent of payments Medicare made in 2011 were for amounts of services that exceeded certain unpublished limits for excess billing and where the claims did not include information from the providers to indicate why the additional services were medically necessary. These limits are set by the Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—as a means to avoid potentially improper payments. To implement these limits, CMS established automated controls in its payment systems called Medically Unlikely Edits (MUE). These MUEs compare the number of certain services billed against limits for the amount of services likely to be provided under normal medical practice to a beneficiary by the same provider on the same day—for example, no more than one of the same operation on each eye. GAO analysis of 2011 claims data found approximately \$14 million out of a total of \$23.9 billion in Medicare payments for services that exceeded unpublished MUE limits and where the claims did not include information from the providers to indicate why the additional services were medically necessary. As GAO has previously reported, claims could exceed the limits because the MUEs are not set up as per-day limits that assess all services billed by a provider for a single beneficiary on the same day. CMS plans to begin implementing MUEs for some services as per-day limits for services where it would be impossible to exceed the limits for anatomical or other reasons. Medicare contractors that pay claims may develop local edits, which can set more restrictive limits for some services than the national unpublished MUE limits. GAO's analysis of claims data applying a few of these more restrictive local limits showed that by applying them instead of the relevant national MUE limits, CMS could have lowered payments by an additional \$7.8 million. However, CMS is not evaluating these local edits to determine if these lower limits might be more appropriate. To the extent that these and other local edits are not evaluated more systematically, CMS may be missing an opportunity to achieve savings by revising some national MUEs to correspond with more restrictive local limits.

CMS and its contractors did not have a system in place for examining claims to determine the extent to which providers may be exceeding unpublished MUE limits and whether payments for such services were proper. CMS officials and contractors told us that they examine aberrant billing patterns at a provider level, that is, across all services billed by the provider, but not specifically for services with unpublished MUE limits. GAO found that payments that exceeded MUE limits were concentrated among certain providers and types of specialties, in certain states, and for certain services. For example, the top 100 providers with payments that exceeded the MUE limits accounted for nearly 44 percent of total payments that exceeded the MUE limits, although they accounted for only about 1 percent of total payments for all services with unpublished MUEs. Moreover, about 26 percent of the top 100 providers included clinical laboratories and durable medical equipment providers, both of which have been identified in the past as having high potential for fraudulent billings. Because unpublished MUEs were developed for services and items that have been fraudulently or abusively billed in the past, without systematically examining billing information and claims from the top providers exceeding those limits CMS may be missing another opportunity to improve its program integrity efforts.

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Abbreviations

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
DOS	date-of-service
FFS	fee-for-service
HHS	Department of Health and Human Services
MAC	Medicare Administrative Contractor
MUE	Medically Unlikely Edit
RA	Recovery Audit contractor
ZPIC	Zone Program Integrity Contractor

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May 9, 2013

Congressional Requesters

In 2012, Medicare covered over 49 million elderly and disabled beneficiaries and had estimated outlays of \$555 billion. Because of its size, complexity, and susceptibility to improper payments, we have designated Medicare as a high-risk program.¹ The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), has estimated improper Medicare fee-for-service (FFS) payments of \$29.6 billion in fiscal year 2012.² Over half (52 percent) of these improper payments were for services under Medicare Part B, although these services accounted for 29 percent of total Medicare FFS payments.³ One internal control strategy that CMS uses to prevent improper payments is the application of “prepayment edits”—automated checks in the electronic claims processing systems that approve or deny claims on the basis of national Medicare coverage and payment policies that apply to all beneficiaries.⁴ One type of these

¹GAO, *High Risk-Series: An Update*, [GAO-13-283](#) (Washington, D.C.: February 2013).

²Medicare fee-for-service consists of Medicare Part A and Medicare Part B. Medicare Part A covers inpatient hospital care, skilled nursing facility care, some home health services, and hospice care. Medicare Part B covers outpatient services including physician, hospital, diagnostic and laboratory, ambulance, durable medical equipment (DME) such as oxygen equipment, wheelchairs, and diabetic supplies. Part B also covers certain home health services, including physical therapy, speech therapy, and supplies and equipment provided to beneficiaries in their homes (rather than in an institutional setting). Providers bill for Part B services using a standardized coding system, known as the Healthcare Common Procedure Coding System.

