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August 16, 1994

Ms. Carol Rasco
Director, Domestic Policy Council
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20071

Dr. Bruce Vladeck
Administrator
Health Care Financing Administration
200 Independence Ave. SW
Washington, D.C. 20201

Re: Medicare Reimbursement Reductions/Venture Resources

Dear Ms. Rasco and Dr. Vladeck:

Late last winter we had the pleasure of meeting with Ms. Rasco to outline a presentation for revamping the present coding for Medicare Part B Reimbursement to reflect more accurately what is being done by providers in the field and to finally attain uniformity in coding, billing and reimbursement. The presentation projected that as part of such a program, immediate savings in Medicare Reimbursement of approximately 6 per cent would be realized.

Ms. Rasco then facilitated a meeting on May 21, 1993, with Dr. Vladeck and certain of his selected aides. That meeting proved to be rather short, since Dr. Vladeck announced at the outset that HCFA was sold on the need to proceed with a request for proposal consistent with the Venture Resources presentation, and

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Dr. Bruce Vladeck
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that such RFP should issue in the fall of 1993. Because Venture Resources, and its later added partners of Coopers & Lybrand and National Center for Advanced Medical Education, desired to leave open the option of responding to the RFP, we promised Dr. Vladeck that we would not make any inquiry concerning the issuance date or status of the RFP.

However, we recently learned that HCFA has scuttled all plans to proceed with the RFP and that it claimed the problems have been corrected by HCFA itself.

All of the information reasonably available to us indicates that the problems have not been "corrected" but are even worse now than they were a year ago. We are at a loss to understand why HCFA, if it has really done so, has made the decision to abandon this effort at reform.

We continue to believe that the rules governing payment must be precise and unambiguous or both the payments made and the description of services submitted for payment will not reflect what is really occurring. We continue to believe that present coding and payment systems are not precise enough to deal with the complexity of the system being administered and provide accountability for detecting abuse and errors. Let us briefly highlight some of the matters which have occurred since our presentation last year.

In responding to a General Accounting Office review of Part B claims, Representative Ron Wyden, Democrat of Oregon, who ordered the GAO audit, remarked that: "Medicare coverage seems to depend more on where the elderly live than on their medical needs."

"Most people think of Medicare as a Federal Program with uniform benefits nationwide. But we are learning that Medicare is really a "crazy quilt" of separate and dramatically different programs run by thirty-four private insurance carriers."

The GAO report is dated August of 1993 and is headed "Reliability of Claims Processing Across Four Carriers". The conclusions and remarks made by GAO representative, Eleanor Chelimsky, in her testimony before Congress on March 29, 1994, included three findings:

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1. First, that there were sizable differences among the carriers with respect to denial rates for the services screened for medical necessity.
2. The GAO found that the number of services that carriers screen for medical necessity vary markedly.
3. The overall denial rate for medical necessity also differed among these six carriers.

In seeking to account for these variabilities, the GAO consulted with HCFA officials who identified differences in the billing practices of providers as a possible explanation for variation in denial rates. HCFA officials gave four reasons to explain this further:

1. That various regions of the country have different levels of fraud and abuse, which in turn produce different denial rates;
2. Difference in denial rates could be due to aberrant billing practices by as few as two or three providers;
3. In certain regions of the country, providers disregard the feedback they receive from denied claims--that is, they continue to bill for services they know are not medically necessary in the hope that some will be approved; and
4. Certain carriers do a better job of educating providers on how to submit Medicare claims correctly.

The GAO, via Ms. Chelimsky's testimony, noted that these findings are new and that the size of this variation had not been previously examined by HCFA. Further, that HCFA was only beginning to conduct evaluations to determine which, if either, of the explanations, that is medical policy or billing practice, best accounts for the inconsistency observed by the GAO in assessing the denial rates.

Toward the end of her remarks, Ms. Chelimsky noted that:

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Dr. Bruce Vladeck
August 16, 1994
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"Medicare is not a local initiative. It is a national program under which beneficiaries should not receive different benefits solely because their place of residence differs." . . . We believe that HCFA needs to play a greater role in using such data to oversee carriers' claims review activities to better assure that beneficiaries and providers are equitably treated.

We would finally note that in the May 27, 1994, edition of Washington Insider's Focus examined some of these issues were examined. It reported, for instance, that at the "consensus conference" organized by the AMA, the American Clinical Laboratory Association and HCFA, a consensus was reached that: "Coding and payment policies generally need a uniformity, in place of the great variation among carriers . . . "

This article further remarked that:

In the end, most observers agree, the growing controversy can be resolved only if the cost considerations underlying it are resolved in a manner regarded as fair to Medicare and to lab service providers. This delicate balance seems elusive, but the recent swing of events dramatizing the inconsistency in present policy has lobbed the ball directly into HCFA's court for what lab service providers hope will be corrective action.

As has been proposed over a year ago, if solutions to such on-going problems are to be effective, the microeconomics of health care delivery behavior must be understood at the provider level and made part of the system coding delineations and definitions.

