REPORT TO THE CONGRESS

Ways To Reduce Payments For Physician And X-Ray Services To Nursing-Home Patients Under Medicare And Medicaid

B-164031 (3)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This is our report on ways to reduce payments for physician and X-ray services to nursing-home patients under Medicare and Medicaid These programs are administered at the Federal level by the Social Security Administration (Medicare) and the Social and Rehabilitation Service (Medicaid), Department of Health, Education, and Welfare Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U S C 53), and the Accounting and Auditing Act of 1950 (31 U S C 67)

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

Comptroller General
of the United States

Contents

ABBREVIATIONS

CPS	California Physicians Service
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

WAYS TO REDUCE PAYMENTS FOR PHYSICIAN AND X-RAY SERVICES TO NURSING-HOME PATIENTS UNDER MEDICARE AND MEDICAID

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D I G E S T

WHY THE REVIEW WAS MADE

Medicaid is a grant-in-aid program under which the Federal Government pays from 50 to 83 percent of costs incurred by States in providing medical care to individuals who are unable to pay. Medicare is a Federal program providing hospital and medical insurance to persons aged 65 and over

States having a Medicaid program can purchase the medical insurance benefits of Medicare (covering physician services and a number of other health services) for persons in the Medicaid program who also meet Medicare eligibility requirements

In California, where this review was made, payments under the Medicare and Medicaid programs during fiscal year 1969 amounted to about $1 7 billion, of which $489 million represented payments to physicians and other providers of medical services About $377 million, or 77 percent, of the $489 million was Federal funds

The General Accounting Office (GAO) examined claims made by physicians and other providers of medical services not only because of the large amount of Federal funds involved but also because GAO noted in its reviews of other nursing-home activities that providers of medical services were overpaid for visits made to more than one patient on the same day in the same nursing home

FINDINGS AND CONCLUSIONS

Although a reduced fee was to be paid for visits made on the same day to a number of patients in the same nursing home (multiple-patient visits), physicians and providers of X-ray services billed, and were paid, the higher single-patient visit fee. For example, a physician who visited 29 patients during a single nursing-home call billed, and was paid, as though 29 separate visits were made That resulted in an overpayment to the physician of $142.

GAO estimates that, in California during 1969, overpayments of about $426,400 were made for multiple-patient visits. The Federal share of those overpayments was about $343,500. (See pp. 9 to 21)

The overpayments occurred because

--physicians and providers of X-ray services had not been made aware of the correct way to bill for multiple-patient visits (see p. 12)

--the claims-processing and payment system did not contain adequate controls to identify multiple-patient visits (see p 13), and

--physician payment profiles (histories of past billings used to determine the reasonableness of the physicians' charges) for multiple-patient visits were developed improperly (See p 15)

Department of Health, Education, and Welfare (HEW) regulations did not provide guidelines to the Medicare and Medicaid paying agents on payment policies for multiple-patient visits. For example, in California, Oregon, Nevada, and Washington, 10 different policies existed for making payments for multiple-patient visits under the programs.

The Social Security Administration made a nationwide study on the diversity of payment policies and the feasibility of prescribing uniform guidelines for use under the Medicare program No such study had been made for Medicaid (See pp 22 to 25)

RECOMMENDATIONS OR SUGGESTIONS

The Secretary of Health, Education, and Welfare, should require

--HEW to provide measures for determining compliance with those Medicaid and Medicare payment policies that currently require paying reduced fees for multiple-patient visits and to take corrective action where warranted (see p 20),

--HEW to make a study similar to the one on Medicare to determine the diversity of payment policies under the Medicaid program for physicians' multiple-patient visits and to ensure that guidelines for Medicaid and Medicare are coordinated, and

--the Administrator of the Social and Rehabilitation Service and the Commissioner of the Social Security Administration to provide ways to measure the implementation of HEW guidelines developed as a result of the studies and to obtain corrective action where warranted (See p 24)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW has informed GAO that it is developing instructions to all Medicare carriers containing uniform guidelines for national application to assist in identifying multiple-patient nursing-home visits and in

ensuring proper reimbursement for such services Under the instructions, all Medicare paying agents (carriers) will be required to pay reduced fees for multiple-patient visits.

