Medicare Ponders 'Medically Unbelievable Edits'

BY JOYCE FRIEDEN
Senior Editor

WASHINGTON — If you don't like medically "unbelievable" edits, how about medically "unusual" ones?

Members of the Practicing Physicians Advisory Council (PPAC), which advises the Centers for Medicare and Medicaid Services (CMS) on issues of interest to physicians, were upset about the name of the proposed Medically Unbelievable Edits program, which aims to find obvious errors in Medicare claims—for example, a claim for doing a hysterectomy on a male patient.

" 'Unbelievable' is a value judgment," PPAC member Dr. Peter Grimm, a radiation oncologist from Seattle, said at a recent council meeting. "You're going to get immediate reaction from people, so changing that word to 'unusual' doesn't change your [acronym] and really accurately describes what you're trying to do."

PPAC member Dr. M. LeRoy Sprang, an Evanston, Ill., ob.gyn., had another idea. "How about 'medically unexpected?' It's a softer word, and it really covers what you want to do. It's just not as obnoxious as 'unbelievable.' "

The program in question is designed to detect implausible Medicare claims submissions and avert inappropriate claims payment, according to Lisa Zone, director of the program integrity group at the CMS Office of Financial Management.

"I realize that this is an unfortunate title," she said. "We are trying to install edits to detect true errors in the system."

A recent CMS report found that Medicare's national paid claims error rate was 5.1%, "and we know that 1.7% is related to improper coding or billing errors," Ms. Zone said. "When you look at the federal dollars expended in the coding error class, it's in the billions of dollars."

The comment period for the proposed program ended on June 19, and Ms. Zone noted that "given that we've [already]

heard from various provider organizations about the MUEs out there today for comment, we are not going to be going forward with the MUEs as they are."

Instead, the office will look at the edits as a whole and make decisions on the best way to move forward. Initially, Ms. Zone's office will concentrate on developing edits to catch "anatomical" errors, such as procedures performed on the wrong body part. Then, they will address edits for typographical errors—someone bills for 500 units instead of 5, for example.

After making those changes, the proposal will go out for more comments. The MUEs will not be implemented until at least January of next year, and there will be a "test period" beforehand, Ms. Zone said. The testing will include an appeals process as well as the use of modifiers. Implementation will be in a "staged" approach, starting with the anatomical and typographical edits.

"We're very interested in what you have to say," Ms. Zone told the council. "We want to have those edits detect errors within the claims processing system, but in no way do we want the edits to affect medical practice or payment policy."

Ms. Zone noted that doctors who make errors will not be on any "hit list."

"Certainly, if we see a group or provider who was hitting edits more frequently than anyone else, then a contractor might decide to do some education or medical reviews for someone who was having problems submitting claims correctly, but that would be found based on data analysis," she said.

Council member Dr. Carlos Hamilton, an endocrinologist and executive vice president for clinical affairs at the University of Texas Health Science Center in Houston, told Ms. Zone that "there is considerably more angst in the medical community about this issue than may immediately appear." He noted that while the idea of using anatomical edits seems workable, there are often exceptions.

For example, one possible edit would return a claim if a surgeon took out two spleens in the same patient on the same day. "I'm not a surgeon, but [I know that] there are some people who do have accessory spleens, and it is conceivable that you might have to take out a second spleen," he said. "I really think you need to come up with a modifier for situations that don't appear to be straightforward before you bring this [system] out."

Thomas Gustafson, Ph.D., deputy director of the agency's Center for Medicare Management, seemed sympathetic to the modifier idea. "Insofar as we're capturing inversions of numbers or stuff like that, which are true coding errors, everybody should be able to agree with that," he said. "We then need to isolate those cases that are not essentially expected to arise in the routine practice of medicine. We've got to have some way of addressing that, some modifier or something of that sort."

He added that although CMS expects to save some money with the MUE initiative, "that's not what's driving this … The intent is truly to try to take care of the hysterectomies on men and those kinds of circumstances and try to do it in a sophisticated way so that we're not interfering with the practice of medicine to a noticeable extent." ■

Systems Issues Exacerbate Malpractice Claims

BY MARY ELLEN SCHNEIDER
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PHILADELPHIA — There are just as many systems failures at the root of malpractice cases as individual errors or negligence, Dr. Luke Sato said at the annual meeting of the American College of Physicians.

For example, the Risk Management Foundation of the Harvard Medical Institutes Inc., the insurance carrier for 18 hospitals and about 10,000 physicians in the Massachusetts area, has spent nearly the same amount of money over the years on malpractice cases involving clinical support processes as on cases resulting from a problem with the patient-clinician interaction. "What we see is that this is a process reengineering problem," said Dr. Sato, assistant professor of medicine at Harvard University and chief medical officer and vice president of the Risk Management Foundation.

An analysis of 2,270 malpractice cases within the insurance carrier from September 1995 to August 2005 shows that there are four high-risk categories in the system—obstetrics, surgery, medication-related problems, and diagnosis-related problems. Dr. Sato advised physicians to take a look at their office processes and set up ways within the practice to gather and document information that is critical to both the continuity of care and to avoiding malpractice claims. ■

Examples of best practices from the system are given online at www.rmf.harvard.edu.