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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

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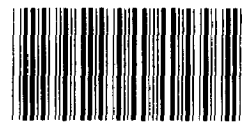
Actions Needed To Stop Excess Medicare Payments For Blood And Blood Products

Billing and replacement practices of blood banks and hospitals have caused substantial Medicare overpayments for blood and blood products.

Blood banks have prevented the use of blood replacement credits to reduce blood fees whenever Medicare would pay the fees.

Hospitals have not followed other Medicare billing instructions, further inflating Medicare charges for blood. Monitoring by the Department of Health, Education, and Welfare and its authorized intermediaries--such organizations as insurance companies authorized to pay for services--has been inadequate to identify and correct these problems.

This report recommends that the Secretary of Health, Education, and Welfare direct the Administrator, Health Care Financing Administration, to clarify Medicare blood billing instructions, improve monitoring of blood bank replacement and hospital billing practices, and initiate appropriate recovery actions.



Report

HRD-78-172

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report describes certain practices followed by hospitals and blood banks which have resulted in improper charges to the Medicare program for blood and blood products. It recommends several actions that the Department of Health, Education, and Welfare should take to stop excess Medicare payments.

Our review was made because information obtained during a survey of blood banking activities indicated that blood billing and replacement practices of certain hospitals and blood banks could result in unnecessary charges for Medicare patients.

Copies of this report are being sent to the Director, Office of Management and Budget, and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

ACTIONS NEEDED TO STOP EXCESS MEDICARE PAYMENTS FOR BLOOD AND BLOOD PRODUCTS

D I G E S T

Medicare insurance for the aged and disabled covers health care services, including blood and blood products. It reimburses hospitals for fees charged by blood banks for blood processing.

Many blood banks also charge a nonreplacement fee when blood used by a patient is not replaced or donated on a patient's behalf. Medicare claims for nonreplacement fees have totaled over $110 million since 1971.

Blood replacement practices at some community and hospital blood banks have not been consistent with Medicare regulations. For several years the blood banks have prevented the use of blood replacement credits to cancel blood fees which Medicare would pay. Consequently, charges to Medicare for blood and blood products have been overstated, and substantial overpayments have occurred.

GAO's evaluation of the nationwide impact of such practices was limited by the lack of data on blood credits available to Medicare patients. However, based on the limited information obtained, GAO concludes that excess payments by Medicare could total millions of dollars annually.

Some hospitals did not follow other Medicare billing instructions that affected Medicare payments:

--Hospitals charged nonreplacement fees to Medicare and to Medicare patients for blood supplied by community blood banks that charged only processing fees. This increased Medicare payments and required patients to either replace blood or pay for units not covered by Medicare.

--Hospitals do not submit corrected bills to Medicare when blood banks release blood credits after the hospital has billed Medicare. When improper replacement practices of blood banks are stopped and blood banks are required to release all needed credits, hospitals' failure to submit corrected bills will result in excess Medicare payments to hospitals. GAO recognizes, however, that submitting corrected bills could result in added administrative costs.

Medicare controls did not prevent unfair blood billing and replacement practices. Intermediaries responsible for administering the program were generally unaware of the blood billing and replacement practices of blood banks and hospitals, or of the impact those practices have on Medicare payments. The intermediaries' monitoring procedures usually ignored these issues. Although the Health Care Financing Administration identified some blood billing and replacement problems, needed improvements in billing instructions and program monitoring activities have not been made.

RECOMMENDATIONS

The Secretary of Health, Education, and Welfare (HEW) should direct the Administrator, Health Care Financing Administration, to:

--Revise Medicare billing instructions to more clearly require that hospitals and blood banks allow Medicare patients the same opportunities as allowed non-Medicare patients to eliminate blood fees.

--Revise Medicare instructions to provide that nonreplacement fees charged on processing-fee-only blood are not allowable charges to Medicare.

--Improve corrected billing requirements for late blood credits to more accurately and economically account for Medicare blood replacements.

--Request the Office of the Inspector General or require its fiscal intermediaries to identify hospitals and blood banks that have engaged in improper practices and seek recovery.

--Require, as a condition for reimbursement of blood costs, that hospitals enter into formal agreements or understandings with community blood banks that obligate the blood banks to comply with Medicare billing and replacement instructions.

--Require intermediaries to review blood billing and replacement practices at hospitals and blood banks as part of their regular review and audit procedures to assure equal replacement opportunities for Medicare patients.

--Periodically assure that intermediary monitoring efforts applicable to the matters covered in this report are properly performed, that appropriate records are being retained by hospitals and blood banks that bill Medicare for patient blood use, and that corrective actions are taken as needed.

HEW generally concurred with GAO's recommendations, but commented that the most comprehensive response to the problems would be remedial legislation. Pending enactment of such legislation, HEW identified other more immediate actions to be taken. GAO believes that the actions planned should alleviate the problems but recognizes that legislation may be a more appropriate long-range solution. In several instances, interim measures could improve the timeliness of planned corrective actions. (See p. 23.)

Contents

ABBREVIATIONS

AABB	American Association of Blood Banks
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare

GLOSSARY

Blood component	A liquid or cellular part of blood such as platelets, plasma, cryoprecipitate, etc., that is not subject to the Medicare blood deductible.
Blood replacement credit	A credit that entitles an individual who replaces blood to reduce or eliminate a nonreplacement fee and, at some blood banks, a processing fee.
Community blood bank	A blood bank that usually is nonprofit and locally organized and operated to serve the blood needs of hospitals in a community.
Fiscal intermediary	An agent of HEW (usually a private insurance company) which makes payments for Medicare services provided.
Hospital blood bank	A blood bank that is self-operated by a hospital and functions primarily to meet the blood needs of its own patients.
Medicare blood deductible	The first three units of whole blood or red blood cells received by a Medicare patient in a benefit period for which Medicare will not pay any nonreplacement fees.
Nondeductible blood	Whole blood and red blood cells in excess of the first three units received in a benefit period and other blood components received by a Medicare patient.
Nonreplacement fee	A fee charged by some blood banks for the blood used but which can be canceled or refunded by direct blood donations or by credits earned through a predeposit program.

Predeposit program	A blood plan in which individuals donate in advance of need to assure blood coverage.
Processing fee	A fee charged by blood banks which generally covers the cost of processing and storing blood.
Processing-fee-only blood	Blood supplied by a blood bank that charges only a processing fee.
Provider	An institution, facility, or agency that has filed an agreement to provide service to Medicare patients.
Replacement donor	An individual that donates a unit of human blood to replace a unit used.

CHAPTER 1

INTRODUCTION

The Social Security Act (42 U.S.C. 1395), as amended, provides hospital insurance and supplementary medical benefit programs for the aged and the disabled. The programs are collectively referred to as Medicare which provides coverage for many important health care services, including blood and blood products.

Sections 1815 and 1871 of the act direct the Secretary of Health, Education, and Welfare (HEW) to prescribe regulations for administering Medicare and to periodically determine amounts to be paid for services provided to Medicare beneficiaries. Section 1861(v)(1) of the act specifies that the Secretary's regulations insure that costs applicable to Medicare patients are not to be borne by non-Medicare patients and costs applicable to non-Medicare patients should not be paid by the Medicare program. The Secretary's regulations are to provide for retroactive adjustments where aggregate Medicare reimbursements are either inadequate or excessive.

The act stipulates that providers of Medicare services may nominate organizations to be fiscal intermediaries for Medicare. Under the act the Secretary is authorized to enter into agreements with nominated organizations, thereby making them HEW agents to pay for Medicare services provided. To insure the propriety of program payments, the Secretary may include in the agreements a requirement that the agents perform audits of provider records.

In determining amounts payable by Medicare for blood, section 1813(a)(2) of the act stipulates that Medicare payments are to exclude blood costs 1/ applicable to the first three units (pints) of whole blood or packed red blood cells during any period of illness. These first three units, called the "blood deductible," are the responsibility of each Medicare beneficiary. However, the Medicare beneficiary has the option

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1/According to Medicare instructions, blood costs generally consist of amounts spent by providers to procure blood, including (1) the cost of soliciting and paying donors and drawing blood for its own blood bank or (2) where the provider purchases blood from an outside blood source, the amount of credit which the outside blood source customarily gives the provider if the blood is replaced.

of replacing any or all of the three units used or paying the provider for unreplaced units. In addition to the costs for whole blood and red blood cells, Medicare will pay the costs for other blood components and for blood processing. 1/

Until March 1977 the Social Security Administration's Bureau of Health Insurance administered Medicare. On March 8, 1977, as a result of an HEW reorganization, the Health Care Financing Administration (HCFA) was established and the primary responsibilities and staff of the Bureau of Health Insurance were transferred to HCFA's Medicare Bureau. All Medicare fraud and abuse activities were transferred to HCFA's Office of Program Integrity.

Available information within HCFA shows that nonreplacement fees billed to Medicare for whole blood and red blood cells have totaled over $110 million since 1971. (See the following table below.) Additional amounts have been billed to Medicare for blood processing and blood components.