HEW has informed GAO that the Social Security Administration will verify that such a policy has been established by the carriers and that it is being effectively implemented Compliance with policies that have been established by the States under the Medicaid program will be determined by regional offices of the Social and Rehabilitation Service. (See pp 20 and 21.)

HEW has stated that the Social and Rehabilitation Service will study the diversity of existing payment policies under Medicaid preparatory to the issuance of national guidelines The Medicaid study will be coordinated with the parallel study in the Medicare area, and the issuance of guidelines will be coordinated with those for Medicare

HEW's monitoring of the Medicare program will include the placement of systems technicians in each Social Security Administration regional office to assist HEW representatives assigned to the larger Medicare carriers and other regional office staff in continuing evaluation of carriers' claims and data processing systems.

HEW said that primary responsibility for reviewing State Medicaid programs had recently been delegated from the HEW central office to HEW regional offices HEW expects that, as a result, State Medicaid activities will be monitored more frequently and more thoroughly than in the past and that corrective action will be initiated promptly. (See pp. 24 and 25)

GAO believes that administrative actions taken or promised by HEW should, if implemented effectively, tend to bring about uniform policies for the payment of reduced fees for multiple-patient visits and appropriate monitoring and appraisal of compliance by the carriers, the States, or their fiscal agents

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report is being issued to the Congress because of expressed congressional concern over the rising costs under the Medicaid and Medicare programs and the significant amounts of Federal funds expended under the programs

CHAPTER 1

INTRODUCTION

The General Accounting Office (GAO) has reviewed the procedures and practices of HEW and agencies of the State of California covering payments to physicians and other providers of medical services to patients in nursing homes in California under titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act (42 U.S.C. 1395 and 1396). Our review did not include payments made on behalf of individuals who were covered only under Medicare (see p. 8 for discussion of Medicare benefits available to Medicaid eligibles).

The Medicare program--enacted in July 1965--provides two forms of health care insurance to persons aged 65 and over. One form, designated as Hospital Insurance Benefits for the Aged (part A), primarily covers inpatient hospital services and is financed principally by a special social security tax paid by employees and their employers and by self-employed persons.

The second form of protection is a voluntary program, designated as the Supplementary Medical Insurance Benefits for the Aged (part B), which covers physician services and a number of other medical and health benefits. Part B is financed by a monthly premium collected from each beneficiary who elects to be covered under this part of the program. From April 1968 through June 1970, the monthly premium was $4.00. Effective July 1, 1970, the monthly premium increased to $5.30. This amount is matched by an equal amount by the Federal Government. The beneficiary pays the first $50 of covered services in each year, and part B of Medicare pays 80 percent of the reasonable charges for covered services in excess of $50.

The Medicaid program--also enacted in July 1965--is a grant-in-aid program under which the Federal Government pays from 50 to 83 percent--depending upon the per capita income in each State--of the costs incurred by the States in providing medical assistance to individuals who are unable to pay for such care. As of December 1970, 48 States, the

District of Columbia, Guam, Puerto Rico, and the Virgin Islands had adopted a Medicaid program. Since its inception, State Medicaid programs have been required to provide inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing-home services, and physician services. Other services, such as prescribed drugs and dental care, may be provided for in a State's Medicaid program if it so chooses.

Our review was undertaken in California because of the large expenditures made to physicians and other providers of medical services to nursing-home patients. During calendar year 1969, total payments for care for these patients under the Medicare and Medicaid programs in California amounted to about $1.7 billion. Of this amount, about $488.5 million represented payments to physicians and other providers of medical services; about 77 percent, or $376.5 million, represented Federal funds. Data is not available to show a breakdown of the expenditures for physician services among patients in nursing homes, hospitals, or elsewhere.

The scope of our review is described in chapter 4.

ADMINISTRATION OF MEDICARE AND MEDICAID PROGRAMS

The Medicare and Medicaid programs are administered at the Federal level by the Department of Health, Education, and Welfare. At the time of our fieldwork, the HEW regional office in San Francisco, California--one of 10 regional offices administering the field activities of the Medicare and Medicaid programs--provided general administrative direction for these programs in Alaska, Arizona, California, Guam, Hawaii, Nevada, Oregon, and Washington.

