Memorandum

Date MAY 31 1996

From June Gibbs Brown
Inspector General

Subject Review of Medicare Providers and Electronic Claims Processing
(A-05-94-00039)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of the final report of our review entitled, "Medicare Providers and Electronic Claims Processing." Our primary objectives were to:

- evaluate the adequacy of internal controls in providers' offices using electronic media claims (EMC),
- determine if EMCs provide sufficient provider accountability in the Medicare claims process,
- assess what obstacles exist to increasing the use of electronic claims by Medicare providers, and
- evaluate the cost-effectiveness of EMC and electronic funds transfers (EFT) and the potential for additional Medicare administrative cost savings through increased use of EMC and EFT.

Our review of EMC at the provider level disclosed that excellent progress is being made in converting Medicare claims processing to a total electronic environment. However, additional provider guidance would be beneficial relative to defining needed internal controls and the responsibilities of each provider in the claims process. NonEMC providers, those still submitting hard copy claims, need further encouragement to convert to an EMC claims processing environment. We, therefore, recommend that HCFA consider (1) developing additional guidance and instruction on internal controls, (2) providing free training and cost-benefit information on EMC to providers still submitting hard copy claims, and (3) phasing in requirements that Medicare providers with significant paper claims volume convert to EMC. In response to our draft report, HCFA concurred with these recommendations and noted several steps already taken to implement them.

In our draft report, we had also recommended that HCFA revise its electronic data interchange (EDI) agreement with Medicare providers and make additional changes in its electronic billing and remittance procedures in order to improve the level of provider accountability for electronic claims submitted and electronic payments received. In its response, HCFA included a copy of the new EDI enrollment form and asserted that this new form and recently promulgated procedural changes to implement it would effectively address the issue of provider accountability. During Fiscal Year 1996, we have been working with your staff to obtain additional information about the new form and the related procedures. However, we have not been able to perform sufficient audit testing to confirm HCFA's assertions. We plan, therefore, to address the issue of provider accountability with respect to EDI as part of our ongoing monitoring of HCFA's implementation of the Medicare Transaction System (MTS).

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. Copies of this report are being sent to interested Department officials.

We would like to call to your attention another Office of Inspector General report, "Encouraging Physicians to Use Paperless Claims" (OEI-01-94-00230) which is also being issued at this time, under separate cover. It provides the results of a nationwide analysis of physicians' attitudes towards paperless claims. Its findings are similar to those included on that subject in this report.

To facilitate identification, please refer to Common Identification Number A-05-94-00039 in all correspondence related to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PROVIDERS AND ELECTRONIC CLAIMS PROCESSING

JUNE GIBBS BROWN
Inspector General

MAY 1996
A-05-94-00039

SUMMARY

Our review of electronic media claims (EMC) at the provider level disclosed that excellent progress is being made in converting Medicare claims processing to a total electronic environment. As with all new systems, however, there are problems associated with implementation. While most of the contacted EMC providers were conscientious and enthusiastic participants, internal controls in some areas could be improved.

- Additional provider guidance from the Health Care Financing Administration (HCFA) would be beneficial in the areas of better defining internal controls and the responsibilities of each provider in the claims process.

- The HCFA's provider agreement for electronic data interchange (EDI) and related controls for establishing authenticity of electronic claims submitted and accountability for electronic payments received need to be reexamined so that HCFA can assure itself that its program integrity safeguards are sufficient and effective.

In addition, there are numerous nonEMC providers still submitting hard copy claims. Based on our review of several of these providers, there are opportunities to convert many of them to electronic processing.

- The HCFA should provide more free training and information to hard copy providers, including cost benefit analysis, to encourage a shift to EMC.

- For providers with a significant volume of Medicare claims, HCFA should consider phasing in requirements to use EMC.

Several studies have been made showing that substantial savings per claim accrue when hard copy providers shift to EMC. Based on these studies, requiring EMC for providers submitting 50 Medicare claims or more per month could produce savings of from $36 to $135 million annually in claims processing costs.

Additional savings, perhaps of a greater magnitude, are available through increased use of electronic fund transfers (EFT), instead of checks, to reimburse providers. While our review of this area was not extensive, we noted that only a small number of providers are on EFT and that HCFA may need to reexamine some of the restrictions it has placed on provider participation in EFT.

Moreover, issues of program integrity and economic incentives involved in a movement towards a totally electronic environment for Medicare claims processing need to be examined in a comprehensive fashion if sound decisions involving sometimes conflicting objectives are

to be made. We believe that HCFA now, with the Medicare Transaction System (MTS) initiative, has an excellent opportunity to examine these issues. The MTS initiative includes a complete redesign of the claims process; streamlining of electronic billing, payment, and reporting; restructuring of provider participation agreements; and revamping of the explanation of benefits sent to beneficiaries. By examining jointly in the context of MTS initiative its options for improving both (1) program integrity and (2) economic incentives for providers in electronic billing, HCFA would be better able to identify and evaluate alternatives and determine where trade-offs need to be made. We plan, therefore, to closely monitor how HCFA deals with these issues as we continue our monitoring of MTS.

The results of our current review are more fully described in the body of this report. Supplemental data obtained from providers for HCFA's information is presented in the attached Appendices A and B. The full text of HCFA's comments to the draft report is included as Appendix C.

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INTRODUCTION

BACKGROUND

Under Part A and Part B of the Medicare program, providers of medical services submit their claims to HCFA's contractors for processing and payment. The Part A contractors (fiscal intermediaries) are responsible primarily for claims from hospitals, nursing facilities, and home health agencies. The Part B contractors (carriers) handle claims from physicians, medical laboratories, and medical equipment suppliers.

The processing of medical claims requires the use of sophisticated computer systems. Several different shared processing systems are currently used by the contractors. As a first step to integrate claims processing within a single system, HCFA awarded a contract in January 1994 to GTE Government Systems for the development of MTS. The MTS will eventually replace the shared systems now being used by the contractors. Although HCFA initially estimated that the MTS would be operational by December 1998, it now projects a target of September 1999. Claims processing efficiency should be greatly enhanced under the MTS through standardization. Also under the MTS, HCFA intends that virtually all Medicare claims will be submitted and paid electronically.

For a number of years, providers have had the option of submitting their medical claims in either paper (hard copy) or EMC formats. Medicare providers who choose the EMC option currently submit claims to local intermediaries and carriers, who in turn process the claims through one of the shared systems. The providers generally submit the EMCs with an in-house computer using a modem, or through a computerized billing service or automated medical payments clearinghouse. The EMCs are transmitted directly to the contractors over telephone lines, or on electronic storage media such as magnetic tapes or diskettes. Payments are made to the providers using either conventional mailed checks or EFT accompanied by Electronic Remittance Advices (ERA).

A topic of concern for both HCFA and the Medicare contractors has been the potential for increased fraudulent or abusive practices within an electronic claims processing environment. Although the Medicare program and the providers benefit from the use of EMCs through the elimination of manual processing efforts, the absence of hard-copy claims requires the implementation of additional controls, safeguards, and procedures to ensure continued program integrity.

In a report issued in October 1994, entitled "Review of Controls Over Electronic Billing and Payment at Selected Medicare Contractors in Region V--Considerations for the Design of the

Medicare Transaction System," we addressed EMC controls and safeguards at selected Region V Medicare contractors. The HCFA concurred with our recommendations for improving the EMC control environment at the contractor level. Because this prior review did not include visits to medical providers, we did not observe or evaluate controls that the contractors had put in place at the provider level.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The primary objective of the review was to address particular concerns expressed by HCFA over EMC-related areas at the provider level, especially those having high risk for fraud and abuse. Specifically, our objectives were to:

- evaluate the adequacy of internal controls in providers' offices using EMC,
- determine if EMCs provide sufficient provider accountability in the Medicare claims process,
- assess what obstacles exist to increasing the use of EMCs and EFT by Medicare providers, and
- evaluate the cost-effectiveness of EMC and EFT and the potential for additional Medicare administrative cost savings through increased use of EMC and EFT.