Nonreplacement Fees Charged to Medicare Patients for Units of Whole Blood and Red Blood Cells

Year	Deductible units a/		Nondeductible units		Total units b/	
	Number of units	Total fees	Number of units	Total fees	Number of units	Total fees
1971	597,000	$ 16,244,000	432,000	$ 11,755,000	1,029,000	$ 28,000,000
1972	668,000	18,183,000	544,000	14,808,000	1,212,000	33,000,000
1973	559,000	14,629,000	436,000	11,421,000	995,000	26,050,000
1974	679,000	18,392,000	638,000	17,289,000	1,318,000	35,681,000
1975	749,000	20,495,000	641,000	17,536,000	1,390,000	38,031,000
1976	734,000	20,209,000	717,000	19,739,000	1,451,000	39,948,000
1977	656,000	18,066,000	640,000	17,630,000	1,295,000	35,696,000
Total	4,642,000	$126,218,000	4,048,000	$110,178,000	8,690,000	$236,406,000

a/Medicare patients must either replace or pay for these units.

b/Numbers may not add due to rounding.

1/According to Medicare instructions, blood processing costs generally consist of amounts spent to process and administer blood, including the cost of such activities as storing, typing, cross-matching, and transfusing blood. Where a provider purchases blood from an outside blood source, processing costs would include that portion of the outside blood source's blood fee which remains after credit is given for blood replacement, i.e., the amount which cannot be credited or rebated by replacement of blood.

BLOOD BANK REPLACEMENT POLICIES

Blood bank charges for blood vary substantially in both type and amount. For example, some blood suppliers charge a single fee--called a "processing fee"--which covers the cost of processing a unit of blood while others charge, in addition to the processing fee, a blood "nonreplacement fee" which is assessed when a patient does not replace blood used. Most blood banks that charge nonreplacement fees apply the fee to whole blood and red blood cells, however, some also apply the fee to blood components.

Blood banks generally will eliminate nonreplacement fees if one or more units of blood are donated for each unit of blood used. A few blood banks will eliminate both the blood nonreplacement and blood processing fees if multiple blood donations are received.

Blood banks charging nonreplacement fees generally use a variety of "predeposit" programs that offer protection against these charges as an incentive to donate blood in advance of need. The yield from these programs reportedly is substantially greater than direct replacement donations. Predeposit plans are of two major types:

--Assurance plans. These plans are similar to insurance policies, except subscribers' premiums are blood donations rather than money. The benefits offered by assurance plans are coverage of nonreplacement fees, with no specified relationship between the number of donations made and the number of units that may later be transfused free. Family or group plans are usually available. In a family plan, an individual's donation earns coverage for any member of his immediate family. Group assurance plans cover members--and their families--of a group, such as a business or industry, a club, or a church, provided donations are made by a specified percentage of the membership.

--Reserve account. This is a group-based arrangement where members' donations accumulate credits in the group's account. These credits are then released to group members, their dependents, or others whom the group chairman designates as eligible to cancel blood charges.

The primary difference between the assurance and the reserve plan is that the reserve plan involves a credit-debit accounting system that establishes a unit-to-unit relationship between the number of donations made and those available to the group's members.

SCOPE OF REVIEW

Our review was accomplished primarily during the period November 1977 through May 1978, with the fieldwork being completed in February 1978. We visited six blood banks charging nonreplacement fees--four community blood banks and two hospital blood banks--in five geographic areas: (1) Northeast (Massachusetts), (2) Southeast (Florida), (3) Midwest (Missouri), (4) Northwest (Washington), and (5) Southwest (California). To determine the impact of the blood bank replacement practices, we visited nine hospitals, ranging in size from 165 beds to 1,129 beds, served by these blood banks.

Our review also included

- --a visit to a seventh blood bank--one that did not charge nonreplacement fees--and to two hospitals that charged nonreplacement fees on blood received from that blood bank,
- --interviews with HEW headquarters and regional officials,
- --interviews with representatives of fiscal intermediaries serving the hospitals and blood banks we visited, and
- --an examination of HEW policies and procedures relating to Medicare and its reimbursement procedures for beneficiaries receiving blood.

We have not identified in this report the hospitals and blood banks visited during our review. The problems we found are not limited to these locations but could involve a potentially large number of hospitals and blood banks throughout the country. Our objective is to get HEW to take appropriate action to eliminate programmatic problems we identified wherever they occur in Medicare. Under these circumstances we believe it is not appropriate to single out those organizations which were audited to identify examples of program weaknesses.

During our review we provided the Administrator, HCFA, with a written summary of our preliminary observations and asked for his comments. (See apps. III and IV.)

CHAPTER 2

BLOOD BANK REPLACEMENT PRACTICES CAUSED EXCESS MEDICARE PAYMENTS FOR BLOOD AND BLOOD PRODUCTS

The blood replacement practices at many community and hospital blood banks provided non-Medicare patients with greater opportunities to reduce their blood fees than was possible for Medicare patients. These practices, which did not comply with Medicare regulations and the Social Security Act, have existed for several years and have resulted in millions of dollars in excess Medicare payments nationwide.

BLOOD BANKS DO NOT RELEASE AVAILABLE BLOOD REPLACEMENT CREDITS TO MEDICARE PATIENTS

Medicare regulations and the Social Security Act require that providers must treat Medicare and non-Medicare patients equally. Also, Medicare instructions require that provider hospitals act in a "prudent and cost-conscious manner" to minimize costs.

Community and hospital blood bank replacement practices have not complied with Medicare regulations and related provisions of the Social Security Act. The blood banks we visited did not treat Medicare patients the same as non-Medicare patients for reducing or eliminating blood fees. The blood banks limited the number of blood credits they would release to offset nonreplacement fees for Medicare patients but placed no such limitations on non-Medicare patients. Some blood banks also allowed credits for non-Medicare patients for either component or blood processing fees but did not allow such credits for Medicare patients.

In response to our inquiry (see app. III), the Administrator, HCFA, stated that the requirement for equal treatment clearly applied to any situation regarding blood, including when provider hospitals obtain their blood supply from community blood banks. Specifically, the Administrator stated that:

> "To refuse to accept replacement blood raises not only the overall cost of blood (because replacement blood must be obtained elsewhere) but also disproportionately increases Medicare's share of the cost of blood where a provider accepts blood replacement from non-Medicare beneficiaries but not from Medicare beneficiaries. Similarly, to

reject replacement credits for Medicare beneficiaries where such credits would reduce blood processing costs or blood component fees is neither a consistent nor a prudent and cost-conscious practice on the part of a provider. Accordingly, assuming the situation of medically sound replacement blood, to the extent that a provider acts in an inconsistent or imprudent manner (or pays a blood bank that acts in this manner), excess costs for blood or blood processing may not be recognized as reasonable costs in the determination of Medicare reimbursement."

Although the intent of Medicare regulations was to require provider hospitals (and, through them, blood banks) to use equal blood charging and replacement practices when billing Medicare, blood banks identified Medicare patient blood users in order to restrict credits for these patients. The blood banks identified Medicare patients by

--obtaining the patient's age from the hospital and assuming that all patients age 65 and over were covered by Medicare,

--requiring hospital personnel to identify Medicare patients by checking a designated box on the blood order form, and/or

--contacting hospital billing clerks to learn the insurance coverage of patients using blood.

Blood banks limited replacement credits for whole blood and red blood cells to the Medicare deductible

The general practice at the six blood banks visited was to apply available blood replacement credits for reducing whole blood and red blood cell nonreplacement fees for non-Medicare patients. No more than three credits (equivalent to the Medicare blood deductible requirement) were used for reducing nonreplacement fees charged to Medicare patients. (See table below.) Four of the six blood banks accepted blood credits to reduce processing fees for non-Medicare patients, but would not allow blood credits to reduce these fees for Medicare patients. As a result, Medicare (through Medicare-participating hospitals) usually paid for all processing fees and all nonreplacement fees over three units.

Types of Blood Bank Fees and Replacement Practices for Whole Blood and Red Blood Cells Provided to Medicare and Non-Medicare Patients (note a)

Blood bank	Nonreplacement fee reduced with replacement credits		Processing fee reduced with replacement credits	
	Medicare (note b)	Non-Medicare	Medicare	Non-Medicare
A	Partial	Yes	No	Yes
B	Partial	Yes	No	Yes
C	Partial	Yes	No	Yes
D	Partial	Yes	No	No
E	Partial	Yes	No	No
F	Partial	Yes	No	Yes

a/Based on the general practices at six blood banks we visited.

b/Replacement credit limited to first three units.

The six blood banks visited collected about 286,000 units of blood in 1977. According to HEW, about 12 million units of blood are collected annually in the United States. Our review included over 700 patient records where whole blood and red blood cells were supplied by these blood banks. We analyzed blood usage at four hospitals for a 1-month period based on billing records from blood banks for 518 Medicare and non-Medicare patients. In addition, we examined a total of about 200 records for Medicare patients at five other hospitals to substantiate that similar practices were occurring elsewhere.

Our review at the nine hospitals showed numerous cases where Medicare did not benefit from full use of blood replacement credits. The impact on Medicare costs is developed in the remainder of this chapter from our analysis of hospital and blood bank records and data obtained from HEW. The following table illustrates the practice we found occurring at locations we visited for Medicare patients with more than sufficient blood credits available to offset the blood used.

Two of the blood banks reviewed had written policies for restricting credits for Medicare patients. One blood bank had a statement included in its fee schedule that if a patient was covered through Medicare, only the first three units received by the patient would need to be replaced. The other bank included a statement in the membership certificate for its Blood Replacement Plan that it was not liable for any blood used for which payment or replacement is covered by any Workmen's Compensation, Medicare, Medicaid, or other similar law. However, agreements 1/ signed by the two blood banks with provider hospitals did not include these statements or any reference to Medicare requirements.