The HEW Audit Agency is responsible for departmental audit activities including audits of State Medicaid programs and audits of costs of administering the Medicare and

Medicaid programs by fiscal intermediaries, carriers,[1] and State agencies. The Audit Agency has made--and is continuing to make--reviews of Medicare and Medicaid activities. Although the HEW Audit Agency and State auditors have reviewed various aspects of the Medicare and/or Medicaid programs in California, they have not reported on the matters covered in chapters 2 or 3 of this report.

Medicare program

The Secretary of Health, Education, and Welfare has delegated responsibility for administering the Medicare program to the Commissioner of the Social Security Administration. Field activities of the Medicare program are carried out by regional representatives of the Administration's Bureau of Health Insurance.

To administer the benefits under part B, the Secretary of Health, Education, and Welfare is authorized under the act to enter into contracts with carriers who (1) determine the rates and amounts of payments for physician services on a reasonable-charge basis and (2) receive, disburse, and account for funds expended in making such payments. Also, to the extent possible, the Secretary is to enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance by the Social Security Administration.

The Administration has certain systems to provide surveillance over the carriers' activities. In addition to the HEW Audit Agency's activities, Social Security Administration contract-performance review teams make periodic onsite visits to observe and analyze the carriers' claims-processing procedures and the application of the reasonable-charge criteria.

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[1]Fiscal intermediaries and carriers are private organizations (generally insurance companies) under contract with HEW to process and pay claims for services provided under the Medicare program.

Medicaid program

The Secretary of Health, Education, and Welfare has delegated the responsibility for the administration of the Medicaid program to the Administrator of the Social and Rehabilitation Service. Authority to approve grants for State Medicaid programs has been further delegated to Regional Commissioners of the Service who are responsible for the field activities of the program.

Under the act, the States have the primary responsibility for initiating and administering their Medicaid programs. The nature and scope of a State's Medicaid program is contained in a State plan which, after approval by a Regional Commissioner, provides the basis for Federal grants to the State. The Regional Commissioners are also responsible for determining whether the State programs are being administered in accordance with existing Federal requirements and the provisions of the States' approved plans. HEW's Handbook of Public Assistance Administration provides the States with Federal policy and instructions on the administration of the several public assistance programs. Supplement D of the handbook and the Service's program regulations prescribe the policies, requirements, interpretations, and instructions relating to the Medicaid program.

The Medicaid program in California became effective March 1, 1966, and is known as Medi-Cal. In California the Department of Health Care Services administers the program. The department is responsible for making State policy determinations, establishing fiscal and management controls, and reviewing Medi-Cal program activities.

Since the inception of the Medi-Cal program, the State has contracted with private organizations, such as the California Physicians Service, the Hospital Service of California, and the Hospital Service of Southern California, to assist the Department of Health Care Services in its administration of the program. These private organizations--acting as fiscal agents--coordinate the program operations between the State and the institutions or persons that provide medical services. In addition, the fiscal agents review, process, and pay providers' claims for services rendered to Medi-Cal beneficiaries.

Persons eligible for Medicaid

Persons receiving public assistance payments under other titles of the Social Security Act[1] are entitled to benefits under the Medicaid program. Persons whose income or other financial resources exceed standards set by the States to qualify for public assistance, but are not sufficient to meet the costs of necessary medical care, may also be entitled to benefits under the Medicaid program at the option of the State.

Supplementary insurance benefits for eligible persons

States having a Medicaid program can enter into a buy-in agreement with HEW to obtain the supplementary insurance benefits under part B of the Medicare program for those persons eligible for both Medicaid and Medicare. The State is responsible for paying the monthly premium, the annual $50 deductible, and 20 percent of the cost of services covered under part B. The remaining 80 percent of the cost of services is paid by the Medicare program. As of January 1970, California had over 371,000 persons enrolled under the Medicaid program for supplementary insurance benefits provided under part B of the Medicare program.

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A listing of principal HEW officials responsible for the administration of activities discussed in this report is included as appendix IV.