To accomplish our objectives, we made site visits or written and telephone inquiries to providers in Illinois, Indiana, and Ohio. Also, we interviewed staff at the applicable Region V Medicare contractors, the HCFA Region V office, and Federal investigative agencies. Our review at the three contractors covered three Part A intermediaries and two Part B carriers, as follows:

- Health Care Service Corporation (HCSC), Chicago, Illinois (Part A and B)
- Associated Insurance Company (AIC), Indianapolis, Indiana (Part A and B)
- Community Mutual Insurance Company (CMIC), Cincinnati, Ohio (Part A)

Our selection of Medicare providers for review was made on a random basis from a universe of providers serviced by the above three contractors. We sampled 200 EMC providers and 100 nonEMC providers. We made site visits to 62 of the providers: 52 using EMC and 10 using paper claims. We obtained information from other sampled providers through use of mailed inquiries and telephone contacts. Our field work was conducted during the period

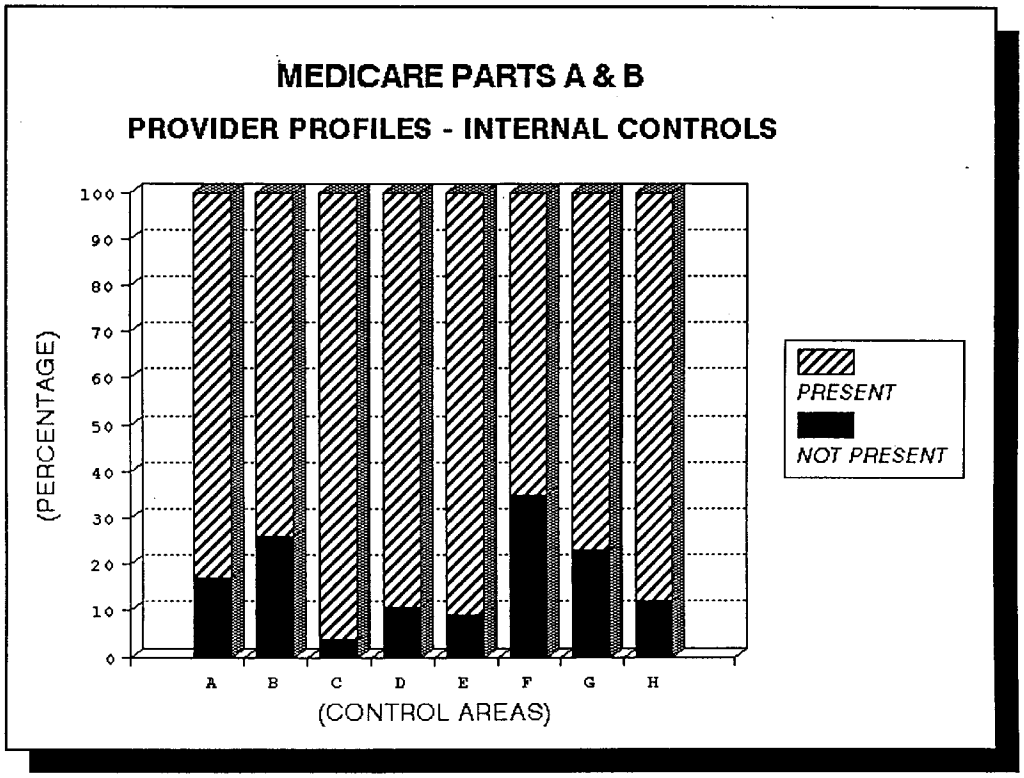
April 1994 through December 1994 and addressed the HCFA EDI provider agreement and related procedures in force at that time. The effective date for these procedures was February 25, 1994.

We issued our draft report on May 30, 1995. The HCFA responded on August 30, 1995. In its response, the HCFA made reference to a new EDI enrollment form and indicated that the new form and EDI enrollment procedures would address some of the recommendations in our draft report. Over the period September 1995 through December 1995, we obtained additional information from HCFA about the new form and procedures and discussed related issues of provider accountability for electronic billing and remittances with HCFA staff in Baltimore. We determined that we could not confirm that HCFA's new EDI form and procedures fully address our concerns without additional field work. To provide the results of our review in a timely manner we have, therefore, incorporated into our final report HCFA's position on the new EDI form and procedures, along with our remaining concerns. And, we plan to more fully address HCFA's assertions regarding provider accountability as it relates to EDI as part of our ongoing monitoring of HCFA's implementation of MTS.

FINDINGS AND RECOMMENDATIONS

EMC CONTROLS AT PROVIDERS

Our review at providers' offices disclosed a fairly high level of controls present. Some improvements could be made, however, in areas where we found controls lacking. The results of review are graphically depicted as follows:



A - Front-end Edits in Billing Software
B - Review of EMC Input
C - Review of Confirmation Reports
D - Creation of Back-up Copies of EMCs
E - Review of Remittance Advices
F - Separation of Duties
G - Physical Security of Computer Areas
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Background

Our review of EMC controls at providers was based on a random sample of 200 Medicare providers serviced by the three Part A intermediaries and the two Part B carriers. Because of greater concern about controls over physician billings, we concentrated primarily on Part B providers and made our selections from a universe of providers who submitted at least 10 claims per month. Our sample included three strata, as follows:

Strata:	Sample	Population
Part B - HCSC	80	8,683
Part B - AIC	80	3,678
Part A - HCSC, AIC, CMIC	40	2,540
	200	14,901

We made site visits to 52 of the 200 sampled providers to review EMC controls and EMC billing procedures. For the remaining 148 providers, we attempted to obtain information through mailed inquiries and, when needed, telephone contacts. Of the 148 providers that we did not visit, 20 providers did not respond to our inquiries.

Our results, therefore, are based on information obtained from 180 providers: 52 visited and 128 mail responses. Since not all of the responses were complete, the number of responses for each control area may differ slightly.

Front-end Edits in Billing Software

In our prior report, we noted that all three contractors were furnishing EMC submitters (providers, billing services, and clearinghouses) with a copy of specifications for front-end edits. The edits were used by the contractors to screen EMCs for accuracy prior to transfer to the shared claims processing systems. These specifications were made available to allow the submitters to incorporate them with their own billing software. We considered this to be a good practice at both the contractor and provider level.

Of 142 providers commenting on this area, 24 providers (17 percent) stated that their billing software did not have front-end edit features. The remaining 118 providers responded that their systems did include front-end edits. These included such features as editing for proper type of alpha and/or numeric characters or editing to verify the accuracy of provider numbers, diagnosis codes, and patient identification numbers relative to information already stored within host computer systems. Several of the providers used the exact front-end specifications of the contractors. Other providers added edits for specific services or locations, and some limited their edits to those that ensure that mandatory claim fields are completed.

Review of EMC Input

Section A-8 of HCFA's EDI provider agreement, as presented in section 3601.4 of the Intermediary Manual and section 3021.4 of the Carrier Manual, requires each EMC provider to "guarantee the accuracy, completeness, and truthfulness of all claims submitted to the contractor." To meet this requirement, providers should verify that there are no input errors and that the submitted EMCs are otherwise accurate based on the supporting medical documentation.

Of 170 providers responding in this area, 45 providers (26 percent) reported that this verification was not made. The 125 providers that reported the presence of this control used various procedures in their verification of EMC input. For example, in several instances at smaller providers, the office manager or administrator personally reviewed all the Medicare claims on a daily basis. In some of the larger group practices, charge sheets with formatted procedure codes, by physician specialty, were used to review the EMC claims.

Review of Confirmation Reports

Section B-1 of the HCFA EDI agreement requires that HCFA, through its contractors, "transmit to the provider an acknowledgement of claim receipt." These electronic transmissions, referred to as confirmation reports, validate that EMCs were received and accepted by the contractors. These reports should be reviewed by the providers to confirm that transmitted EMCs were accurately received by the contractors. Problems concerning transmissions can be readily identified from a review of these reports.