Officials at most blood banks reviewed told us their replacement policies were based on their understanding of Medicare requirements. For example, they said that Medicare pays for all nonreplacement fees after the first three units. However, only one blood bank director referred us to a written document supporting this position--a 1971 Medicare handbook designed to inform Medicare beneficiaries of their Medicare coverage. This document stated that:

> "Hospital insurance cannot pay for the first 3 pints of blood you receive in a benefit period.
>
> * * * * *
>
> "* * * the blood you get under hospital insurance is fully paid for starting with the fourth pint during a benefit period * * *."

The blood bank director said he interpreted these statements to mean that Medicare always was to pay for blood after the first three units in a benefit period rather than reduce the fees with replacement credits. Several blood bank directors told us that limiting the number of replacement credits to three for Medicare patients was common practice by blood banks that charged nonreplacement fees and that the procedure had been in effect for several years.

1/Blood banks which initiate written agreements usually include statements on blood supply, prices, or general replacement policies.

The American Association of Blood Banks (AABB) 1/ expressed concern about this practice in a 1969 statement to the House Committee on Ways and Means. The AABB's statement included the following comment:

> "The consensus seems to be that Government prefers to make monetary payments for blood beyond the first three transfusions even though blood banks may have replacement credits available. As a result, often the patient's account had not been credited with additional replacements and Medicare was billed."

In addition, the AABB said that earlier that year it had issued the following statement to its member institutions:

> "Individual blood banks should use their own discretion in deciding how to handle replacements for Medicare patients beyond the first three transfusions. The AABB recommends, however, that blood banks accept all available replacements and that Medicare only be billed for those units for which blood replacements cannot be obtained."

Of six blood banks visited, all AABB members, none followed the AABB recommendation. Officials at three of the six blood banks told us they were unaware of the AABB position. After our visits, however, these officials told us they began crediting blood replacements for Medicare patients either because of information we supplied or subsequent discussions with regional HCFA or fiscal intermediary officials.

Blood banks limited Medicare patients in using blood replacement credits to reduce blood component fees

Four of the six blood banks we visited allowed non-Medicare patients to use blood credits to reduce blood component fees. However, three of the four blood banks would not allow any blood credits to cancel component fees for Medicare patients. The fourth blood bank

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1/The AABB is a national organization representing (1) hospital and community blood banks and (2) transfusion services. Historically, the AABB has supported the use of the nonreplacement fee as an incentive for blood donations.

limited Medicare patients to three replacement credits to reduce such fees. This unequal treatment resulted in component fees being improperly billed to Medicare.

We reviewed selected patient records where blood banks supplied components and found several cases where Medicare did not benefit from full use of blood replacement credits. In the following table each patient had more than sufficient replacement credits available to cover the blood components used. This table illustrates the impact on Medicare when blood banks do not allow replacement credits to be used to reduce nonreplacement fees on blood components.

Examples Where Blood Component Replacement Credits Were Not Allowed for Medicare Patients

Patient	Units used	Replacement units credited (note a)	Units improperly billed to Medicare	Charge per unit	Improper charges to Medicare
A	118	0	118	$25	$2,950
B	72	0	72	30	2,160
C	58	0	58	25	1,450
D	8	0	8	25	200
E	10	0	10	13	130

a/Blood components are not subject to the blood deductible but are covered under Medicare.

Blood bank officials told us they do not apply replacement credits for blood components because they understand that the Medicare program pays for all blood component fees rather than have such fees reduced through replacement credits.

REPLACEMENT PRACTICES RESULTED IN IMPROPER CHARGES TO MEDICARE

Provider hospitals have charged Medicare substantial sums for nonreplacement fees as well as blood component and blood processing fees. Although the amount of improper charges resulting from blood bank replacement credit restrictions on Medicare was difficult to determine, we believe it could total millions of dollars annually.

To obtain information on comparative replacement percentages of Medicare and non-Medicare patients, we selected a sample of 518 patients that received blood from four community blood banks. We found that Medicare bore a substantial

portion of the blood bank fees. (See the following table below.) Total fees of Medicare patients were reduced by only 9.6 percent through replacements while fees of non-Medicare patients were reduced by 51.8 percent. The biggest difference between Medicare and non-Medicare replacements was for the fourth and more units (nondeductible units) of whole blood and red blood cells transfused. Whereas no blood bank applied replacement credits to reduce Medicare patient fees for the nondeductible units, the blood banks applied replacement credits to reduce non-Medicare patient fees by 46.1 percent.

Medicare Patient and Non-Medicare Patient Nonreplacement Fees a/

	Whole blood and red blood cells					
	First 3 units	4th and more units	All units	Components	Total fees	Percent of combined fees
MEDICARE PATIENTS (187)						
Gross fees	$10,139	$7,858	$17,997	$10,793	$28,790	37.2
Replacements (credits)	2,753	0	2,753	0	2,753	9.9
Net fees	$ 7,386	$7,858	$15,244	$10,793	$26,037	52.7
Percent of fees replaced	27.2	0	15.3	0	9.6	
NON-MEDICARE PATIENTS (331)						
Gross fees	$16,287	$13,862	$30,149	$18,427	$48,576	62.8
Replacements (credits)	6,920	6,394	13,314	11,851	25,165	90.1
Net fees	$ 9,367	$ 7,468	$16,835	$ 6,576	$23,411	47.3
Percent of fees replaced	42.5	46.1	44.2	64.3	51.8	
COMBINED PATIENTS (518)						
Gross fees	$26,426	$21,720	$48,146	$29,220	$77,366	100.0
Replacements (credits)	9,673	6,394	16,067	11,851	27,918	100.0
Net fees	$16,753	$15,326	$32,079	$17,369	$49,448	100.0
Percent of fees replaced	36.6	29.4	33.4	40.6	36.1	

a/Based on selected patients that received blood at four hospitals.

The nationwide blood replacement rate for nondeductible units by Medicare patients appears to be similar to our sample data. HEW provided us with information on Medicare blood usage and replacement for all hospitals in the United States where a nonreplacement fee was billed during March 1978. This data showed that Medicare was given replacement credits for about 2 percent of the nondeductible units used. Based on discussions with HEW, we recognize that certain limitations in the data exist and that actual blood replacement could be somewhat higher. However, we believe that any necessary adjustments would not demonstrate significantly different results. Replacement credits would still represent only a small percent of the nondeductible units used.

The lack of information on the additional unused blood coverage available to Medicare patients limited our evaluation of the nationwide effect on Medicare from these restrictive blood replacement practices. Even at the locations we visited, the full impact on Medicare payments from restricting blood replacement credits was difficult to determine. One blood bank did not keep comprehensive records of a patient's blood usage but, instead, accumulated hospital blood order invoices for each day. Consequently, identifying the Medicare patients and the amount of blood they received became time consuming. An official at another blood bank related that his blood bank retained records of the blood credits pledged to a Medicare patient for only 6 months after the patient was discharged from the hospital.

Despite these problems, we were able to estimate at two locations the impact of limitations on blood replacements based on information provided by blood bank officials.

--One hospital blood bank transfusing about 18,000 units a year analyzed its Medicare claims for fiscal years 1976 and 1977 as requested by its fiscal intermediary and found:

	1976	1977
Total units received by Medicare patients	11,702	12,028
Blood credits allowed when replacement credits restricted	2,606	2,679
Additional blood credits allowable if no restriction	2,461	2,529
Percent increase in Medicare blood replacements	94	94
Savings resulting from additional replacements (rounded to nearest thousand)	$31,000	$36,000

Based on this analysis the hospital told us it was adjusting its Medicare cost reports for those years, thereby reducing the total Medicare payments by about $67,000.

--Based on our sample data from one hospital and information furnished by a community blood bank which supplied hospitals that transfused over 66,000 units in

1977, we estimate that eliminating the restrictions on Medicare replacement credits for whole blood and red blood cells could have reduced Medicare payments by $38,000 for 1977. This estimate does not include excess Medicare payments for nonreplacement fees on blood components which we believe were also substantial.

Since blood bank officials informed us that the practice of restricting blood credits for Medicare patients has been widespread for several years among U.S. blood banks charging nonreplacement fees, we believe Medicare has made excess payments which could total several million dollars each year for nonreplacement fees on whole blood and red blood cells. Had blood banks applied available replacement credits to Medicare, we believe that Medicare's payments for component nonreplacement fees and for all processing fees that could have been replaced would also have been substantially reduced. The HEW statistical data did not identify the total fees charged to Medicare for blood which could have been replaced, but sample data from four hospitals indicate that available blood replacement credits, if applied, could have eliminated many fees.

CHAPTER 3

HOSPITAL BILLING PRACTICES ADVERSELY AFFECTED MEDICARE PAYMENTS

Some hospitals did not comply with the intent of certain Medicare blood billing requirements. Specifically, some hospitals (1) charged nonreplacement fees to Medicare for blood supplied by community blood banks that charged processing fees only ("processing-fee-only" blood) and (2) did not submit corrected bills to Medicare when additional blood credits became available. Such practices usually result in increased Medicare payments.

HOSPITALS CHARGED NONREPLACEMENT FEES ON PROCESSING-FEE-ONLY BLOOD

Several hospitals at two locations we visited charged nonreplacement fees for blood supplied by blood banks that do not charge such fees, i.e., for processing-fee-only blood. This practice, which is contrary to the intent of Medicare instructions, results in excess payments by both the Medicare program and its beneficiaries.