³Services provided by physicians, diagnostic and laboratory facilities and ambulance providers accounted for about 26 percent of total FFS payments and about 32 percent of improper payments, while DME services accounted for only 3 percent of total FFS payments, but about 22 percent of improper payments. The estimated improper payment rate for DME services is therefore considerably higher than the overall rate for all FFS payments—66 percent compared to 8.5 percent respectively.

⁴See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

Most prepayment edits are fully automated within the electronic system—if a claim meets the denial criteria of the edit, it is automatically denied—while other prepayment edits are manual, meaning that they flag individual claims for medical review by a trained individual to determine if beneficiaries’ medical conditions meet Medicare coverage criteria.

national edits for Part B services is the “Medically Unlikely Edit” (MUE), which sets limits on the maximum units of services that may be billed by a provider for a beneficiary on a single date of service. For example, a provider may bill for no more than five biopsies of soft tissue in the forearm or wrist for a beneficiary on a given day. CMS allows additional units in excess of the MUEs to be billed when providers believe the services are clinically appropriate. In such cases, special codes, or modifiers, may be included on the claim to indicate why the services were clinically appropriate.⁵

CMS has developed MUEs for three types of services: services provided by physicians and other practitioners; durable medical equipment (DME) services; and services provided in an outpatient hospital setting. While most of the MUEs are publicly available on the CMS website, MUEs for certain services are not published so as to deter providers from billing up to the maximum allowable MUE limit. These unpublished MUEs are for services and items that have been billed fraudulently or abusively in the past, including certain Part B drugs and certain DME items. As of January 1, 2013, CMS had implemented 20,750 published and 4,150 unpublished MUEs for the three types of services. Medicare Administrative Contractors (MAC) that process and pay claims in specific geographical jurisdictions⁶ have also developed local edits that set limits on the number of units of a particular service that may be billed by a provider for a beneficiary on the same day.⁷

We issued a report last year on CMS’s use of prepayment edits and identified about \$8.6 million in payments for services that exceeded the published MUE limits in fiscal year 2010.⁸ We also identified weaknesses

⁵For example, providers may use modifiers ‘RT’ and ‘LT’ to indicate a procedure performed twice, on the right and left side respectively. However, some modifiers are descriptive and may not explain the need for additional services. For example, modifier ‘AQ’ indicates services performed in a health professional shortage area.

⁶Each MAC covers one or more specific geographical jurisdictions, each made up of one or more states.

⁷These limits may be set for a single day or for a period of time, such as 1 month. In some cases, both local edits and national MUEs may exist for the same service, and the local limit may have been less restrictive if it was developed prior to the national MUE limit. In such cases, the more restrictive national MUE limit applies.

⁸GAO, *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, [GAO-13-102](#) (Washington, D.C.: Nov. 13, 2012).

in how the MUEs were operationalized, and recommended that CMS implement MUEs that assess all quantities of services provided to the same beneficiary by the same provider on the same day, allowing providers to bill for additional units if they included modifiers that explained the medical necessity of exceeding the limits. HHS agreed to further investigate how to address the recommendation and noted that there are numerous clinical situations in which MUE limits can reasonably be exceeded.

You requested that we further examine issues related to MUEs. This report examines the extent to which CMS has (1) paid for services that exceeded the unpublished MUE limits and (2) examined billing from providers that exceeded unpublished MUE limits to determine if it was proper.

To examine the extent to which CMS has paid for services that exceeded the unpublished MUE limits, we analyzed Medicare claims data and interviewed five MACs. Specifically, we analyzed Medicare paid claims in calendar year 2011 from CMS's Carrier Part B 100 percent Standard Analytic File (which contains claims data about noninstitutional providers, such as physicians and other practitioners), as well as their 100 percent DME claims file.⁹ We obtained the unpublished MUE limits for calendar year 2011 from CMS and analyzed the extent to which payments exceeded the per-day MUE limits. About 1,800 of the 4,150 services with unpublished MUEs were included in the Carrier Part B Standard Analytic File and DME claims files, and these were the services we analyzed. We excluded any services billed with modifiers that potentially explained the reason for claiming additional units.¹⁰ We reviewed relevant documentation describing how claims data are collected and processed, and examined other research, including our prior reports, that have used these data. We determined that the data we used were sufficiently reliable for the purposes of our work. We also interviewed five Part A/B and DME MACs¹¹ in three states that CMS had identified as having high

⁹We did not examine hospital outpatient claims.