Of 158 providers that responded to this control area, only seven (4 percent) replied that they did not review their EMC confirmation reports. Rather than using the confirmation reports, one provider indicated it used its on-line capability to inquire about the accepted and rejected status of claims.

Creation of Back-up Copies of EMCs

A good system of internal controls should include the creation of back-up files of the EMCs submitted by the providers. This would prevent the need for reconstructing EMC batches in the event that transmitted files are not properly received by the contractor. It would also serve as an archive record of the submitted data.

Of 142 providers responding, 15 providers (11 percent) indicated that they were not creating data back-up files of their EMC submissions.

Review of Remittance Advices

The remittance advice is a report that provides final claim adjudication details, such as the amounts paid and amounts rejected for each claim submitted. Remittance advices are prepared in hard copy format when payments are made by check and are generally in electronic format when payments are by EFT. A good system of internal controls would include a review of remittance advices, when received, to ensure that payments are accurate and complete.

For this control area, 157 of 173 responding providers indicated that procedures had been implemented to compare remittance advices to the claims submitted. The larger providers, in general, have built payment reimbursement schedules for Part A and Part B into their computer software systems. The schedules are checked against the contractor's remittance advice to ensure that appropriate payments are received. Some providers reported they were able to make the review electronically since the remittances were in electronic format. Many of the smaller providers scrutinized each individual payment on the remittance advice when manually posting to their patient receivable accounts.

The remaining 16 providers (9 percent) indicated that the remittance advices were not reviewed for accuracy. These providers often accepted the payment amounts without question but did use account receivable aging reports to identify claims unpaid by the Medicare contractor. Several of these providers used billing services and did not receive remittance reports for review. We are concerned that these providers, by placing complete reliance on the third-party billing service and relinquishing their responsibility and control over claims processing, may be jeopardizing the accuracy and integrity of Medicare benefit payments. For example, in our on-site visits, we found one physician received only monthly summary totals of Medicare receipts and outstanding claims. The billing service independently resolved all claims matters with the contractor. The physician provided the billing service with a signature stamp and authorized the service to deposit all collections in the bank account.

Separation of Duties

Separation of duties should generally exist between EMC billing and remittance functions. Due to staffing constraints, it may not be practical for providers to maintain distinct separation of duties in all cases. However, providers should be conceptually aware of the importance of separating these functions whenever possible.

Of 170 providers that responded to this area of inquiry, 59 providers (35 percent) did not (or could not) separate these duties. The small staff size of several of these providers precluded any separation of duties. In other facilities, we noted that the office manager or bookkeeper undertook all responsibilities relating to EMC claims. Some of the 111 providers who reported a separation of duties offered additional information on this control. For example,

in addition to separating functional responsibilities, one provider also rotated clerical personnel between the EMC billing and remittance receipt functions.

Physical Security of Computer Areas and System Access Controls

Section A-10 of the HCFA EDI agreement requires that providers "prevent unauthorized users from submitting claims or committing other data security violations." Section A-14 further stipulates that providers must use "sufficient security procedures to ensure that all transmissions of documents are authorized and protect all patient-specific data from improper access." In order to fulfill these requirements, providers should maintain adequate physical security over their computer systems and utilize password control systems to help reduce the likelihood of unauthorized system access.

In the area of computer security, results of our review showed that:

- ***With respect to facility security,*** 167 providers that responded, 39 providers (23 percent) took no precautions to assure physical system security. The remaining 128 providers reported that they locked their data processing facilities when not in use. Other security measures reported included the employment of security guards at the provider facilities. Another provider installed an electronic security code which limited employee access within the building to specific hours of the day.

- ***With respect to system access controls,*** most of the responding providers indicated that they were using passwords. Of 171 responding providers, 150 (88 percent) indicated that they used some form of password protection as an access control while 21 (12 percent) stated that they had no system of password control over their internal computer systems. Of the 150 providers that reported the use of passwords, 75 providers stated that they did not change their passwords, and 25 providers indicated that they did not change their passwords more frequently than once every six months. Of the remaining 50 providers who were using passwords, 48 providers replied that these were changed on a more frequent basis than semiannually while 2 providers did not report the frequency of their changes. Of the providers who responded that passwords were not being used, one commented that the complexity of gaining access to the contractor's claims system and the computer illiteracy of the office staff was sufficient security.

To enhance security measures and prevent unauthorized access to patient information, we found that some of the larger providers had purchased or were about to purchase commercial security packages for their computer systems. These packages provided individual access controls which limited access to system information necessary to perform each particular job function.

Additional Areas of Concern

In responding to our inquiries, providers also reported the following areas of concern related to the Medicare EMC control environment:

- Of 132 responding providers, 34 providers (26 percent) complained of technical problems with modems, phone lines, or other equipment used in EMC transmission. Although some of these problems may have been the result of faulty provider equipment, other problems with EMC submissions were allegedly caused by contractor system "down time" or an insufficient number of contractor telephone lines for EMC submissions and assistance requests.

- Responses from 29 of 160 providers (18 percent) indicated that they had experienced EMC vendor-related service problems, or problems with EMC software that were difficult to resolve.

- Of 130 responding providers, 51 providers (39 percent) reported problems with Medicare fliers and bulletins distributed by the contractors on EMC issues. The primary complaint was that Medicare requirements had often changed before the providers receive appropriate notification. Several of the providers also suggested that an index of annual bulletins would be helpful in organizing the information.

These additional areas of concern are presented solely for information purposes and/or follow-up by HCFA. Further information, including demographics, is included in Appendices A and B.

Recommendations

We recommend that HCFA:

1. *Develop a pamphlet listing good internal controls for providers and the associated risks related to electronic claims submission. The pamphlet should be furnished to providers at the time of executing the EDI agreement and reinforced periodically through provider publications.*

   HCFA Response

   The HCFA concurs with this response and will address this recommendation through its ongoing efforts to promote EMC among the provider community.

2. *Require that all Medicare payments and remittance advices be sent to the providers to assure their direct participation in the payment receipt process.*

HCFA Response

The HCFA does not concur with this recommendation. In its view, requiring that payments and remittance advice be sent directly to the provider may infringe on the provider's contractual rights and create additional hassles for the provider. The HCFA indicated that many providers prefer that payments and final claims determination be handled by a third party billing service. Also, HCFA believes that, by signing the recently revised EDI enrollment form (included in Appendix C), the provider agrees to take responsibility for Medicare claims submitted by itself, its employees, or agents.

OIG Comment

The recently issued EDI enrollment form referred to by HCFA in its response to our draft recommendation was issued after we performed our field work; thus, we have not assured ourselves that the new enrollment process adequately involves providers in the verification of the accuracy and adequacy of Medicare payments received electronically. We plan to analyze this issue further as we continue to monitor the implementation of MTS.

FRAUD AND ABUSE CONCERNS IN THE EMC ENVIRONMENT

The EMC claims processing environment, due to its paperless nature, may be susceptible to a greater degree of fraud and abuse than a hard copy environment; i.e., there is no paper claim to establish direct accountability for services rendered and payments received by the provider. However, good control procedures at all levels--including HCFA, the Medicare contractors, and the EMC submitters--will help establish the framework necessary to provide adequate assurance over the integrity of EMC data.

We discussed the importance of adequate documentation in support of EMC case prosecutions or settlements with officials from the HCFA Chicago regional office, Department of Health and Human Services (HHS)/Office of Inspector General (OIG), Office of Investigations, Federal Bureau of Investigation (FBI), Office of General Counsel, and the Department of Justice (DOJ). We also consulted with carrier and intermediary personnel to identify perceived weaknesses in the EMC processing environment which could promote instances of fraud and abuse.

Our review identified segments of HCFA's EDI provider agreement and instructions which could be strengthened through the incorporation of additional language. We also discovered instances of inadequate control procedures, at the contractor level, over the procurement and maintenance of the EDI agreements. Additionally, we confirmed that password assignment techniques used by one contractor could be improved to reduce the likelihood of illegal use of EMC submitter identification codes by unauthorized parties.