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[1]Title I, old-age assistance; title IV, aid to families with dependent children, title X, aid to the blind; title XIV, aid to the permanently and totally disabled; and title XVI, optional combined plan for other titles.

CHAPTER 2

NEED FOR IMPROVED CONTROLS OVER PAYMENTS FOR PHYSICIAN AND PORTABLE X-RAY SERVICES PROVIDED NURSING-HOME PATIENTS

At the inception of the Medicare and Medi-Cal programs in California, the Social Security Administration and the Department of Health Care Services contracted with California Physicians Services (CPS) to assist in administering these programs. CPS was given the authority and responsibility to establish policies for payment of medical, dental, and drug claims. CPS--as a carrier for Medicare and as a fiscal agent for Medi-Cal--also reviewed, processed, and paid claims for services provided by physicians and other medical providers for most of the State.[1]

CPS's payment policy requires that amounts paid to physicians be reduced when visits are made on the same day to patients in the same nursing home (multiple-patient visits). CPS's payment policy also allows only one portable X-ray equipment setup fee, although several patients might be X-rayed during the same nursing-home visit. Although these policies were put into effect in early 1968, multiple visits by physicians and X-ray setup fees were billed and paid on the basis of single visits or separate services. For these medical services, we estimate that about $426,000 in overpayments--of which about $260,000 were Medicare and about $166,000 were Medicaid funds--were made by CPS during calendar year 1969.

The overpayments occurred because

--physicians and providers of X-ray services had not been advised by CPS as to the correct way to bill for multiple-patient visits,

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[1]Medicare claims for Los Angeles and Orange Counties were paid by Occidental Life Insurance Company of California.

--the claims-processing and payment system did not contain adequate controls to identify multiple-patient visit claims, and

--physician payment profiles (a history of past billings to determine the reasonableness of the physician's charges) for multiple-patient visits were improperly developed

From an examination of claims paid by CPS during February 1969 under three medical procedure codes used by providers in billing for multiple-patient services, we estimated the amount of overpayments made during February and, on the basis of this estimate, projected the amount of overpayments made during the entire year, as shown in the following table

Basis for overpayment	Estimated February overpayment	Estimated overpayment for 1969	Estimated Federal share of overpayment
Multiple-patient visits paid as routine single-patient visit	$27,300	$327,600	$256,000
Payment for additional patients seen during routine visit based on defective profiles	6,370	70,000[a]	63,000
Multiple-patient portable X-ray unit setup paid as single-patient setup	2,400	28,800	24,500
Total	$36,070	$426,400	$343,500

[a]These overpayments were projected for 11 months only, because in December 1969, as a result of our work, CPS took corrective action which resulted in reducing physician fees on those claims identified as multiple-patient visits

Because of the manner in which CPS maintained and filed its claims data, it was not practicable for us to obtain and analyze a sample from all claims paid during 1969. We selected the month of February for examination because, on the basis of monthly claim volume (number and amount) and discussions with CPS officials, this month appeared to be representative of monthly transactions during 1969. Since the claims-processing procedures did not change during the year, annual overpayments of about $426,400 could have occurred. We believe that our estimate of overpayments for the entire year--on the basis of tests of February claims--is reasonable

The details of the findings and weaknesses noted are presented below

PAYMENTS TO PHYSICIANS FOR PATIENT VISITS

Procedures established by CPS to implement the policy that amounts paid to physicians be reduced for multiple visits on the same day to patients in the same nursing home require the physician making multiple-patient visits to identify in his billings the first patient seen by use of procedure code 9014 (single-patient visit) and other patients by use of procedure code 9018 (multiple-patient visit)

Our examination of records at 10 nursing homes in Alameda, Fresno, Los Angeles, and Santa Clara Counties, showed that physicians were generally visiting their patients once a month and that more than one patient was being seen by the physician during each nursing-home visit.