¹⁰We did not exclude claim lines with modifiers that were descriptive and did not explain why the additional units were medically necessary.

¹¹Part A/B MACs process claims from institutional providers such as hospitals, and noninstitutional providers such as physicians and other practitioners, while DME MACs process claims from DME providers.

improper billing and suspected fraud (California, Florida, and Texas).¹² We requested local edits the MACs had developed for their jurisdictions that, similar to the national unpublished MUEs, set limits on the number of units of a service that could be billed by a physician for a beneficiary on the same day. We selected 13 high-volume services where the local limits were more restrictive than the national unpublished MUE limits. We estimated the extent of potential savings if CMS were to implement these local limits on a national basis in place of the unpublished MUE limits. We consulted with the MACs and the MUE contractor on an ongoing basis to ensure the validity of our results. Finally, we identified which internal controls were significant for our engagement and then compared them to the processes CMS uses to ensure adequate communication with, and collection of information from, its contractors and adequate monitoring of program activities.

To examine the extent to which CMS examined billing from providers that exceeded the unpublished MUE limits, we interviewed officials from CMS and the five MACs. We also reviewed materials from CMS regarding the activities of its contractors that are tasked with reducing fraud and improper payments.

We conducted our work from August 2012 to May 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Most Medicare beneficiaries receive their care on an FFS basis, with providers submitting claims for payment for each service provided. In addition to the Part A/B and DME MACs that process and pay claims, CMS also employs other types of contractors to specifically address fraud and improper payments. These include: Recovery Audit contractors (RA), which review claims postpayment in four RA jurisdictions to identify improper payments and Zone Program Integrity Contractors (ZPIC),

¹²Overall, the MACs we interviewed were responsible for processing and paying Medicare Part A/B and DME claims in 31 other states.

which review claims on a pre- and postpayment basis in seven ZPIC jurisdictions to identify potential fraud.

All of these contractors use data analysis to identify providers who bill improperly, whether by mistake or intentionally, to help target their claims review. CMS has expanded its Integrated Data Repository, which was set up to integrate Medicare and Medicaid claims, beneficiary, provider, and other data, and is currently populated with 5 years of historical Part A, Part B, and Part D paid claims data.¹³ CMS's contractors can use these data to analyze previously undetected indicators of aberrant billing activity throughout the claims processing cycle. CMS intends to develop shared data models and is pursuing data sharing and matching agreements with other federal agencies to identify potential fraud, waste, and abuse throughout federal health care programs. CMS has set expectations that RAs and ZPICs will provide information on types of potentially problematic claims to help the agency identify vulnerabilities.

CMS has also recently developed a "Fraud Prevention System" which uses predictive modeling technology to screen all FFS claims before payment is made. Claims are streamed through the Fraud Prevention System prior to payment and analyzed on the basis of algorithms that include other information, such as past billing, to identify patterns of potentially fraudulent billing by providers. The billing is prioritized for risk of fraud, with the highest-priority cases investigated by ZPICs. Prior to applying predictive models to claims prepayment, CMS tests the algorithms to try to ensure that resources are targeted to the highest-risk claims or providers while payment of claims to legitimate providers continues to occur without disruption.

Development and Implementation of MUEs

Consistent with Medicare law, CMS sets national coverage and payment policies regarding when and how services will be covered by Medicare, as well as coding and billing requirements for claims.¹⁴ CMS has developed national payment policies related to MUEs to limit potentially

¹³Part D provides a voluntary, outpatient prescription drug benefit for eligible individuals 65 years and older and eligible individuals with disabilities.