Background

To help compensate for reduced hard-copy documentation in an EMC environment, HCFA has developed an "EDI Agreement" which must be signed by all providers who wish to submit Medicare EMCs. This agreement is the contract between HCFA and the Medicare EMC provider. The use of EDI contractual agreements and other investigative and litigation issues were recently addressed by the DOJ subcommittee on Health Care Fraud Working Group. Conclusions of this subcommittee, transmitted by DOJ to HCFA in December 1994, stressed the importance of medical providers accepting responsibility and liability for the accuracy and truthfulness of their claims. The DOJ subcommittee further suggested that "all provider agreements between Medicare contractors and providers should follow a standardized format and be uniform in language and effect."

EMC Investigative Concerns

Based on discussions with investigative personnel from the HHS/OIG and the FBI, we determined that there have been no recent cases prosecuted in HCFA's Chicago region for fraudulent submissions of EMC claims. However, discussions with these personnel identified the following EMC concerns:

- The penalty statement on HCFA's EDI provider agreement is inadequate because it does not explicitly address the issue of medical indication and necessity of services being billed to Medicare.

- EDI provider agreements are being signed by individuals who lack sufficient authority to enter into an agreement on behalf of the provider.

- EDI agreements may be lost or unavailable when needed as evidence.

- Persons responsible for preparation and submission of EMC claims are not identified on the transmitted claim.

- Providers do not certify the authenticity and accuracy of claim submissions and payments on a periodic basis.

The validity of these issues and other, related concerns of billing fraud and abuse was confirmed by the results of our review described as follows:

EDI Provider Agreements

Section A-15 of the HCFA standardized EDI agreement states that the provider must acknowledge "all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law."

For hard copy submissions, when a provider of medical services signs the HCFA form "1500" claim, the provider certifies that the services:

> "...were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision...."

The signed certification also states that:

> "For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills."

Our review of the HCFA standardized EDI agreement disclosed the following:

- The agreement does not stipulate that the rendered services must be "indicated and necessary" as defined on the hard copy form. This lack of definition within the penalty statement may diminish the value of the agreement as evidence of intentional wrongdoing when prosecuting EMC providers.

- The agreement does not include space to designate Medicare provider, Medicare submitter, tax identification, and Federal employer identification numbers assigned to the provider. Including these numbers on the agreement could simplify contractor administrative and record keeping requirements.

The agreement and instructions are presented in section 3601.4 and section 3021.4, respectively, of the HCFA intermediary and carrier manuals. These instructions state that the agreement "... must be executed by each provider of health care services, physician, or

supplier that makes EMC submissions. Each new EMC biller must sign the HCFA standard EDI Agreement and submit it to you before you accept the first claim from that biller."

Our review confirmed that these instructions do not stipulate or define who is actually authorized to sign the agreement on behalf of the provider. We found the wording in the instructions to be vague to the extent that providers could mistakenly conclude that virtually any employee (or entity conducting their EMC billing) is authorized to sign the EDI agreement on their behalf.

Control Over EDI Agreements

We requested that the contractors provide us with EDI agreements applicable to the 200 EMC providers included in our statistical sample. The contractors were able to provide only 153 of the 200 requested agreements. Of this group, 29 of the agreements (19 percent) were signed by provider employees such as "business managers", "patient account directors", "insurance clerks", or "office administrators." In each of four cases (3 percent), we found that the agreement had been signed by a representative of the provider's private billing service. We were unable to determine if 13 additional agreements (9 percent), although signed by provider personnel, had been executed at a sufficient level of management. Consequently, Medicare contractors should strengthen their controls over the review of EDI agreements to be certain that they are signed by an authorized representative of the provider entity.

Only one contractor was able to furnish us with all of the requested EDI agreements. A second contractor furnished us with 86 of 103 agreements (83 percent), while the third was only able to furnish 59 of 89 sampled agreements (66 percent).

Two primary control deficiencies at the third contractor, as described below, resulted in the high proportion of missing agreements:

- The contractor's filing system was decentralized, allowing contractor support personnel to keep original EDI agreements at their desks. An improved system should utilize a secure centralized file for the original agreements, with contractor personnel using copies at their desks as needed.

- Responsibility for obtaining the signed EDI agreements, for those providers submitting EMCs through billing agents, was delegated to the billing agents themselves. These agents were charged with the responsibility of forwarding the original signed agreements to the contractor. However, the contractor had no control in place to ensure that the signed agreements were received from the billing agent prior to processing EMCs for a given provider. A control measure, such as a front-end system edit, should be designed to verify the existence of a valid agreement before any EMCs are processed for a given provider.

The value of the EDI agreement, as a contractual enforcement tool, is greatly diminished in those circumstances where the original agreement cannot be produced, or where the agreement has been signed by an unauthorized representative of the provider. It is imperative that effective controls be incorporated into the EMC processing system to provide assurance that the agreements are properly executed and maintained at the contractor level.

EMC Authenticity

The DOJ subcommittee of the Health Care Fraud Working Group expressed concern that the actual persons responsible for preparing, submitting, or authorizing provider EMC transmissions are not identified on the EMC claim. Our review confirmed that although contractors can identify submitters and providers, they cannot identify specific individuals who are responsible for claim submission. One contractor suggested that existing blank or optional fields on an EMC could be used for this purpose.

The DOJ also recommended that providers be required to periodically certify (every 3, 6, or 12 months) to the accuracy and truthfulness of submitted claims. This certification process would require providers to confirm the validity of remittances.

We believe that HCFA could benefit from a review of procedures used by other third-party payers of medical services. For example, in Illinois, the state Medicaid agency uses a certification form which is attached to each remittance advice and verifies the accuracy of submitted EMCs and remittance information. This certification is to be signed by the provider and maintained in its records. A quality assurance review unit within this agency regularly reviews physician records and has the responsibility for verification that the signed certifications are being properly maintained in the provider's files. Use of a similar type of certification process by HCFA could provide for a routine verification by the provider regarding the accuracy of claims submitted and payments received.

EMC Systems Security

To help deter fraud and abuse, EMC systems security measures are also needed. On page 8, we reported that some providers were not using passwords, or otherwise were not changing passwords, to control access to their own computer systems. In the course of our review, we also noted weaknesses within a particular EMC claims submission software package used by several providers serviced by one contractor. Specifically:

- Submitter passwords and identification numbers were arbitrarily, rather than randomly, assigned.

- Submitter passwords and identification numbers were issued using short strings of similar characters which could more easily be deciphered than randomly generated numbers.

- Submitter passwords could not be changed by the user and could only be cycled (at user request) through the Medicare contractor.

Unauthorized access to submitter identification numbers and passwords could allow improper access to the contractor's host computer system, confidential Medicare data, or allow the submission of fraudulent claims. The HCFA and its Medicare contractors should ensure that EMC submitter passwords are assigned in a random manner to prevent unauthorized system access. Additionally, claims submission software should require (or at least allow) systems users to periodically change their passwords to minimize the risk of security breaches.

Recommendations

We recommend that HCFA:

1. *Consider the following modifications to the EDI provider agreement:*

   - *Strengthening the agreement to include similar wording to the HCFA form "1500" which states that all medical services rendered must be "indicated and necessary."*

     HCFA Response

     The HCFA does not concur and indicates that the new EDI enrollment form already has language similar to that referenced on the HCFA 1500. Furthermore, HCFA noted that its General Counsel, as well as many other Federal agencies and provider groups, have concurred with the legally binding language on the EDI enrollment form.

     OIG Comment

     We have examined the new EDI enrollment form and cannot find any explicit reference to the services provided as being "indicated and necessary." Since HCFA still requires providers submitting paper claims to assert that services provided are indicated as necessary, we see no reason why such an explicit assertion should not also be required for providers submitting EMCs.

   - *Modifying the agreement to include spaces for additional provider information including Medicare provider, Medicare submitter, tax identification, and Federal employer identification numbers.*

     HCFA Response

     The HCFA concurs with this recommendation but indicates that, in its view, the recently revised EDI agreement contains all necessary information to

identify the parties signing the agreement. The HCFA also indicates that it is pursuing another initiative which deals with provider enrollment/reenrollment in the Medicare program. Under this initiative, HCFA indicates that it plans to collect additional information--including tax identification numbers--on physicians, nonphysician practitioners, and medical group practices submitting paper or electronic claims to Medicare.