Medicare billing instructions provide that hospitals may charge Medicare for nonreplacement fees on blood that is considered as unreplaced beyond the three-pint deductible. Before April 1976, Medicare instructions contained a provision on blood charges stating that, if a blood bank furnished a hospital blood at no charge or made a charge for all pints furnished whether replaced or not, the blood was considered to be replaced. Thus, a hospital could charge Medicare for nonreplacement fees only when a blood bank charged such fees to the hospital.

In April 1976, HEW made some revisions to Medicare billing instructions. Although the previously discussed provision was not contained in the revised instruction, an HEW headquarters official said that the intent of its instructions has remained the same--hospitals cannot charge nonreplacement fees to Medicare or its beneficiaries for processing-fee-only blood. In any event, blood bank officials said the practice of charging nonreplacement fees on processing-fee-only blood existed long before April 1976 and still does.

Patients covered by Medicare are also adversely affected when hospitals improperly charge nonreplacement fees for

processing-fee-only blood. They must either replace the first three units of blood or pay the nonreplacement fees for those units. However, the existing instructions' intent is that patients covered by Medicare are not required to replace or pay for this blood.

HOSPITALS DO NOT SUBMIT CORRECTED BILLS TO MEDICARE WHEN ADDITIONAL BLOOD CREDITS BECOME AVAILABLE

Most hospitals did not submit corrected bills to Medicare when blood credits became available after the original bill was submitted. The hospitals' failure to submit corrected bills would still result in significant overpayments by Medicare even if the blood replacement credit practices discussed in chapter 2 were discontinued. Blood banks often do not notify transfusing hospitals of a Medicare patient's total blood replacement credits until after the hospital bills Medicare for that patient's total hospital charges.

Medicare billing instructions require hospitals to submit corrected bills whenever (1) blood charges change by $10 or more or (2) a patient's remaining blood deductible requirement changes. Therefore, when a hospital receives blood credits after an original bill has been submitted to Medicare, Medicare instructions usually require a corrected bill to be submitted reflecting the reduced charges.

In justifying their practice of not submitting corrected billings, some hospital officials stated they

--were not aware of the requirement that corrected bills be submitted for late blood credits,

--did not follow the requirement in order to eliminate the clerical costs associated with those changes, or

--followed an alternative practice of accumulating late replacement credits and making yearend adjustments to their blood charges at the time of annual Medicare cost report preparation.

Although we believe this latter procedure would, if properly followed, be satisfactory, our review at the hospital citing this procedure indicated that its yearend adjustment was too small to account for the high rate of late blood replacements usually made by Medicare patients.

HEW officials in one region expressed concern about the administrative costs associated with the corrected billing requirement. In every instance requiring a corrected bill, the hospital must prepare and forward the new bill to the intermediary, who then would have to process the document and correct its records. Accordingly, Medicare would bear the added administrative costs incurred by both to process each corrected bill through reimbursements to the intermediary and its hospitals.

We recognize that presently the failure of hospitals to submit corrected bills may have little impact on Medicare payments because only deductible units are affected. However, if the blood bank practice of restricting credits is corrected, and replacement credits for nondeductible units are passed on to hospitals when available, the hospitals' failure to submit corrected billings will result in substantial overpayments to the hospitals.

Although we did not attempt to evaluate the reasonableness of existing billing requirements, HEW may need to develop more realistic requirements to accurately and economically account for all blood replacements, especially when present improper blood replacement practices cease. One approach might be to require hospitals to account to Medicare for credits on a periodic basis rather than for each individual patient, as is now required.

CHAPTER 4

MONITORING OF BLOOD BILLING AND REPLACEMENT PRACTICES SHOULD BE IMPROVED

Medicare controls did not prevent improper blood billing and replacement practices. HCFA and fiscal intermediaries made isolated attempts to identify and correct these practices, but their efforts did not prompt the programwide actions necessary to (1) collect past overpayments and (2) eliminate future overpayments. Without needed changes, these abuses will likely continue.

MONITORING BY INTERMEDIARIES IS INADEQUATE

Intermediaries we visited did not routinely monitor blood billing and replacement practices. These intermediaries were responsible for assuring that Medicare payments were in accordance with Medicare law and regulations. Intermediary officials told us they generally were unaware of the blood billing and replacement practices followed by either blood banks or hospitals or the impact of those practices on Medicare payments. Specifically, they did not assure that Medicare patients had the same opportunities to reduce nonreplacement, processing, and component fees as did non-Medicare patients. Instead, the only blood activity reviews they mentioned were the following:

--Bill reviews, which involved a mathematical verification that the hospital correctly computed patient blood charges, based on the number of unreplaced blood units and the charge per unit.

--Hospital utilization reviews, which involved selected verifications that Medicare patients actually received the blood products billed by the hospital.

--Hospital cost reimbursement audits, which assumed that blood charges were billed correctly.

HEW has not clearly defined intermediary responsibility for reviewing blood activities. One intermediary official said no programwide effort to monitor blood billing practices existed.

Another official summarized the problem as one where blood billing and replacements "fall through the crack" as far as intermediary review is concerned. For example, one

intermediary's cost reimbursement auditors stated that, even if abuses occurred in Medicare charges for blood and blood products, the cost reimbursement section was not responsible for trying to identify and correct those abuses. These auditors said that bill review people had this responsibility. The bill review chief related that such an evaluation should be conducted by the utilization review department. Yet the utilization review department made no such evaluations.

Intermediary cost reimbursement auditors at another location, however, said they did attempt to identify and evaluate hospital blood billing and replacement practices. They made hospital cost report adjustments when these practices were found to adversely affect Medicare payments. This intermediary's evaluation of one hospital we visited, however, was not adequate to determine that blood billing and replacement practices were causing excess Medicare payments. Based on information that we provided to this intermediary, we were told that Medicare payments to the hospital for 1976 and 1977 were reduced by about $67,000. (See p. 13.)

ISOLATED ATTEMPTS MADE TO IDENTIFY BLOOD BILLING AND REPLACEMENT PROBLEMS

In addition to the limited intermediary monitoring procedures, in a few instances, HCFA attempted identifying and correcting improper blood replacement practices. These efforts included:

--A 1975 review by the Boston Regional Office of hospital blood deductible procedures in the Northeastern United States. This review disclosed that (1) one blood bank restricted credits for Medicare patients at one hospital and (2) some hospitals failed to submit corrected Medicare bills when a patient replaced blood after the original bill had been submitted. The fiscal intermediaries for these hospitals were informed of the results of the review. Officials responsible for the review had no information of any corrective action taken by any hospital but were aware that some intermediaries issued instructions to hospitals emphasizing appropriate Medicare billing procedures.

--A 1977 review by the Kansas City Regional Office of a midwestern community blood bank's replacement practices. This review disclosed that the blood bank had restricted Medicare blood replacement credits. The blood bank has discontinued this practice but no

decision had been made at the time of our review regarding any recovery of past Medicare payments.

--A 1977 survey by the San Francisco Regional Office of hospital blood billing and cost accounting practices in the Southwest United States. This survey was conducted as a result of an inquiry by a staff member of the Senate Finance Committee. Although the primary objectives of this survey were to determine if hospitals treated non-Medicare and Medicare patients equally and, if not, whether the practice resulted in excess Medicare and/or patient blood costs, the information obtained was inadequate to disclose any improper practices that existed.

Although two of these efforts demonstrated the need for improvements in both blood billing instructions and Medicare monitoring, HEW has not clarified its instructions or assured that intermediary review procedures were improved. Such actions are necessary to assure that hospitals and blood banks comply with Medicare regulations.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS, AND HEW COMMENTS AND OUR EVALUATION

CONCLUSIONS

Community and hospital blood bank replacement practices did not allow Medicare patients the same opportunities as non-Medicare patients to eliminate blood fees. The general practice at the blood banks visited was to avoid using blood replacement credits for Medicare patients for any blood for which the Medicare program would otherwise pay. Thus, charges to Medicare for blood and blood products were overstated, resulting in substantial program overpayments.

Some hospitals did not follow other Medicare blood billing instructions affecting Medicare payments by (1) charging nonreplacement fees on processing-fee-only blood and (2) failing to submit corrected bills to Medicare when blood credits became available after the original bill had been submitted. Unclear Medicare billing instructions may have contributed to the proliferation of these billing and replacement practices.

Medicare program controls should be improved. HCFA should assure that intermediaries (1) monitor hospital and blood bank compliance with blood billing and replacement instructions and (2) take corrective measures when deficient practices exist.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Secretary of HEW direct the Administrator, HCFA, to:

--Revise Medicare billing instructions to more clearly require that hospitals and blood banks allow Medicare patients the same opportunities as allowed non-Medicare patients to eliminate blood nonreplacement, replaceable blood processing, and component fees.

--Revise Medicare instructions to provide that nonreplacement fees charged on processing-fee-only blood and blood components are not allowable charges to Medicare.

--Improve corrected billing requirements for late blood credits to more accurately and economically account for Medicare blood replacements.

--Request the Office of the Inspector General or require its fiscal intermediaries to identify hospitals and blood banks that have engaged in the improper blood billing and replacement practices and seek recovery from providers for each year where recoveries are allowable under Medicare regulations.

--Require, as a condition for reimbursement of blood costs, that hospitals enter into formal agreements or understandings with community blood banks that obligate the blood banks to comply with Medicare billing and replacement instructions.