¹⁴However, most coverage decisions are made by MACs using local coverage determinations, which delineate the circumstances specific to that geographic area under which services are considered reasonable and necessary and are therefore covered in the jurisdiction where that MAC processes claims.

improper and excess payments to providers for many services, especially those that are prone to potential fraud or that result from billing errors.¹⁵ A CMS MUE Workgroup, which includes staff from CMS and the MUE contractor, is responsible for developing the national MUE limits, in consultation with the medical community. MUE limits are developed as per-day limits on the number of units of a given service or medical product that can be provided by the same physician to the same beneficiary. The limits are developed on the basis of coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology manual,¹⁶ national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, as well as an analysis of current provider billing practices. Prior to their implementation, proposed MUE limits are released for a review and comment period to the AMA, national medical/surgical societies, and other national health care organizations. However, unpublished MUEs are not released for comment. The MUE files are updated quarterly and new limits may be added at these times.

Although MUEs were developed as limits on the number of units of a service a provider could bill for a beneficiary in a single day, as we previously reported¹⁷ they are not implemented as such. Specifically, they do not look at total units on all claims from one provider for the same beneficiary across an entire day, and the limits may therefore be exceeded. A claim can have multiple lines and providers may bill multiple units of the same service for the same beneficiary on the same day on multiple lines of a claim. In processing the claim, contractors' automated systems only examine the number of units on each claim line. If the number of units on the claim line exceeds the MUE limit, the entire claim line is denied. However, as long as the units on a claim line are at or below the MUE limit, they are paid. Thus, the automated claims-processing systems allow the MUE per-day limits to be exceeded for a beneficiary if providers bill multiple units of the same service on multiple claim lines. The systems also allow limits to be exceeded for a beneficiary if a provider bills for multiple units of the same service performed on the

¹⁵For example, a provider may mistakenly bill 1,000 units instead of a 100 units of a particular service.

¹⁶The manual includes five-digit codes that physicians and other providers use to report medical services and procedures that they perform.

¹⁷See [GAO-13-102](#).

same day on different claims. When claiming multiple units of the same service for one beneficiary, providers may, but are not required to, include a “modifier”— a special code that indicates why the additional units are medically necessary.

MAC Local Coverage Policies

MACs may develop local coverage policies as long as these policies are consistent with national policies. To implement these local policies, some MACs have developed local edits for certain services. Similar to the national MUEs, these local edits set limits on the maximum number of units that may be billed by a provider for the same beneficiary on the same day.¹⁸ Providers may not exceed the local limits by billing additional units on multiple claim lines, unless they include modifiers to explain why the additional units are medically necessary. The local edits were developed for services that may be overused or abused in their jurisdiction, including services for which the MUE limits were being frequently exceeded. Without these local edits, the MUE limits would be exceeded much more frequently. The local limits were developed on the basis of clinical input from the MAC’s medical directors and other clinicians, as well as analysis of claims data.¹⁹

Almost All 2011 Payments for Services with Unpublished MUEs Were within Established Limits

The vast majority of Medicare payments in 2011 for services with unpublished MUEs were for services where the numbers of units were at or below the per-day MUE limits. However, because the MUE limits were not implemented as per-day limits, approximately \$14 million was paid for services that exceeded MUE limits. Moreover, by applying on a national basis the more restrictive local limits used by some contractors, (which are implemented as per-day limits), we found that CMS could have lowered payments by an additional \$7.8 million. We also found that payments exceeding unpublished MUE limits were concentrated within certain services and states.

¹⁸In some cases, the local edits may be for a longer period of time, such as a month or a year. In implementing the edits, all services billed during that time span are assessed against the local limit.

¹⁹Limits set by local edits may differ from MUEs because of differences in how services are utilized in a particular region compared to the rest of the country. They may also differ because MUEs are based on coding and payment rules rather than medical necessity or utilization limits, while the local edits are intended specifically to address medical necessity or utilization limits.

Over 99 Percent of 2011
Payments Were for
Services under
Unpublished MUE Limits

In 2011, Medicare paid approximately \$23.9 billion for 1,845 types of services with unpublished MUEs. The vast majority—about 99.9 percent—was paid for services where the number of units providers billed was at or below the per-day MUE limits. The MUE contractor indicated that the limits were generally set high, so that the MUEs would not deny claims for medically necessary services.