OIG Comment

We are aware of the provider enrollment-oriented projects that HCFA is pursuing as part of the overall MTS effort and plan to monitor the progress made in these efforts as we continue our monitoring of this initiative.

- *Augmenting the instructions to stipulate that the agreement must be signed by the actual provider of services, or a representative having the legal authority to enter into an agreement on behalf of the provider.*

HCFA Response

The HCFA concurs and indicates that it has included this requirement on the new EDI enrollment form and covered it in revised carrier and intermediary instructions.

OIG Comment

We are aware of the new requirements on the form and instructions to the Medicare contractors; however, because the new form and instructions were implemented after the period of our review, we have not yet determined if provider signature requirements are adequate and being complied with. We plan to address this issue as our monitoring of MTS proceeds.

2. *Consider implementing the following control enhancements to help reduce the likelihood of fraud and abuse in the EMC environment:*

- *Monitoring Medicare contractors to verify that controls exist to ensure proper completion, receipt, and retention of the provider EDI agreements.*

HCFA Response

The HCFA concurs that this is a good control mechanism and indicates that it will be working on implementing it during Fiscal Year (FY) 1996.

- *Using optional or blank data fields on the EMC to identify the party responsible for preparing and/or submitting the EMC.*

HCFA Response

The HCFA concurs with this recommendation and indicates that the EMC record contains space for both the EMC submitter name and EMC submitter identification number.

- *Requiring Medicare providers, or where indicated, their legal representatives, to periodically certify with their signature the accuracy of EMC claim and remittance information.*

HCFA Response

The HCFA does not concur with this recommendation. It believes that the newly issued EDI enrollment form adequately covers the legal need for any periodic certification in that it indicates that providers must agree to the statement, "That it [i.e., the provider] will submit claims that are accurate, complete, and truthful ... and that the HCFA assigned unique identifier number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that the services were performed as billed." The HCFA further indicates that this recommendation would impose an additional burden on the providers.

OIG Comment

Because the new EDI enrollment form was issued after the end of our field work, we cannot confirm that the new form and procedures provide the necessary assurance for program integrity that HCFA's comments suggest. Furthermore, we note that the new form does not require periodic certification of the correctness of payments received electronically, one of the requirements for provider accountability identified by DOJ. We plan to address the overall adequacy of EDI and related provider enrollment procedures as we continue our monitoring of MTS implementation.

- *Requiring Medicare contractors to assign randomly generated EMC submitter user identification numbers and passwords and permitting providers to periodically change their passwords.*

HCFA Response

The HCFA concurs and refers to section 3021.1 of the Contractor Manual (Data Security Confidentiality Requirements) which states that contractors

should "[m]ake sure that all data are password protected and that passwords are modified at periodic but irregular intervals, when an individual having knowledge of the password changes positions, and when a security breach is suspected or identified."

CONVERSION OF HARD COPY PROVIDERS TO EMC

The results of our review of a statistical sample of 100 nonEMC providers showed that many of the sampled providers had a great deal of interest in converting to EMC, while others continue to resist because of costs or objections to the technology. Since five of the sampled providers did not respond to our inquiries, our results are based on information obtained from the remaining 95 providers. Of the 95 providers responding, 43 providers were interested in EMC, while 52 providers were not interested.

The OIG has performed additional work in this area on a nationwide basis. The results are described in a final report entitled "Encouraging Physicians to Use Paperless Claims (OEI-01-94-00230)," which is being issued as a companion to this report.

Background

One of HCFA's primary objectives is to establish a complete electronic claims and payment environment prior to implementing the MTS. To advance this objective, HCFA has been using annual goals for EMC submission rates for each Part A and Part B contractor. The three Region V contractors in our review have been very successful in achieving HCFA's goals for EMC participation. During FY 1994, the EMC participation rate for the total Part A Medicare claims volume was approximately 97 percent for the three contractors. The two Part B contractors experienced an EMC rate of nearly 74 percent for the same period.

A major reason for the high EMC participation rates for these contractors was the effort devoted to soliciting providers with high claims volumes to convert to EMC. Numerous low-volume providers continue to submit their claims by hard copy. EMC participation rates expressed as a percentage of total providers served by the three contractors were 88 percent (Part A) and 56 percent (Part B). The contractors advised us that they continue their efforts to increase EMC utilization by low-volume providers. Some of these efforts include:

- Providing workshops to demonstrate and train providers about EMC technology and available services.

- Publishing bulletins and fliers citing the advantages of EMC and the latest changes and service packages available to providers in electronic technology.

- Publishing directories of EMC vendors and billing agents that meet the certification requirements of the contractors pertaining to accuracy, timeliness, claims volume, and software support.

- Contacting providers directly by telephone to encourage their participation in EMC.

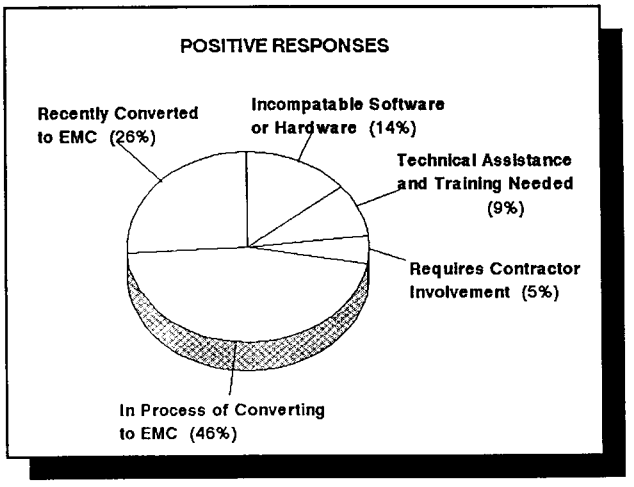
Because of the large number of providers that continue to use paper-based systems, HCFA is rightly concerned that nonEMC providers will create a burden and excess cost to the MTS system if they do not interface with HCFA's electronic system.

The objective of this review was to determine reasons why some providers are not converting to EMC. Our results are described below. Additional results of a nationwide review on this issue performed by the OIG are described in the final report "Encouraging Physicians to Use Paperless Claims," referenced above.

Sample Selection and Results of Review

To accomplish our objective we reviewed a random sample of "hard copy" providers (Part A and Part B) serviced by the three contractors. We limited our review by excluding from the population those providers that submitted less than 10 claims per month. On this basis, we selected an unrestricted random sample of 100 providers from a population of 7,947 providers (248 Part A and 7,699 Part B) that submitted their claims in hard copy formats. Site visits were made to gather the information for 10 of the 100 providers. Mailed inquiries and telephone contacts were used to solicit responses from the other 90 providers. We received no response from five of the providers included in our sample.

Positive Responses: Of 43 providers expressing some interest in EMC, 11 providers (26 percent) had already implemented EMC. Another 20 providers (46 percent) were in the process of converting to EMC or seeking information on vendor packages or software modifications for existing systems. In addition, six providers (14 percent) indicated that, although their office operations were computerized, their systems could not convert to an EMC format or were incompatible with the contractor's system for billing electronically. Each of these six providers was considering changing vendors or software.