--Require intermediaries to review blood billing and replacement practices at hospitals and blood banks as part of their regular review and audit procedures to assure equal replacement opportunities for Medicare patients.

--Periodically assure that intermediary monitoring efforts applicable to the matters covered in this report are properly performed, that appropriate records are being retained by hospitals and blood banks that bill Medicare for patient blood use, and that corrective actions are taken as needed.

HEW COMMENTS AND OUR EVALUATION

In commenting on a draft of our report (see app. II), HEW noted that the problems we cited are not unique to Medicare but exist wherever there are third-party arrangements to pay for blood. HEW believes that the most comprehensive response to the problems would be remedial legislation to permit the Federal Government to directly influence blood bank practices to assure equal treatment of all patients. HEW noted that, pending enactment of legislation, it had identified certain actions it would take to address specific problems identified in our report.

HEW agreed with our recommendations that Medicare billing instructions be revised. HEW recognized the need to clarify and expand regulations and policies concerning the application of replacement credits and, to this end, has changed some instructions and is considering changing others. HEW also agreed to revise its regulations to

eliminate Medicare recognition of nonreplacement fees for processing-fee-only blood as a reimbursable cost.

Although HEW recognizes the need to clarify its policy in these areas, we are concerned that it is not acting to resolve these matters quickly. Although we notified HCFA by our December 12, 1977, letter that improper blood charges were being made, it has yet to take action to curtail such practices. We believe that HCFA should continue its plans to revise the Medicare regulations but, in the interim, it should notify providers as soon as possible that replacement credit practices we found are contrary to Medicare policy and should be stopped.

Regarding our recommendation for improving corrected billing requirements, HEW noted that Medicare policy clearly mandates complete accounting for late blood credits, but that it would continue to review corrected billing procedures to determine whether additional improvements could be developed. HEW also noted that late credits must be accounted for by the provider on its cost report. We found, however, that this procedure did not appear to assure proper accounting for late credits. We believe HEW should give more attention to developing reliable procedures to assure that such credits are properly accounted for by providers.

Regarding our recommendation that HEW take action to recover excess Medicare payments, HEW said it would instruct its intermediaries to make appropriate financial adjustments to provider cost reports whenever significant errors in blood replacement practices are identified during the course of its audit process. HEW also suggested that our report identified several areas where its instructions were ambiguous or not specific, and therefore subject to different interpretations. HEW stated that it may therefore be difficult to hold hospitals and blood banks accountable for past actions and to make a persuasive legal argument for recovery of overpayments.

While we did point out certain problems concerning the clarity of Medicare regulations, in this case the applicable regulations are clear. As stated in our report, Medicare regulations specifically provide for equal treatment of Medicare and non-Medicare patients, but the blood banks we visited did not treat Medicare patients the same as non-Medicare patients for the purpose of reducing or eliminating blood fees. The customary blood replacement credit practices which the blood banks applied to non-Medicare patients were not applied to Medicare patients. We continue to believe that in this matter, the applicable regulations provide a sufficient basis for HEW to seek to recover excess Medicare payments.

HEW concurred with our recommendation that hospitals enter into agreements that would obligate blood banks to comply with Medicare instructions. HEW noted, however, that this would still be an indirect control of blood bank practices and would be administratively complex and expensive. HEW believed that legislation to clarify responsibilities of blood banks might be a more workable approach. We agree that our recommendation would be an indirect control and recognize that legislation may be a more appropriate long-range solution. As HEW noted in its comments, it intends to study the overall implication of a comprehensive revision of the provider agreement. We believe that study should be undertaken and the results evaluated before further considering any legislative recommendations. However, we continue to believe that, in the interim, prompt action is needed to remedy existing problems.

HEW agreed with our recommendations on the need for improved monitoring of blood billing and replacement practices by fiscal intermediaries and on the need to assure that intermediary monitoring efforts are properly performed. HEW noted, however, that it does not have legal authority to audit the books of independent blood banks.

Not all blood banks are independent. In a number of cases, blood banks are operated by hospitals which are Medicare providers and, therefore, are subject to review and audit by intermediaries. We recognize that in cases where a hospital is dealing with an independent blood bank, intermediaries cannot audit the blood bank itself, but rather will have to rely on information available at the hospital as a means of reviewing blood billing and replacement practices.

EXPLANATION OF THE IMPACT OF INCORRECT BLOOD BILLING AND REPLACEMENT PRACTICES FOLLOWED BY BLOOD BANKS AND HOSPITALS

To measure the effect of blood bank and hospital blood billing and replacement practices, costs and charges used in Medicare cost reports must be analyzed. Basically, Medicare pays the "cost" a hospital incurs in providing services to Medicare patients. To compute these costs, a cost report is prepared comparing the total costs incurred for each hospital cost center with the total charges levied by each cost center. The resulting ratio (costs/charges) is multiplied by the total charges for Medicare patients for each cost center. This computation provides Medicare's portion of the hospital's total costs for each cost center. Total Medicare costs for all cost centers are reduced by deductibles and coinsurance in determining the actual Medicare payment.

MEDICARE BLOOD COST CENTER MODEL

(1) $\frac{\text{Total costs}}{\text{Total charges}} \times \text{Total charges for Medicare patients} = \text{Reimbursable costs}$

(2) Reimbursable costs - deductible fees = Medicare payment

Hospitals prepare Medicare cost reports based on gross charges. One exception, however, is the blood cost center where nonreplacement fees (charges) for both Medicare and non-Medicare patients are reduced by the value of patient blood replacement credits. As a result, the nonreplacement fee portions of Medicare blood charges and hospital blood charges are "adjusted gross" figures because the total charges are "net" of blood replacements.

The unequal treatment of Medicare and non-Medicare patients in "netting-out" blood nonreplacement charges is a major reason that the problems discussed in chapters 2 and 3 affect Medicare payments. To the extent that blood replacement credits are not properly applied, costs will not be fairly apportioned. An accurate accounting of the Medicare and non-Medicare blood replacements is essential to a fair and equitable apportionment of reimbursable costs.

The nonreplacement fee is not usually characterized as a cost-recovery fee. Instead, it is intended to be an incentive for patients to arrange for replacement of the blood they use. Nevertheless, when a community blood bank charges a nonreplacement fee on its blood, this charge becomes a cost to hospitals since the hospitals must pay the blood bank for all unreplaced blood. Since in this case the nonreplacement charge equals the hospital's cost, the costs/charges ratio for nonreplacement fees (ignoring hospital overhead allocations to these costs) is 1. Such is not the case, however, for hospital blood banks that charge nonreplacement fees because hospital costs associated with those fees are often less than the charges. Although blood billing and replacement practices that are unfair to Medicare increase Medicare costs, the adverse effect is greater when nonreplacement fees are charged by community blood banks than when they are charged by hospital blood banks.

The hypothetical assumptions described below and in the tables on pages 27 and 28 demonstrate the effect of improper blood billing and replacement practices on Medicare payments. The analysis assumes the following for each situation.

Nonreplacement fee per unit is $25
Patient has full blood coverage
Patient blood deductible has not been met

Situation 1:
Improper replacement practices
Blood bank limits replacement credits to the Medicare deductible.
Hospital submits corrected bill if needed.

Situation 2:
Improper billing practices
Blood bank provides all required replacement credits, but they arrive after the hospital submits the original Medicare bill.
Hospital does not submit corrected bill.

NONREPLACEMENT FEES CHARGED BY COMMUNITY BLOOD BANK

Situation 1: Improper replacement practices
Blood bank limits replacement credits to the Medicare deductible.
Hospital submits corrected bill if needed.

Situation 2: **Improper billing practices**
Blood bank provides all required replacement credits but they arrive after the hospital submits the original Medicare bill.
Hospital does not submit corrected bill.

	Situation 1: 3 units transfused		Situation 1: 10 units transfused		Situation 2: 3 units transfused		Situation 2: 10 units transfused	
	3-unit limit on replacement	No limit on replacement	3-unit limit on replacement	No limit on replacement	**Corrected bills are not submitted**	**Corrected bills are submitted**	**Corrected bills are not submitted**	**Corrected bills are submitted**
A. Nonreplacement fee @ $25/unit	$ 75	$ 75	$250	$250	$ 75	$ 75	**$250**	**$250**
B. Blood replacement credits @ $25/unit	75	75	75	250	a/0	75	**a/0**	**250**
C. Medicare charges on bill submitted	0	0	175	0	75	0	**250**	**0**
D. Medicare costs (costs/charges ratio X C) (note b)	0	0	201.25	0	86.25	0	**287.50**	**0**
E. Less deductible	0	0	0	0	c/75	0	**c/75**	**0**
F. Medicare reimbursable costs	0	0	201.25	0	11.25	0	**212.50**	**0**
Amount of excess (under) payment to hospital from improper practice		$0		$201.25		$11.25		**$212.50**

a/Late replacement credits are not reflected since corrected bills are not submitted.

b/The hospital costs/charges ratios for blood collected by the community blood banks we visited were usually greater than 1.0. This usually occurs because a charge by the community blood bank becomes a cost to the hospital. In addition, the hospital assigns an overhead allocation to this blood for which a charge may not be made. For this analysis, the costs/charges ratio is assumed to be 1.15.

c/When replacement credits are not reflected in Medicare statistics by submitting a corrected bill, Medicare costs are reduced by the amount of the blood deductible (i.e., the nonreplacement fee on the first 3 units).