However, because MUEs were not implemented as per-day limits, approximately \$14 million was paid for services where total units billed by a provider for a beneficiary on the same day exceeded the MUE limits.²⁰ These payments were made for units of services exceeding MUE limits that were billed on multiple lines of a claim or across multiple claims. Although the automated claims-processing systems check each claim line, they do not check all units billed by a provider for a beneficiary on the same day to see if they exceed the limit. While providers may use modifiers on claim lines to indicate when it is medically necessary to exceed the MUE limits, no modifiers were included for the approximately \$14 million in payments that we identified as exceeding the unpublished MUE limits to explain why the additional units were medically appropriate. CMS does not expect its contractors to check claims to determine if modifiers are included when billing additional units of services related to unpublished MUEs on multiple lines. CMS officials stated that because the MUEs are unpublished, providers may not know a given service has an MUE and therefore may not include a modifier when billing for services.

The MUE contractor recently announced that CMS began converting some MUEs from claim-line edits to “date-of-service” (DOS) edits as of April 1, 2013, and other services will be converted in future quarters. As a DOS edit, all units billed by a provider for a beneficiary on a particular date of service would be totaled across all claims and claim lines to see if they exceed the MUE limit. Depending on how it is implemented, this change could address a recommendation in our previous report that CMS should implement MUEs that assess all quantities of services provided to the same beneficiary by the same provider on the same day.²¹ CMS officials said the criteria CMS plans to use are still being developed, but

²⁰This estimate is based upon CMS’s policy of denying the total units on a claim line if billed units exceed the MUE, not just the excess units over the MUE limit.

²¹See [GAO-13-102](#).

some MUEs that are likely to become DOS edits include those where it is anatomically impossible to exceed the MUE limit. For example, anatomical limits such as having only two eyes limits the number of times a given procedure could be performed for which a provider could submit a claim on the same day for the same patient. CMS officials told us that they probably will not apply this policy to some of the unpublished MUEs where clear anatomical or other restrictions may not exist, such as those for some Part B drugs and DME. Contractors that we interviewed were aware of the new policy, had seen the draft version, and were generally supportive of the effort.

**Use of More Restrictive
Local Contractor Edits for
Certain Services Could
Have Reduced Payments
by an Additional
\$7.8 Million**

Our examination of 13 services where MACs developed more restrictive local edits than the unpublished MUEs showed Medicare payments could have been reduced had CMS examined these edits and adopted them as part of its program integrity responsibilities. If CMS had used these limits and implemented them as per-day edits, instead of using the unpublished MUE limits on these services, Medicare payments would have been lowered by an additional \$7.8 million. This indicates that there is a potential for additional savings if some of these local edits were applied nationally. Four of the MACs from whom we requested local edits had implemented edits related to unpublished MUEs.²² At least three of the contractors had more restrictive limits for the 13 services we analyzed.²³

Contractors told us that they had developed more restrictive edits because the MUE limits were being exceeded frequently or they had observed potentially fraudulent or abusive billing for these services. While the unpublished MUE limits were implemented at a claim-line level, contractors told us that their local limits were implemented as per-day limits.²⁴ Contractors also told us that CMS does not request information

²²The fifth contractor was transitioning responsibility for its jurisdiction to a different MAC and was therefore not able to provide us its local edits on a timely basis.

²³Some limits specified in these local edits were less restrictive than the unpublished MUEs for certain services. Contractors told us that some of the less restrictive local limits were developed prior to the implementation of CMS's unpublished MUEs, and that since the implementation of the unpublished MUEs, these more restrictive limits would always be applied in such circumstances.

²⁴In some cases, local edits set limits for periods of time longer than 1 day—for example a month. In these cases, the total units billed by a provider for a beneficiary across all claim lines or multiple claim lines during this period were assessed against the limit.

on their local edits, nor do they routinely share them with CMS. The MUE contractor told us that the MUE Workgroup was aware of one contractor's local edits for certain services with unpublished MUEs, but was not aware of other contractors' local edits for these services. Because CMS has not communicated with its contractors regarding their local edits or monitored their use, it is not evaluating these local edits. As a result, it may be missing an opportunity to identify situations in which savings could be achieved by implementing some of the local edits nationally.

Payments That Exceeded MUE Limits Were Concentrated within Certain Services and States

Payments for services that exceeded the per-day MUE limits were concentrated within certain services. For example, of the over 1,800 services with unpublished MUEs, 717 had payments that exceeded the MUE limits. Of these, 20 services accounted for almost half of all payments that exceeded the MUE limits, with the top service alone accounting for over 8 percent of such payments. Many of these top 20 services were for prescription drugs, DME, and clinical laboratory services.