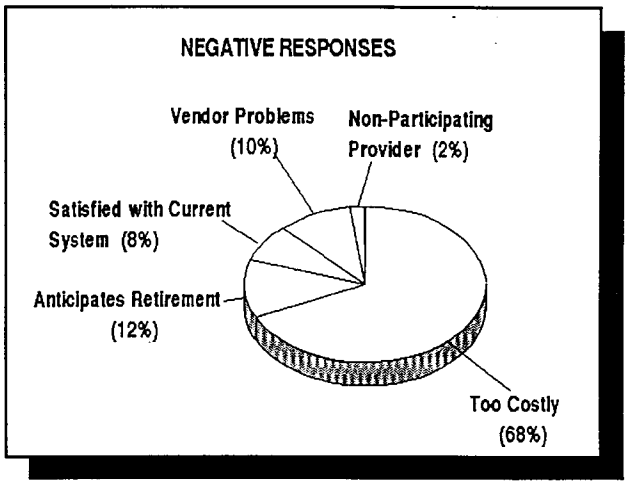


Six other providers expressed an interest in billing Medicare electronically. Of these, four providers (9 percent) wanted low cost technical assistance and on-site training in the use of

computer hardware and software. One of these four providers was a physician who told us that although he recently purchased a computer and a modem, he doesn't know how to use them. He indicated that access to technical assistance and software was limited in his rural community. Each of these four providers also indicated that they had not been personally contacted by the contractors about participating in EMC. One of the providers stated that after repeated requests to the contractor, information on EMC billing requirements was still not made available to him. Two other providers expressing interest in EMC (5 percent) had not been approached by the contractor. One was an optometrist, while the other was a chiropractor who had a mistaken understanding that EMC was not available to chiropractors.

We believe that the contractors should give priority to assisting any providers that express interest in EMC. The HCFA should consider having its contractors provide "free" or "low cost" on-site training for such providers who indicate a willingness to participate in EMC. The additional administrative costs required to provide the necessary technical assistance would eventually be offset by the reduced cost of claims processing.

<u>Negative Responses</u>: Responses from the remaining 52 providers in our sample indicated that the providers did not want to convert to EMC at this time. All but two providers expressed their specific reasons for not converting to EMC. The general categories of reasons for the 50 providers declining to participate in EMC were as follows:



- Thirty-four providers (68 percent) stated that the expense of EMC hardware and software was not cost-effective or warranted for the benefits derived in a small or part-time practice with a low volume of Medicare claims.

- Six providers (12 percent) anticipated retirement or leaving their practices within the next year and did not want to invest money in the hardware and software.

- Five providers (10 percent) had converted back to hard copy after experiencing problems with either vendor software, systems, time sharing, or billing services.

- Four providers (8 percent) were completely satisfied with their current systems for billing and expressed their resistance to any changes. We noted that two of the four providers were computerized--their systems automatically produce hard copy claims. These providers believed that the expense of adding wire transmission capability to their systems was not justifiable.

- One nonparticipating physician (2 percent) was not interested in EMC and the associated expediency of payments because the payments were made to the beneficiaries.

As reflected above, the cost factor was the primary reason given by 34 of the 50 providers for not having interest in EMC. We noted that 24 of these 34 providers submit less than 50 Medicare claims per month.

We found no evidence during our site visits that any of the providers had made a cost analysis of converting to EMC. A few providers understood that it would require an investment of about $2,000 to purchase a Personal Computer and a modem for use with the contractor's free software. Even at that cost, the providers were hesitant to invest in EMC technology.

Recommendations

We recommend that HCFA consider:

1. *Providing "free" or "low cost" on-site training for providers on the use of EMC hardware and software.*

   HCFA Response

   The HCFA concurs and indicates that Medicare contractors have been providing free support services through help desks, seminars, and bulletins. The HCFA further indicates that these have been cost-effective ways to reach the greatest number of providers.

2. *Developing a listing of advantages to providers for converting to EMC, including a basic cost benefit analysis, and distribute the listing through published bulletins and fliers.*

   HCFA Response

   The HCFA concurs and notes that many of the Medicare contractors currently produce information that lists the advantages of switching to EMC.

COST-EFFECTIVENESS AND POTENTIAL FOR PROGRAM SAVINGS

Although HCFA's use of contractor goals has proven effective in increasing EMC utilization, such efforts have reached a point of diminishing return. The HCFA should now consider phasing-in requirements for Medicare claims to be transmitted in an EMC format in order to make further significant gains. Not only would such requirements help meet a major objective of the MTS--a totally electronic claims and payment environment--but administrative cost savings would also be realized. For example, based on a conservative estimate, if Medicare providers that submit at least 50 Medicare claims per month converted to EMC, the Medicare program could save from about $36 to $135 million annually under the Part B program.

Administrative cost savings would also be achieved through increases in the use of EFT. While requiring providers to use EFT may not be appropriate at this time, we believe that HCFA should discontinue its requirement that providers submit 90 percent or more of their claims by EMC in order to qualify for EFT.

Background

The HCFA has recognized that electronic claims and payments are generally more cost-effective than traditional paper transactions. Historically, HCFA has targeted the increased use of EMC and EFT as the primary means for effecting short-term reductions in Medicare claims processing unit costs among its contractors. With respect to EMC participation, HCFA has encouraged higher utilization through annual goals for each contractor. To meet their goals, the contractors were required to recruit "hard copy" providers that were willing to convert to an EMC format. For increasing the use of EFT, similar goals were not used. In a prior report[1], we recommended that HCFA implement contractor goals for encouraging the use of EFT.

The contractors' efforts have been quite successful in increasing the use of EMC under Part A. Nationwide, during FY 1994, about 93 percent of Part A claims were in an EMC format. (The rate of EMC participation under Part A is now approaching 100 percent.) Similar success has not been obtained under Part B, where nationwide, only about 71 percent of claims submitted during FY 1994 were in an EMC format. Over one-half of the contacted "hard copy" providers had no interest in converting to EMC.

The EFT is available to Part A and Part B EMC providers as an alternate payment method to conventional check and remittance. The EFT consists of a fund transfer to the provider's

[1]"Review of Controls Over Electronic Billing and Payment at Selected Medicare Contractors in Region V--Considerations for the Design of the Medicare Transaction System (A-05-93-00056)," October 1994.

bank, in conjunction with an electronic remittance. In order for providers to qualify for EFT, HCFA requires them to transmit, at a minimum, 90 percent of their claims by EMC for three consecutive months.

Cost-Effectiveness of EMC

Based on statistics accumulated during an industrial engineering study in 1989, HCFA previously estimated that each EMC saves the Federal Government about 50 cents in processing costs over a hard copy submission. In its October 1993 report, the Workgroup for Electronic Data Interchange (WEDI), a voluntary public-private task force, concluded that the per claim savings to the payer would range between $.50 and $1.50.

Only one of the three contractors included in our review had made an analysis of the unit cost savings associated with an EMC. This analysis showed that the contractor was experiencing a savings of $.65 per Part A EMC claim and $.27 per Part B EMC claim. Although we did not audit the contractor's calculations, we believe that the cost efficiency of the contractor's Part B EMC processing will improve as its volume of EMC increases and its volume of hard copy claims decreases.

Considering all the estimates cited above, we believe that it is reasonable to expect savings in the range of $.27 to $1.00 per paper Part B claim converted to EMC.

Converting Additional Providers to EMC

In order to make significant further gains in the utilization of EMCs by providers, we believe that HCFA may have to require the use of EMC. Requirements for providers having significant Medicare claims volume could be phased in, over a period of time intended to coincide with implementation of the MTS. In our opinion, providers with significant volume could be defined as those submitting 50 or more Medicare claims per month.

We realize that some providers operate in rural areas with inadequate telecommunications capabilities or encounter other problems that hinder an efficient conversion to EMC. Consequently, any requirements may have to be subject to a temporary (or permanent) waiver for those providers who demonstrate that they are unable to utilize an EMC format.

Calculation of Savings from Additional Use of EMC

If providers who submit 50 or more hard copy claims per month converted to EMC, we estimate that annual savings to the Medicare Part B program would be between $36 million and $135 million. Our estimate was made as follows:

Our analysis of information obtained from the two Part B carriers (HCSC and AIC) revealed that 2,790 of 11,977 Part B "hard copy" providers were submitting 50 or more Medicare hard copy claims per month. This group of 2,790 providers accounted for about 75 percent

of the total paper claims volume submitted by all of the Part B "hard copy" providers serviced by these two carriers. According to statistics published by HCFA, a total of about 179.5 million hard copy claims were processed nationwide under Part B during FY 1994. Based on our results at the two carriers, about 134.6 million claims (75 percent of the 179.5 million hard copy claims) would apply to providers who submitted 50 or more paper claims per month. We then applied the $.27 unit savings figure developed by one of the contractors to the 134.6 million claims as the lower end of the range of potential savings and applied $1.00 unit savings to the 134.6 million claims as the upper end of the range of potential savings.[2]

EFT Considerations

Program savings also accrue as more providers elect to receive Medicare payments by EFT instead of conventional checks. According to unit cost estimates included in the October 1993 report issued by the WEDI, a health care payer (Medicare contractor) expends between $.45 and $1.00 to process a conventional payment and paper remittance as compared to between $.11 and $.35 to process an EFT/ERA. Additional cost data analysis addressing EFT was not available at the contractors included in our review.