Ms. Carol Rasco
Dr. Bruce Vladeck
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This is precisely one of the essential goals that we proposed to the administration last winter and spring. If it has changed we would appreciate an explanation since all concerned in this effort have gone to considerable expense and devoted substantial time to an issue we believe would advance the administration's comprehensive goals of health care reform.

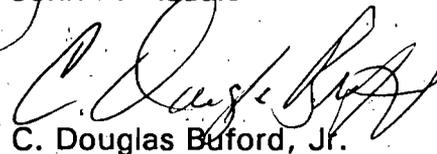
Cordially yours,

WRIGHT, LINDSEY & JENNINGS



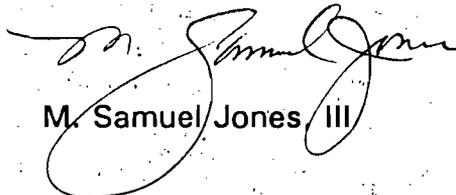
John R. Tisdale

John R. Tisdale



C. Douglas Buford, Jr.

C. Douglas Buford, Jr.



M. Samuel Jones III

M. Samuel Jones III

MSJ/drz
J:cjb1041.030
11666-32731



HEALTH CARE FINANCING ADMINISTRATION



9/22/94 - CLK + Bruce V. Tacke
and response attached
will be mailed 9/27/94
HARV

ADDRESSEE: Rosalyn Miller		FROM: Betty G. Davis
PHONE: 456-2249		OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201
		PHONE: 202-690-6726 FAX : 202-690-6262

TOTAL PAGES: C+2	ADDRESSEE'S FAX MACHINE NUMBER: 202/456-2878	DATE: 9/14/94
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REMARKS:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

Mr. John R. Tisdale
Mr. C. Douglas Buford, Jr.
Mr. M. Samuel Jones, III
Wright, Lindsey and Jennings
200 West Capitol Avenue, Suite 2200
Little Rock, Arkansas 72201-3699

Dear Messrs. Tisdale, Buford and Jones:

I am responding to your letter to Ms. Carol Rasco and me regarding coding for Medicare Part B payments.

As I indicated at our meeting in May of last year, the Health Care Financing Administration (HCFA) published a Request for Proposal (RFP) in the Commerce Business Daily, on December 2, 1993, for the National Rebundling Policy for Medicare carriers. The rebundling RFP solicited the development of a revised payment policy to control Medicare Part B overpayments resulting from the manipulation of coding. HCFA has requested that the end product of the contract include a recommendation for rebundling edits to be installed in the claims processing system of all carriers, and a reference document that addresses rebundling policy for all codes identified in the analysis of the HCFA database and the codes contained in Common Procedure Terminology-4 (CPT-4).

HCFA received seven proposals in response to the RFP. After review of the Best and Final Offers, on July 26, 1994, AdminaStar was awarded the rebundling contract. The contract's base year period will be 12 months with two 1-year options.

There appears to be some confusion about the Medicare coverage process and the possibility of uneven coverage of certain services from one area to another. In the absence of a specific national coverage decision, the local Medicare contractor is responsible for making the coverage determination. In making this determination, the contractor must work with the Carrier Advisory Committee which includes broad representation from the medical community in the service area. The carrier also uses medical literature and other sources it finds appropriate.

Carriers are permitted to reach alternative coverage decisions in the absence of national coverage policy. We do not believe, however, that diversity in carrier decisions is the

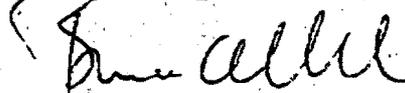
Page 2 - Mr. John R. Tisdale, Mr. C. Douglas Buford, Jr., and
Mr. M. Samuel Jones, III

result of carrier differences in opinion on medical efficacy. Rather, we believe the differences are the result of a number of well-founded reasons that we outlined for the General Accounting Office (GAO), and that you mentioned in your letter.

I assure you that we are striving to bring more uniformity to the Part B claims process, without intruding in the provision of medical care, or unduly burdening the people who provide the services. Our research and work on claims processing systems, coding education, and the knowledge we have gained on medical advances, should all serve to improve this area of the program.

I appreciate your interest in these matters.

Sincerely,



Bruce C. Vladeck
Administrator

cc: Ms. Carol Rasco

9/22/94 CJR phone con w/ Bruce Vlodavich

Bruce V.

- '79 rule

Pulled by Sullivan

'93 after inaug. re-reviewed

Decided to hold on health care reform



SEP 21 1994

The Administrator
Washington, D.C. 20201

Mr. John R. Tisdale
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Mr. M. Samuel Jones, III
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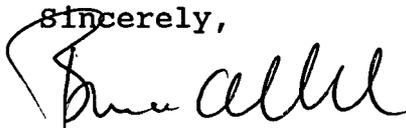
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I appreciate your interest in these matters.

Sincerely,

A handwritten signature in cursive script, appearing to read "Bruce Vladeck".

Bruce C. Vladeck
Administrator

cc: Ms. Carol Rasco