Payments for services that exceeded the unpublished MUE limits also tended to be concentrated in certain states. Five states with the highest payments that exceeded the MUE limits (Arkansas, California, New York, Pennsylvania, and Texas) accounted for almost half of these payments, although they accounted for 30 percent of total payments for all services with unpublished MUEs.

CMS Has Not Systematically Examined Claims That Exceeded Unpublished MUE Limits to Determine Whether They Were Proper

CMS and its contractors do not have a system in place for examining claims to determine the extent to which providers may be exceeding unpublished MUE limits and whether payments for such services were proper. Payments that exceeded MUE limits were concentrated among certain providers, which could facilitate such examination.

CMS's Contractors Did Not Systematically Examine Claims for Services above Unpublished MUE Limits to Determine If They Were Appropriate

CMS officials and contractors that we interviewed said they do not have a system in place for regularly examining claims related to services with unpublished MUEs from providers that most often exceeded MUE limits.²⁵ While CMS has several strategies to reduce improper payments, and it reviews aberrant billing patterns at a provider level, that is, across all services billed by the provider, officials told us that they have no plans to review services specifically related to MUEs. Similarly, contractors told us that they do not examine claims specifically related to MUEs, although they do review claims to detect other aberrant billing patterns and identify emerging new vulnerabilities. For example, one contractor told us it evaluates weekly billing reports to examine whether its medical review strategies are appropriate and focused on problem areas. It also reviews data from multiple other sources including reports from the Office of the Inspector General and those we have issued, and findings from the RAs. However, the contractor's reviews are conducted at a provider level, that is, across all services billed by the provider but not specifically for services with unpublished MUE limits. As a result, providers may be unlikely to have their billing reviewed more closely if they frequently bill above unpublished MUE limits, but do not have other aberrant billing patterns.

We provided a list of 10 providers with payments of at least \$3,000 that exceeded the unpublished MUE limits in each contractor's jurisdiction to the contractors we interviewed to determine if they were scrutinizing these providers' billing patterns. One contractor told us that it was reviewing claims submitted by 1 of the 10 providers that was included on the list we had forwarded to them. The contractor had received a potential fraud referral on this provider, although not specifically related to billings for services with unpublished MUEs. However, the remaining contractors were not reviewing any of the providers we identified.

Payments That Exceeded MUE Limits Were Concentrated among Certain Providers

We found that a small number of providers accounted for a large share of payments for services that exceeded the unpublished MUE limits. For example, 419 providers received at least \$5,000 for services that exceeded the unpublished MUEs in 2011. Of these, the 100 providers with the highest payments that exceeded the MUE limits accounted for

²⁵While the claims-processing systems automatically deny units of services that exceed the MUE limit on an individual claim line, they do not check all units billed by a physician for a beneficiary on the same day.

nearly 44 percent of total excess payments, although they accounted for only about 1 percent of total payments for all services with unpublished MUEs. In addition, the provider with the highest payments that exceeded the unpublished MUE limits alone accounted for about 4 percent of these payments, although this provider accounted for less than 0.1 percent of total payments for all services with unpublished MUEs.

Certain provider types were more likely to have payments that exceeded the MUE limits. About 26 percent of the top 100 providers exceeding unpublished MUE limits included clinical laboratories and DME providers. Researchers have noted that there is potential for fraud and abuse with some laboratory services that can be self-referred, such as certain pathology tests. For example, a pathologist examining a surgical pathology specimen may self-refer by ordering and performing additional tests on the pathology specimen without seeking the consent of the original ordering physician. Some contractors we interviewed told us that certain DME items, such as diabetic testing supplies, are prone to potentially fraudulent billing. CMS has also estimated improper DME billing of 66 percent in fiscal year 2012—higher than for any other service measured.²⁶

Conclusions

Developing more cost-effective strategies for ensuring the appropriateness of Medicare payments could help ensure the long-term sustainability of the program. Although almost all payments for services with unpublished MUEs were made for services at or below the MUE limits, we found that there are still opportunities to realize savings. When analyzed on a per-day basis, payments that potentially should not have been made for services that exceeded the unpublished MUE limits totaled approximately \$14 million. In November 2012, we recommended that CMS implement MUEs that assess all quantities of services provided to the same beneficiary by the same provider on the same day—in other words, as per-day limits—but allow the limits to be exceeded if the provider included modifiers to explain the medical necessity of exceeding the limits. The MUE contractor recently announced that CMS began implementing our recommendation for certain services as of April 1, 2013. However, CMS officials told us these are unlikely to be applied to some of