We do not know the number of Medicare providers, nationwide, that receive payments by EFT. Of 172 EMC providers responding to our EFT questions, only 18 were receiving EFTs. Due to this low level of participation in EFT, HCFA needs to continue to address ways to increase interest in EFT among the providers. Responding to a recommendation in our prior report, HCFA indicated that it will consider establishing goals to expand the use of EFT by Medicare providers, physicians, and suppliers. We now believe that HCFA should also discontinue its requirement that providers must submit 90 percent or more of their claims through EMC in order to qualify for EFT. Of the 138 responding EMC providers that were not receiving EFT, 61 providers responded that they were interested in receiving their payments by EFT. We realize that HCFA's "90 percent EMC" requirement may have encouraged some providers to convert to an EMC format. This requirement, however, is counter-productive in today's automated claims environment.

Recommendations

We recommend that HCFA consider:

1. *Establishing requirements to phase-in EMC for all Medicare providers exceeding a specified claims volume.*

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[2]The estimate for potential savings of between $34 million and $126 million included in the contemporaneously issued OIG report "Encouraging Physicians to Use Paperless Claims" (OEI-01-94-00230) applies to all 126 million nonEMC physician claims for Calendar Year 1994. The savings estimate in this report applies to the 134.6 million FY 1994 Part B nonEMC claims we calculated for Part B providers (physicians and others) submitting 50 or more hard-copy claims per month in that fiscal year.

HCFA Response

The HCFA concurs. The HCFA notes, however, that Medicare already has the highest EMC rates in the nation and that our recommendation would require legislation--prior proposals for which have failed to receive congressional approval.

2. *Discontinuing the requirement that providers must submit 90 percent or more of their claims by EMC in order to qualify for EFT.*

HCFA Response

The HCFA concurs and explains that, because most providers are already submitting EMCs, the EMC incentive value of this requirement is no longer significant. Thus, HCFA intends to discontinue this requirement.

APPENDIX A

EMC CONTROL UTILIZATION FOR SAMPLED PROVIDERS MEDICARE PARTS A AND B

EMC CONTROL UTILIZATION FOR SAMPLED PROVIDERS
MEDICARE PARTS A & B

Control Feature	Respondents Yes	Respondents No	Total	Did Not Respond to Item	Total Tabulated
The provider's billing software includes front-end edit features.	118 (83%)	24 (17%)	142 (100%)	38	180
Claims are reviewed to ensure that there are no EMC input errors and that the EMCs are supported by medical documentation.	125 (74%)	45 (26%)	170 (100%)	10	180
Confirmation reports are reviewed to ensure transmitted EMCs are accurately received by contractor.	151 (96%)	7 (4%)	158 (100%)	22	180
Back-up copies of submitted EMCs are created.	127 (89%)	15 (11%)	142 (100%)	38	180
Remittances are reviewed to ensure that payments for EMCs are accurate and complete.	157 (91%)	16 (9%)	173 (100%)	7	180
There is a separation of duties between billing, receipt, and posting of payments.	111 (65%)	59 (35%)	170 (100%)	10	180
The provider's computer area is securely locked when not in use.	128 (77%)	39 (23%)	167 (100%)	13	180
The provider's computer systems are password protected.	150 (88%)	21 (12%)	171 (100%)	9	180
Passwords are changed periodically.	73 (49%)	75 (51%)	148 (100%)	2	150
Other Areas					
Provider receives adequate assistance on EMC problems from the contractor when requested.	150 (89%)	19 (11%)	169 (100%)	11	180
Provider has experienced technical problems with modems, phone lines, or other equipment.	34 (26%)	98 (74%)	132 (100%)	48	180
Provider has experienced vendor related service problems or software problems which were difficult to resolve.	29 (18%)	131 (82%)	160 (100%)	20	180
Medicare bulletins/fliers received from the contractor can be improved	51 (39%)	79 (61%)	130 (100%)	50	180

EMC CONTROL UTILIZATION FOR SAMPLED PROVIDERS
MEDICARE PART A

Control Feature	Respondents Yes	Respondents No	Total	Did Not Respond to Item	Total Tabulated
The provider's billing software includes front-end edit features.	24 (89%)	3 (11%)	27 (100%)	7	34
Claims are reviewed to ensure that there are no input errors, and that the EMCs are supported by medical documentation.	25 (83%)	5 (17%)	30 (100%)	4	34
Confirmation reports are reviewed to ensure transmitted EMCs are accurately received by contractor.	27 (93%)	2 (7%)	29 (100%)	5	34
Back-up copies of submitted EMCs are created.	20 (80%)	5 (20%)	25 (100%)	9	34
Remittances are reviewed to ensure that payments for EMCs are accurate and complete.	30 (97%)	1 (3%)	31 (100%)	3	34
There is a separation of duties between billing, receipt, and posting of payments.	20 (65%)	11 (35%)	31 (100%)	3	34
The provider's computer area is securely locked when not in use.	27 (87%)	4 (13%)	31 (100%)	3	34
The provider's computer systems are password protected.	30 (91%)	3 (9%)	33 (100%)	1	34
Passwords are changed periodically.	17 (59%)	12 (41%)	29 (100%)	1	30
Other Areas					
Provider receives adequate assistance on EMC problems from the contractor when requested.	28 (90%)	3 (10%)	31 (100%)	3	34
Provider has experienced technical problems with modems, phone lines, or other equipment.	9 (38%)	15 (62%)	24 (100%)	10	34
Provider has experienced vendor related service problems or software problems which were difficult to resolve.	9 (30%)	21 (70%)	30 (100%)	4	34
Medicare bulletins/fliers received from the contractor can be improved	13 (54%)	11 (46%)	24 (100%)	10	34

EMC CONTROL UTILIZATION FOR SAMPLED PROVIDERS
MEDICARE PART B

Control Feature	Respondents Yes	Respondents No	Total	Did Not Respond to Item	Total Tabulated
The provider's billing software includes front-end edit features.	94 (82%)	21 (18%)	115 (100%)	31	146
Claims are reviewed to ensure that there are no EMC input errors, and that the EMCs are supported by medical documentation.	100 (71%)	40 (29%)	140 (100%)	6	146
Confirmation reports are reviewed to ensure transmitted EMCs are accurately received by contractor.	124 (96%)	5 (4%)	129 (100%)	17	146
Back-up copies of submitted EMCs are created.	107 (91%)	10 (9%)	117 (100%)	29	146
Remittances are reviewed to ensure that payments for EMCs are accurate and complete.	127 (89%)	15 (11%)	142 (100%)	4	146
There is a separation of duties between billing, receipt, and posting of payments.	91 (65%)	48 (35%)	139 (100%)	7	146
The provider's computer area is securely locked when not in use.	101 (74%)	35 (26%)	136 (100%)	10	146
The provider's computer systems are password protected.	120 (87%)	18 (13%)	138 (100%)	8	146
Passwords are changed periodically.	56 (47%)	63 (53%)	119 (100%)	1	120
Other Areas					
Provider receives adequate assistance on EMC problems from the contractor when requested.	122 (88%)	16 (12%)	138 (100%)	8	146
Provider has experienced technical problems with modems, phone lines, or other equipment.	25 (23%)	83 (77%)	108 (100%)	38	146
Provider has experienced vendor related service problems or software problems which were difficult to resolve.	20 (15%)	110 (85%)	130 (100%)	16	146
Medicare bulletins/fliers received from the contractor can be improved	38 (36%)	68 (64%)	106 (100%)	40	146