APPENDIX I

NONREPLACEMENT FEES CHARGED BY HOSPITAL BLOOD BANK

Situation 1: Improper replacement practices
Hospital blood bank limits replacement credits to the Medicare deductible.
Hospital submits corrected bill if needed.

Situation 2: Improper billing practices
Hospital blood bank provides all required replacement credits but they arrive after the hospital submits the original Medicare bill.
Hospital does not submit corrected bill.

	Situation 1: 3 units transfused		Situation 1: 10 units transfused		Situation 2: 3 units transfused		Situation 2: 10 units transfused	
	3-unit limit on replacement	No limit on replacement	3-unit limit on replacement	No limit on replacement	Corrected bills are not submitted over (under)	Corrected bills are submitted	Corrected bills are not submitted	Corrected bills are submitted
A. Nonreplacement fee @ $25/unit	$ 75	$ 75	$250	$250	$ 75	$ 75	$250	$250
B. Blood replacement credits @ $25	75	75	75	250	a/0	75	a/0	250
C. Medicare charges on bill submitted	0	0	175	0	75	0	250	0
D. Medicare costs ($\frac{\text{costs}}{\text{charges}}$ ratio x C)(note b)	0	0	105	0	45	0	150	0
E. Less deductible	0	0	0	0	c/75	0	c/75	0
F. Medicare reimbursable costs	0	0	105	0	d/(30)	0	75	0
Amount of excess (under) payment to hospital from improper practice	$0		$105		($30)		$75	

a/Late replacement credits are not reflected since corrected bills are not submitted.

b/The hospital costs/charges ratios for blood collected by the hospital blood banks we visited were less than 1.0. This generally occurs because the hospitals charge more for blood than the costs they incur to collect, process, and administer the blood. For this analysis, the ratio is assumed to be .60.

c/When replacement credits are not reflected in Medicare statistics by submitting a corrected bill, Medicare costs are reduced by the amount of the blood deductible (i.e., the nonreplacement fee on the first 3 units).

d/A negative figure in this cost center reduces the total costs payable by Medicare.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JAN 19 1979

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Actions Needed to Stop Excess Medicare Payments For Blood and Blood Products." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

APPENDIX II

Comments of the Department of Health, Education, and Welfare on the General Accounting Office Draft Report Entitled, "Actions Needed to Stop Excess Medicare Payments For Blood and Blood Products," B-164031(4), dated October 2, 1978

Overview

In general, GAO has cited problems in reimbursement for blood and blood products which are not unique to Medicare but exist wherever there are third party arrangements to pay for blood. Therefore, the most comprehensive response to the problem would be remedial legislation which permits the Federal Government to directly influence charging and replacement credit practices of blood banks to assure equal treatment of all patients. Pending enactment of such legislation, we have identified some more immediate actions to be taken to address specific problems identified by GAO. These are described below.

GAO Recommendation

That the Secretary direct the Administrator, HCFA, to:

- - Revise Medicare billing instructions to more clearly require that hospitals and blood banks allow Medicare patients the same opportunities as non-Medicare patients to eliminate blood nonreplacement fees and replaceable blood processing and component fees.

Department Comment

We concur.

The Department recognizes the need to clarify and expand existing regulations and implementing policies concerning application of replacement credits. Some manual clarifications have already been made regarding replacement credits as applied toward deductibles. We are also exploring the implications of modifying provider participation agreements to require each provider which receives blood from an outside source to enter into agreement with the blood bank which specifies that the blood bank will abide by Medicare replacement policies. (Such modification would become unneeded if legislation is enacted.) Modification of reasonable cost regulations to recognize costs only after steps have been taken to assure all replacement credits have been given is also being considered.

GAO Recommendation

That the Secretary direct the Administrator, HCFA, to:

- - Revise Medicare instructions to specifically provide that nonreplacement fees, charged on processing-fee-only blood and blood components, are not allowable charges to Medicare.

Department Comment

We concur.

Regulations will be revised to eliminate Medicare recognition of nonreplacement fees for processing-fee-only blood as a reimbursable cost. However, Medicare regulations cannot prevent the provider from charging his customary charge to the beneficiary for blood which is subject to the blood deductible.

GAO Recommendation

That the Secretary direct the Administrator, HCFA, to:

- - Improve corrected billing requirements for late blood credits to more accurately and economically account for Medicare blood replacements.

Department Comment

Current Medicare policy clearly mandates complete accounting for late blood credits. A corrected bill must be submitted whenever such credits exceed prescribed dollar threshold. Late credits which do not require a corrected bill must, nevertheless, be accounted for by the provider on its cost report. We will continue to review corrected billing procedures to determine whether additional improvements can be developed. Even before receipt of the draft GAO report, Medicare had modified its threshold amount to reduce the number of corrected bills which must be submitted. Administrative savings are anticipated as a result of this modification.

GAO Recommendation

That the Secretary direct the Administrator, HCFA, to :

- - Either request the Office of the Inspector General, or require its fiscal intermediaries, to promptly identify hospitals and blood banks that engaged in the blood billing and replacement practices discussed in this report and begin recovery actions for each year where recoveries are allowable under Medicare regulations.

APPENDIX II

Department Comment

In its report, GAO has identified several areas where Medicare regulations and implementing instructions were ambiguous or not specific and, therefore, were subject to different interpretations. Given this GAO finding, it may be difficult to hold hospitals and blood banks accountable for past actions and to make a persuasive legal argument for recovery of overpayments. However, HCFA will issue an instruction to all intermediaries alerting them in the course of the audit process, to examine hospital records to see if program rules are being correctly applied. Where intermediaries identify significant errors in the reimbursement of blood costs and the application of blood credits, they are required to reopen all cost reports subject to review and make the appropriate financial adjustments. We are currently directing our staff efforts in this area toward revising and clarifying regulations and instructions to assure that policies are more uniformly followed in the future.

GAO Recommendation

That the Secretary direct the Administrator, HCFA, to:

- - Require as a condition for reimbursement of blood costs, that hospitals enter into formal agreements or understandings that obligate community blood suppliers to comply with Medicare blood billing and replacement instructions.

Department Comment

We concur.

As indicated in our reply to the first recommendation, we are studying the overall implications of a comprehensive revision of the provider agreement. The GAO recommendation would make the Medicare provider agreement the means for controlling charging and replacement credit practices of blood banks. This would still be an indirect control and would be administratively complex and expensive. Therefore, legislation to clarify responsibilities of blood banks may be a more workable approach.

APPENDIX III

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

DEC 12 1977

Mr. Robert Derzon
Administrator, Health Care
Financing Administration
Department of Health, Education,
and Welfare

Dear Mr. Derzon:

The General Accounting Office is reviewing selected activities of our Nation's blood banking organizations and governmental agencies responsible for those activities. As a part of this review, we are examining the propriety of selected Medicare program inpatient payments for blood and blood products. Although our review is not yet complete, our analysis to date indicates that certain hospitals and blood banks are exercising discriminatory practices in assessing charges to Medicare and non-Medicare patients for blood and blood products. Such practices may not be in accordance with the intent of existing laws and regulations and could involve millions of dollars in unnecessary Medicare program costs. Our findings to date are discussed briefly below and in more detail in the enclosed summary.

BLOOD BANK REPLACEMENT PRACTICES

Three of the six blood banks included in our review to date were charging all patients a nonreplacement fee in addition to processing and blood component fees. These blood banks had blood replacement policies which permitted the cancellation of processing fees. However, at two of the three blood banks the credit policies for blood donations made on behalf of Medicare patients were much more restrictive than the policies in effect for non-Medicare patients.

At this time, we have completed our analysis of one of these two blood banks, which is discussed further in this letter and in the accompanying summary. We found as a result of the different policies being followed by the

APPENDIX III

blood bank that, in relation to the percentage of total blood charges applicable to Medicare patients, a disproportionately low amount of replacement credits were used by the blood bank to offset Medicare blood charges. In this regard, we noted the following:

Blood credit replacements limited to Medicare deductible

Generally, available blood credits were used by the blood bank to cancel nonreplacement fees for non-Medicare patients. However, the blood bank's policy for Medicare patients was to allow no more than three blood replacement credits--the amount of the Medicare blood deductible--to be used to offset nonreplacement fees and to bill the Medicare program for all additional blood fees, regardless of the number of replacement credits available on the Medicare patient's behalf.

Processing fee replacement credits not accepted

The blood bank's replacement policy further provided that all fees, including blood processing fees, were to be canceled if non-Medicare patients replaced two units of blood for each unit used. Conversely, the blood bank did not allow any blood replacement credits to be used to reduce processing fees assessed the Medicare program.

Blood component replacement credits not accepted

The blood bank also had a replacement policy which canceled component fees for non-Medicare patients based on one-for-one replacements, i.e., a donation of one unit of blood canceled the blood component fee for one unit of either fresh frozen plasma, platelets, or cryoprecipitate. However, in the case of Medicare patients, the blood bank did not allow the use of any blood replacement credits to reduce blood component fees charged to the Medicare program.

HOSPITAL REPLACEMENT PRACTICES

In one metropolitan area, we found that although the blood bank we reviewed was not distinguishing between Medicare and non-Medicare patients, several hospitals supplied by that blood bank were discriminating against Medicare blood users.