²⁶The HHS Office of the Inspector General has also issued several reports on potentially fraudulent billing practices by clinical laboratories.

the services with unpublished MUEs, such as Part B Drugs and DME services. We continue to believe that our recommendation should be implemented for all MUEs to help strengthen the financial health of the program.

Continuously seeking new methods for improving oversight of provider payments is another important way to strengthen program integrity. Contractors' local edits could serve as a resource for CMS to use in developing or revising MUEs and in reducing payments for services that are potentially improperly billed. Unpublished MUEs were developed for services and items that have been fraudulently or abusively billed in the past. Therefore, systematically examining billing information and claims from providers that exceed these limits and do not use modifiers to indicate the excess units are medically appropriate, could help identify improper payments and could inform CMS's program integrity efforts.

Recommendations for Executive Action

To improve the effectiveness of the unpublished MUEs and better ensure Medicare program integrity, we recommend that the CMS Administrator take the following two actions:

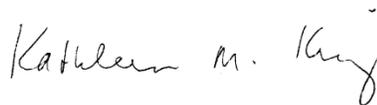
- examine contractor local edits related to unpublished MUEs to determine whether any of the national unpublished MUE limits should be revised; and
- consider periodically reviewing claims to identify the providers exceeding the unpublished MUE limits and determine whether their billing was proper.

Agency Comments

We provided a draft of this report to HHS for comment and received written comments, which are reprinted in appendix I. In its written comments, HHS concurred with both our recommendations. For the recommendation to examine contractor local edits related to unpublished MUEs, HHS concurred and indicated that CMS would review making revisions to the MUEs in order to ensure that the edit levels are appropriate on the basis of input from national health care organizations, providers, Medicare Administrative Contractors, and CMS personnel, as well as data analysis. For the second recommendation, HHS concurred and indicated that CMS would conduct further analysis to determine the appropriate actions, if necessary.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions regarding this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.



Kathleen M. King
Director, Health Care

List of Requesters

The Honorable Thomas R. Carper
Chairman

The Honorable Tom Coburn
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Claire McCaskill
Chairman
Subcommittee on Financial and Contracting Oversight
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable John S. McCain
United States Senate

Appendix I: Comments from the Department of Health and Human Services



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Assistant Secretary for Legislation
Washington, DC 20201

APR 24 2013

Kathleen M. King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicare Program Integrity: Few Payments in 2011 Exceeded Limits Under One Kind of Prepayment Control, but Reassessing Limits Could be Helpful" (GAO-13-430).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE PROGRAM INTEGRITY: FEW PAYMENTS IN 2011 EXCEEDED LIMITS UNDER ONE KIND OF PREPAYMENT CONTROL, BUT REASSESSING LIMITS COULD BE HELPFUL" (GAO 13-430)

The Department appreciates the opportunity to review and comment on this draft report.

GAO Recommendation

GAO recommends that to improve the effectiveness of the unpublished MUEs and better ensure Medicare program integrity, CMS should examine contractor local edits related to unpublished MUEs to determine whether any of the national unpublished MUE limits should be revised.

HHS Response

HHS concurs with this recommendation. CMS will review making revisions to the MUEs in order to ensure that edit levels are appropriate based on input from national health care organizations, providers, Medicare Administrative Contractors, CMS personnel, as well as data analysis.

GAO Recommendation

GAO recommends that to improve the effectiveness of the unpublished MUEs and better ensure Medicare program integrity, CMS should consider periodically reviewing claims to identify the providers exceeding the unpublished MUE limits and determine whether their billing was proper.

HHS Response

HHS concurs with this recommendation and CMS will conduct further analysis to determine appropriate actions, if necessary.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov

Staff Acknowledgments

In addition to the contact named above, Sheila K. Avruch, Assistant Director; Iola D'Souza; Eagan Kemp; Richard Lipinski; and Laurie Pachter made key contributions to this report.

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