APPENDIX B

DEMOGRAPHIC AND OTHER INFORMATION FOR SAMPLED PROVIDERS MEDICARE PARTS A AND B

DEMOGRAPHIC AND OTHER INFORMATION FOR SAMPLED PROVIDERS MEDICARE PARTS A & B

	Respondents	Did Not Respond To Item	Total Tabulated
EMC Billing Performed by:			
Office Staff	108 (55%)		
Billing Service	37 (19%)		
Physician Billing Group	31 (16%)		
Clearinghouse	20 (10%)		
	196 (100%)	1	197*
Computer Equipment Used to Submit EMCs:			
Personal Computer	80 (48%)		
Mainframe System	69 (42%)		
Other	16 (10%)		
	165 (100%)	25	190*
Method of EMC Submission:			
Direct Line Modem Connection	136 (85%)		
Diskette	1 -		
Magnetic Tape	11 (7%)		
Remote On-Line Terminal	12 (8%)		
	160 (100%)	23	183*
EMC Payment by:			
EFT to Provider's Bank Account	18 (10%)		
Check Mailed to Provider	136 (79%)		
Check Mailed to Billing Service	15 (9%)		
Other	3 (2%)		
	172 (100%)	8	180
154 Providers Not Receiving EFT:			
Aware of EFT Option	128 (89%)		
Not Aware	16 (11%)		
	144 (100%)	10	154
Interested in Receiving EFT	61 (44%)		
Not Interested	77 (56%)		
	138 (100%)	16	154
Approached by Contractor About Receiving EFT	46 (49%)		
Not Approached	47 (51%)		
	93 (100%)	61	154

*Does not total 180, since some providers reported more than one method for EMC billing.

APPENDIX C

FULL TEXT OF HCFA'S COMMENTS TO THE DRAFT REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE AUG 30 1995

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "Review of Medicare Providers and Electronic Claims Processing," (A-05-94-00039)

TO June Gibbs Brown
Inspector General

We reviewed the above-referenced report in which OIG expressed concerns about the processing of electronic media claims by Medicare contractors. The report concerns itself with necessary controls and safeguards in fraud and abuse situations within the electronic claims processing environment.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments.

Attachment

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG) Draft Report: "Review of Medicare Providers and Electronic Claims Processing," (A-05-94-00039)

ELECTRONIC MEDIA CLAIMS (EMC) CONTROLS AT PROVIDERS

OIG Recommendation

HCFA should develop a pamphlet listing good internal controls for providers and the associated risks related to electronic claims submission. The pamphlet should be furnished to providers at the time of executing the Electronic Data Interchange (EDI) agreement and reinforced periodically through provider publications.

HCFA Response

Concur. HCFA will address this recommendation through our ongoing efforts to promote EMC among the provider community.

OIG Recommendation

HCFA should require that all Medicare payments and remittance advice be sent to the providers to assure their direct participation in the payment receipt process.

HCFA Response

Nonconcur. Requiring that payments and remittance advice be sent directly to the provider may infringe on the provider's contractual rights and create additional hassles for the provider. Many providers prefer that payments and final claims determination be handled by a third party billing service. Also, by signing the EDI enrollment form, the provider agrees to take responsibility for Medicare claims submitted by itself, its employees, or its agents.

FRAUD AND ABUSE CONCERNS IN THE EMC ENVIRONMENT

OIG Recommendation

HCFA should strengthen the EDI agreement to include wording similar to the HCFA form "1500" which states that all medical services rendered must be "indicated and necessary."

HCFA Response

Nonconcur. The EDI enrollment form has language similar to that referenced on the HCFA 1500. The Office of the General Counsel, as well as many other provider groups and Federal agencies, have concurred with the legally binding language on the EDI enrollment form.

OIG Recommendation

HCFA should modify the EDI agreement to include spaces for additional provider information including Medicare providers, Medicare submitter, tax identification, and Federal employer identification numbers.

HCFA Response

Concur. However, it is our belief that the EDI agreement already contains all necessary information to identify the parties signing the agreement. HCFA is, however, pursuing another initiative which deals with provider enrollment/reenrollment in the Medicare program. Under this initiative, additional information, including tax identification numbers, will be collected on physicians, nonphysician practitioners, and medical group practices submitting paper or electronic claims to Medicare.

OIG Recommendation

Augment the instructions to stipulate that the EDI agreement must be signed by the actual provider of services or a representative having the legal authority to enter into an agreement on behalf of the provider.

HCFA Response

Concur. HCFA includes this requirement on the standard EDI enrollment form (attached). Instructions to this effect are contained in both the carrier and intermediary manuals.

OIG Recommendation

HCFA should monitor Medicare contractors to verify that controls exist to ensure proper completion, receipt, and retention of the provider EDI agreements.

HCFA Response

Concur. This is a good control mechanism, and we will begin working on this initiative during fiscal year 1996.

OIG Recommendation

HCFA should use optional or blank data fields on the EMC to identify the party responsible for preparing and/or submitting the EMC.

HCFA Response

Concur. The EMC record contains space for both the EMC submitter name and EMC submitter identification number. Although, Medicare contractors are prohibited from modifying the agreement, they may require additional information in an attachment to the agreement.

OIG Recommendation

HCFA should require Medicare providers or, where indicated, their legal representatives to periodically certify with their signature the accuracy of EMC claim and remittance information.

HCFA Response

Nonconcur. We believe the EDI enrollment form adequately covers the legal need for any periodic certification. The agreement indicates that providers agree to the following: "That it will submit claims that are accurate, complete, and truthful . . . and that the HCFA assigned unique identifier number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed." This recommendation would impose an additional burden on the providers.

OIG Recommendation

HCFA should require Medicare contractors to assign randomly generated EMC submitter user identification numbers and passwords and permit providers to periodically change their passwords.

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Concur. Section 3021.1 of the Carrier Manual Contractor Data Security Confidentiality Requirements addresses this issue by stating the following: "Make sure that all data are password protected and that passwords are modified at periodic but irregular intervals, when an individual having knowledge of the password changes positions, and when a security breach is suspected or identified."

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HCFA should consider establishing requirements to phase in EMC for all Medicare providers exceeding a specified claims volume.

HCFA Response

Concur. Medicare has the highest EMC rates in the nation. As of June 1995, 96 percent of claims were submitted electronically to Medicare fiscal intermediaries and 77 percent of claims were received electronically by Medicare carriers. This recommendation would require legislation. In the past, legislative proposals mandating EMC submission failed to receive congressional approval.

OIG Recommendation

HCFA should consider discontinuing the requirement that providers must submit 90 percent or more of their claims by EMC in order to qualify for Electronic Funds Transfer.

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HCFA Response

Concur. Originally, this requirement served as an incentive for providers to submit claims electronically. However, given today's environment this requirement will be discontinued.

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Medicare claims electronically to HCFA or to HCFA's contractors.

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to HCFA by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except HCFA and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file.

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:

- Beneficiary's name,
- Beneficiary's health insurance claim number,
- Date(s) of service,
- Diagnosis/nature of illness, and
- Procedure/service performed.

5. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and HCFA guidelines.

6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare is the primary payer.

7. That it will submit claims that are accurate, complete, and truthful.

8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid.

9. That it will affix the HCFA-assigned unique identifier number of the provider on each claim electronically transmitted to the contractor.

10. That the HCFA-assigned unique identifier number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed.

11. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from HCFA or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify the contractor or HCFA within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Health Care Financing Administration will:

1. Transmit to the provider an acknowledgement of claim receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each remittance advice sent to the provider.

3. Ensure that payments to providers are timely in accordance with HCFA's policies.

4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic billers have equal access to any services that HCFA requires Medicare contractors to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by HCFA under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to HCFA or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name

_____

_____

_____
Title

_____
Address

_____
City/State/Zip

_____
By

_____
Title

_____
Date