At least 5 of the more than 70 hospitals supplied by the blood bank charged nonreplacement fees to blood users, but refused to accept more than three replacement credits from the blood bank for Medicare patients to offset such fees. In many cases, these patients had additional blood credits available which could have been used to reduce or eliminate nonreplacement fees charged to the Medicare program. Had these been non-Medicare patients, the nonreplacement fees would have been reduced or eliminated by use of all available blood credits. This differential treatment appears to have resulted in the Medicare program paying these hospitals substantially more for blood than is paid by or for non-Medicare patients.

HEW REPLACEMENT POLICY INQUIRIES

Based on an inquiry by the staff of the Senate Committee on Finance, HEW's Medicare Bureau (formerly the Bureau of Health Insurance), through its intermediaries in Region IX, has begun an investigation of questions raised about the propriety of certain hospitals rejecting available blood credits in excess of three units for Medicare patients. Although this investigation was not complete at the time of our review, our analysis of the results of one major intermediary's actions in this regard indicates that the three-credit limit issue was not satisfactorily addressed by that intermediary.

- - - -

Because of our mutual interest in eliminating unneeded and/or improper health care costs, we would appreciate your comments regarding our observations on questionable practices being followed by certain blood organizations. Specifically, we request your comments on the following matters:

1. Under existing laws and regulations, can hospitals or blood banks legitimately reject replacement credits available for use by Medicare patients to offset (a) blood nonreplacement fees over and above the three-unit Medicare deductible, (b) blood processing fees, or (c) blood component fees?

2. If not, what action can HEW take to recover excess payments made to hospitals or blood banks not accepting such blood credits?

APPENDIX III

3. If so, should HEW regulations governing blood replacement requirements be clarified to ensure compliance with the intent of the Social Security Act, as amended, relative to the requirements that the Medicare program not pay for non-Medicare costs?

4. Should regulations (or legislation) be expanded to include a Medicare policy regarding acceptance of blood replacements to reduce processing or component fees?

We would appreciate your responses to the above questions by January 15, 1978, so that we may take them into consideration as we complete our review and prepare our draft report.

If you have any questions concerning our review or this letter, please call Mr. Matthew Solomon, Assistant Director, Human Resources Division, at 496-2107.

Sincerely yours,

Gregory J. Ahart

Gregory J. Ahart
Director

Enclosure

APPENDIX III

SUMMARY ON BLOOD AND BLOOD PRODUCT REPLACEMENT PRACTICES OF SELECTED BLOOD SERVICE ORGANIZATIONS

BACKGROUND

The Secretary of Health, Education, and Welfare (HEW), under sections 1815 and 1871 of the Social Security Act (hereinafter referred to as the act), as amended, was directed to prescribe regulations for carrying out the administration of the Medicare program and to periodically determine amounts to be paid for services provided to Medicare beneficiaries. Section 1813(a)(2) of the act stipulates that for whole blood or packed red blood cells, Medicare reimbursements are to exclude blood costs 1/ applicable to the first three pints (units) of blood furnished during a defined period of illness. Also, section 1861(v)(1) of the act specifies that the Secretary's regulations were to ensure that costs applicable to Medicare patients were not to be borne by non-Medicare patients, and, conversely, costs applicable to non-Medicare patients were not be be borne by the Medicare program. In addition, these regulations were to provide for retroactive adjustments where aggregate Medicare reimbursements were found to be either inadequate or excessive.

Blood bank and hospital charges for blood and blood products vary substantially in both form and amount. For example, some blood suppliers charge a single fee--referred to as a "processing fee"--which covers the cost of processing a unit of blood. Other blood organizations have a blood "nonreplacement fee," in addition to the processing fee, that is assessed when a patient does not replace the blood he uses. Blood banks will eliminate nonreplacement fees if one or more units of blood are replaced for each unit of blood used.

1/HEW regulations define blood costs as the amounts a provider spends to procure blood including (a) the cost of soliciting and paying donors and drawing blood for its own blood bank and (b) where the provider purchases blood from an outside blood source, the amount of credit which the outside blood source customarily gives the provider if the blood is replaced.

Some blood banks will cancel both the blood nonreplacement and blood processing fees if a patient makes multiple blood replacements. Since patients that comply with a multiple replacement requirement are not charged for the blood they use, the blood bank must recover related processing costs from other sources. As discussed further below (page 3), the Medicare program was the primary reimbursement source for at least one blood bank.

BLOOD BANK AND HOSPITAL REPLACEMENT PRACTICES DISCRIMINATE AGAINST MEDICARE BENEFICIARIES

We have found two blood banks and five hospitals that have blood replacement policies that cause the Medicare program to subsidize non-Medicare blood users. It appears these organizations would not allow more than three blood replacement credits for Medicare patients, although HEW regulations require that providers take into account the total number of units donated on a Medicare beneficiary's behalf in billing the Medicare program for blood non-replacement fees. If Medicare patients were allowed to use all available blood replacement credits to offset replacement fee charges, as was the case with non-Medicare patients, Medicare program blood costs would have been substantially reduced.

Blood bank replacement practices

Three blood banks included in our review charged all patients a nonreplacement fee in addition to processing and blood component fees. The blood banks had replacement policies which permitted the cancellation of nonreplacement fees and fees charged for blood components. One blood bank also permitted the cancellation of processing fees. However, two of the banks had credit policies for blood replacements which distinguished between non-Medicare and Medicare patients. We are presenting below our analysis of one of these two blood banks to demonstrate the potential effect that these different replacement policies can have on the Medicare program.

Blood replacement credits limited to Medicare deductible

Generally, available blood credits were used to cancel the nonreplacement fee for non-Medicare patients. However, the blood bank's policy for Medicare patients was to allow no more than three blood replacement credits for purposes of

APPENDIX III

cancelling nonreplacement fees and to bill the Medicare program (through Medicare-participating hospitals) for all additional blood fees regardless of the number of replacement credits available to the beneficiary. This appears to conflict with HEW replacement requirements that all blood donated on the patient's behalf will be considered in arriving at Medicare program blood charges.

Processing fee replacement credits not accepted

The blood bank also had a blood replacement policy which provided that all fees, including blood processing fees, were to be canceled if non-Medicare patients replace two units of blood for each unit used. Conversely, the blood bank did not allow the use of any blood replacement credits to reduce processing fees assessed to Medicare beneficiaries. This practice resulted in the Medicare program paying for all processing costs attributable to blood used by Medicare patients, and, in addition, processing costs attributable to some non-Medicare patients.

In distinguishing between blood nonreplacement fees and blood processing fees, HEW regulations state as follows:

> "* * * where an outside blood source [blood bank] does not charge any fee for replaced blood, i.e., it charges only for replaced blood, the entire blood fee is considered to be a blood [nonreplacement] cost to the provider [hospital]."

> "Where an outside blood source charges providers more for blood furnished Medicare beneficiaries than for blood furnished nonbeneficiaries, or gives a larger credit for blood replaced by nonbeneficiaries than it gives for blood replaced by beneficiaries, the [Medicare] program will use only the lower charge and higher credit as a basis for determining the provider's reasonable costs for blood furnished by that particular blood source."

> "The portion of a provider's blood charge, which is constant even though the blood is replaced is considered to be the blood processing charge."

Since non-Medicare patients can, by making multiple blood donations, eliminate all blood fees charged by the

APPENDIX III

blood bank, it would appear that the same cost-reducing benefits should be available to Medicare beneficiaries. HEW regulations require that all blood fees assessed by this blood bank be treated as blood nonreplacemnt fees and appropriately reduced to the extent that blood units have been donated on the Medicare patient's behalf.

Blood component replacement credits not accepted

The blood bank also had a replacement policy which canceled blood component fees for non-Medicare patients based on one-for-one replacements, i.e., a donation of one unit of blood canceled the blood component fee for one unit of either fresh frozen plasma, platelets, or cryoprecipitate. However, in the case of Medicare patients, the Medicare program was billed for all blood components used, regardless of the amount of blood replacement credits available on the Medicare patient's behalf. This practice may not be in accordance with that portion of the act which prohibits the medicare program from paying for non-Medicare costs.

The effect of the blood bank's discriminatory practices is indicated by the following table, which includes pertinent data on blood usage and replacements at one hospital supplied by the blood bank during 2 selected months.

APPENDIX III

Medicare charges disproportionately high because of unequal treatment of blood replacement credits

Type of patient	Non-replacement fees	Processing fees	Component fees	Total fees
Medicare				
Gross fees	$6,750	$4,320	$1,084	$12,154
Replacement credits	2,300	0	0	2,300
Net fees	$4,450	$4,320	$1,084	$ 9,854
Net fees/gross fees	66%	100%	100%	81%
Non-Medicare				
Gross fees	$9,750	$6,240	$ 832	$16,822
Replacement credits	6,950	2,368	428	9,746
Net fees	$2,800	$3,862	$ 404	$ 7,076
Net fees/gross fees	29%	62%	49%	42%

Based on the above table, it appears that a substantial portion of the blood bank costs attributable to non-Medicare patients are being improperly borne by the Medicare program. For example, 42 percent ($12,154 divided by $28,976) of the total blood charges are applicable to Medicare patients, but only 19 percent ($2,300 divided by $12,021) of the total blood replacement credits were used to offset Medicare charges. Conversely, 58 percent of the total blood charges are applicable to non-Medicare patients, but 81 percent of the blood replacement credits were used to offset non-Medicare blood charges. Some of this disproportionate crediting of blood donations is undoubtedly due to Medicare patients having (a) a greater difficulty in obtaining replacement donors because of their advanced age and (b) a lesser incentive to replace more than the three units needed to eliminate the Medicare blood deductible. We believe, however, that the predominant reason for the disproportionately low amount of replacement credits being applied to the Medicare program is the blood bank's discriminatory billing practices.

APPENDIX III

Further, since the blood bank also has a policy that earned replacement credits are lost if not used within 12 months, the probability that the Medicare program will ever recoup the benefit of replacement credits that were not used is minimal. The blood bank administrator informed us that, although the blood bank has followed these practices for at least the last 5 years, no one connected with the Medicare program has ever investigated the propriety of the blood bank's charging practices.

Since the fees charged by an outside blood source represent costs to hospitals and, as such, are passed on to the Medicare program, Medicare costs are excessive to the extent that Medicare blood replacement credits are available but not used to offset program blood charges.

We also discussed the blood bank's charging practices with regional HEW officials and were told they were unaware of those specific practices. The officials indicated that, although the blood bank's charging practices appeared to adversely discriminate against the Medicare program, they were unsure whether, under existing regulations, the blood bank could be required to equate future charges between the two types of patients or refund past excessive payments by Medicare.

Since HEW uses intermediaries (insurance companies) to administer the Medicare program, we also discussed this matter with local intermediary officials. They were also unaware of the blood bank's disparate charging practices and stated they had never had occasion to question the propriety of blood charges billed to Medicare. Instead, the intermediary normally accepted and paid for blood charges listed on interim Medicare billing forms submitted by hospitals even though Medicare patients served by the blood bank apparently never received replacement credits for more than three units of donated blood.

Hospital replacement practices

In one metropolitan area, we found that although the blood bank we reviewed was not distinguishing between Medicare and non-Medicare patients, several hospitals supplied by that blood bank were discriminating against Medicare blood users.

We have already found that at least five of the more than 70 hospitals supplied by the blood bank charged non-replacement fees to blood users but refused to accept more

than three replacement credits from the blood bank for Medicare patients to offset those fees. When the supplying blood bank sent Medicare patient blood credits to those hospitals, the hospitals rejected all credits in excess of three units, i.e., those credits in excess of the number the patient needed to meet his Medicare program blood deductible. This practice, which appears to violate HEW regulations by discriminating against Medicare blood users, is illustrated by the following examples.

Hospitals bill Medicare rather than accept blood credits

		Replacement credits			Excess billed to Medicare		
Patient	Units transfused	Authorized by blood bank	Used	Rejected by hospital	Units	Unit charge	Total
A	12	5	3	2	2	$32	$ 64
B	18	20	3	17	15	32	480
C	12	12	3	9	9	30	270
D	6	5	3	2	2	30	60

The following comment, which appeared to be typical of the comments of other hospitals, was made at the time bood credits were rejected (by a hospital) and returned to the blood bank:

> "This is a Medicare account. We are only allowed to accept 3 pints. Medicare pays for the rest."

Had these been non-Medicare patients, the nonreplacement fees would have been reduced or eliminated by the available blood credits. This differential treatment resulted in the Medicare program paying substantially more for blood than did non-Medicare patients.

We discussed this billing practice with officials of one of the five hospitals involved. We were told the reason for the practice was to avoid the additional recordkeeping associated with accounting for a greater number of replacement units than the three units required to be deducted to comply with the Medicare deductibility provision of the act. The hospital officials also informed us that, although this practice does inflate interim Medicare program billings, final Medicare reimbursements are based upon hospital costs, as negotiated,

APPENDIX III

at the end of each accounting year. They stated that, because the hospital does not account for its costs by type of fee, it is not possible to determine the extent of final hospital reimbursement for costs applicable to nonreplacement fees.

Nevertheless, because of the way in which this and other large hospitals estimated the Medicare portion of their total blood costs--that is, the ratio of total blood costs to total blood charges applied to total Medicare blood charges--we estimate that final Medicare blood reimbursements may have been excessive by about 50 percent of the amount by which their interim Medicare blood payments were inflated.

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Based on HEW data on blood utilization by Medicare beneficiaries, we estimate that Medicare paid nearly $19 million in nonreplacement fees in 1976 for blood used by Medicare beneficiaries. However, our review has already disclosed many nonreplacement fees that probably should not have been paid by the Medicare program.

One sample of 40 Medicare patients from 2 hospitals showed that blood replacement credits for 16 Medicare patients were restricted to those necessary to meet Medicare's three unit blood deductible requirement. This occurred even though credits were available to reduce or eliminate the blood nonreplacement, processing, and component fees charged. Had available blood donation credits been used for the 16 patients, a 74 percent reduction (from $5,825 to $1,496) in Medicare program blood costs for those patients would have resulted. Based on our limited review, it would appear that Medicare has paid each year, substantial amounts of money to providers based on billing practices that appear to conflict with the intent of the Medicare law.

HEW INQUIRIES

By letter dated May 10, 1977, the Director of the former Bureau of Health Insurance, Health Care Financing Administration, responded to an inquiry from the staff of the Senate Committee on Finance. According to the letter, a Red Cross official had raised questions about possible abuses by hospitals in California with respect to Medicare reimbursement for blood. One of the questions raised concerned the propriety of certain hospitals' rejecting available blood credits in excess of three units for Medicare patients, preferring instead

to bill Medicare for such blood. The context of the letter indicated to us, however, that the Bureau Director did not direct his response to that issue.

The Bureau has continued to investigate the matter, however, and in August 1977, the region IX medical director advised the committee staff that the region, which includes the State of California:

--had asked each intermediary in the region to review the blood billing and cost accounting practices of a sample of hospitals through on-site reviews;

--will decide, after reviewing the results of the intermediaries' efforts, what further action needs to be taken; and

--will undertake further investigation if it is found that either the Medicare program or its beneficiaries are incurring improper costs as a result of discriminatory blood billing practices.

A region IX official informed us that, as of October 3, 1977, all of the region's intermediaries had completed their reviews of the billing and cost accounting practices of selected providers, but the region had not yet completed its analysis of the results of those reviews. Based on our review of the early results of one intermediary's actions, however, it appears that the issue raised by the Red Cross official, as well as the ones we are addressing, have not been satisfactorily resolved.

APPENDIX IV

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

WASHINGTON, D.C. 20201

FEB 01 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office

Dear Mr. Ahart:

In response to your letter dated December 12, 1977, enclosed are our comments on the questions raised during your review of "Blood and Blood Product Replacement Practices."

If you have any questions concerning our comments please contact Mr. Harold E. Arnold, Director, Division of Finance, phone 245-0602.

Sincerely yours,

Robert A. Derzon
Administrator

Enclosure

Comments
Blood and Blood Product Replacement Practices

1. Under existing laws and regulations, can hospitals or blood banks legitimately reject replacement credits available for use by Medicare patients to offset (a) blood nonreplacement fees over and above the three-unit Medicare deductible, (b) blood processing fees, or (c) blood component fees?

   Comments: As quoted on page 3 of the enclosure to your letter, section 3235.B (under the "NOTE") of Health Insurance Manual-13 (HIM-13) emphasizes that both Medicare and non-Medicare beneficiaries must be treated equally. While this particular section of the manual was inserted regarding deductible blood, the principle clearly applies in any situation regarding blood. Moreover, the Medicare program expects that a provider of services will always act in a prudent and cost-conscious manner in seeking to minimize costs (section 2103 of HIM-15). To refuse to accept replacement blood raises not only the overall cost of blood (because replacement blood must be obtained elsewhere) but also disproportionately increases Medicare's share of the cost of blood where a provider accepts blood replacement from non-Medicare beneficiaries but not from Medicare beneficiaries. Similarly, to reject replacement credits for Medicare beneficiaries where such credits would reduce blood processing costs or blood component fees is neither a consistent nor a prudent and cost-conscious practice on the part of a provider. Accordingly, assuming the situation of medically sound replacement blood, to the extent that a provider acts in an inconsistent or imprudent manner (or pays a blood bank that acts in this manner), excess costs for blood or blood processing may not be recognized as reasonable costs in the determination of Medicare reimbursement.

2. If not, what action can HEW take to recover excess payments made to hospitals or blood banks not accepting such blood credits?

   Comments: The remedy available to recover excess Medicare payments made to providers of services that have acted imprudently or inconsistently (or that have made payments to blood banks that have acted in this manner) is through the reopening of the applicable provider cost reports within the proper 3-year period (no limit where fraud is established) as specified in section 405.1885 of Medicare regulations 42 CFR Part 405.

3. If so, should HEW regulations governing blood replacement requirements be clarified to ensure compliance with the intent of the Social Security Act, as amended, relative to the requirements that the Medicare program not pay for the non-Medicare costs?

4. Should regulations (or legislation) be expanded to include a Medicare policy regarding acceptance of blood replacements to reduce processing or component fees?

Comments: We believe that Medicare instructions clearly mandate a consistent handling of blood for both Medicare and non-Medicare beneficiaries and furthermore that the program will accept nothing less than a prudent and cost-conscious manner from a provider in always attempting to minimize costs. However, we will consider adding some further clarification, perhaps in section 3235 of HIM-13, to emphasize that the principles contained therein apply not only to the application of the blood deductible but, in fact, to any situation where blood is involved. This clarification would extend to the reducing of processing costs or component fees through replacement blood available to Medicare beneficiaries.

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