Our review of the payment records at CPS for those physicians identified as having seen more than one patient during their visit showed that many claims were billed and paid as though single-patient visits had been made The following table illustrates the overpayments made to one physician as a result of his having used the single-visit procedure code in billing for multiple-patient visits

Date of service	Number of patients visited during a single nursing-home call	Total amount paid	Total amount that should have been paid	Over-payment
Jan. 7, 1969	29	$ 342	$ 200	$142
Feb 3, 1969	44	504[a]	318	186[a]
Mar. 10, 1969	26	286	198	88
Apr 2, 1969	44	502[a]	374	128[a]
Total	143	$1,634	$1,090	$544

[a]The difference in amounts paid and estimated overpayments for the same number of patients visited on February 3 and April 2, 1969, resulted from a different combination of Medicare and Medi-Cal patients visited on these dates.

To ascertain the extent of the overpayments resulting from improperly billed multiple-patient visits, we analyzed a sample of claims paid by CPS during February 1969 We found that about 60 percent of the single-patient visit claims should have been identified by the physician and paid by CPS under the multiple-patient visit code (see app. I for sample results) Using CPS's Medi-Cal and Medicare criteria for claiming payment for multiple-patient visits, we estimated that the February claims paid under the single-patient visit code were overpaid by about $27,300 On a yearly basis this would be about $327,600

We contacted several physicians who had used the single-patient visit code in lieu of the multiple-patient visit code in their billings to CPS for payment. These physicians informed us that they had not received written instructions from either CPS or their local medical societies on how to bill for nursing-home visits and that they were not aware of CPS's policy of paying reduced fees for multiple-patient visits.

CPS officials confirmed that written billing instructions had not been issued to physicians They stated that the correct billing procedure is explained in the California

Medical Association's Relative Value Studies[1] which they assumed would be used by physicians in preparing their claims. CPS officials told us that special lectures on this matter had been presented to county medical societies. We were also told that the county medical societies had a CPS payment policy manual and physicians could call their local societies for information on a particular billing procedure. CPS officials explained that, although it was not a general practice to provide physicians with special billing guidelines, they acknowledged that nursing-home services possibly required the issuance of such guidelines.

Our review showed that CPS has no prepayment procedures to identify claims for multiple-patient visits. CPS acknowledged that it was possible for improperly billed claims to be processed and paid unless claims examiners compared each single-patient visit claim with all other claims for services rendered on the same day and at the same location. Neither HEW nor the State had evaluated the adequacy of CPS's claims-processing system to ensure that the policy of paying reduced fees was being followed.

Our review showed also that improperly paid claims could not be easily detected or identified after payment. The basis for CPS' postpayment reviews are patient and provider payment records. Neither of these records show the place where the service was performed. We were told by CPS officials that, to determine if a paid claim was for a multiple-patient visit, the place of service had to be manually researched from the billing document and then compared with a microfilm copy of other claims with the same date of service. Even after going through this time-consuming process, there is no assurance that improperly paid claims will be detected, because paid claims frequently do not show the place of service.

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[1]The Relative Value Studies is a catalogue-type index which assigns procedure numbers to particular medical services as well as a relative-value number indicating the degree of skill and time required in providing such services.

CPS officials agreed that, if the place of service were shown on the provider payment record, an effective postpayment review of multiple-patient services could be made. CPS has taken steps to ensure that (1) the place where a service is rendered is recorded on both the Medicare and Medi-Cal claim before payment is made and (2) guidelines explaining the correct way to bill for nursing home visits would be furnished to physicians.

PHYSICIAN PAYMENT PROFILES
INCORRECTLY DEVELOPED

As a Medicare carrier, CPS is responsible for determining whether the rates and amounts of payments to physicians and other medical providers under part B of Medicare are reasonable. CPS's procedures for processing part B claims provide for an evaluation for reasonableness on the basis of the customary charge made by the physician for his services as well as on the basis of the prevailing charges in the locality for similar services. We estimated, however, that overpayments of about $70,000 had been made during 1969 because CPS erroneously used single-patient visit charges to develop the reasonable-payment level for multiple-patient visit charges.

At CPS the customary and the prevailing charges for particular medical procedures have been developed and are maintained in a computerized system The computer-stored history of past billings for each physician is called a provider payment profile If the amount billed does not exceed (1) the provider's customary charge or (2) the prevailing charge in the locality, then the claim is paid without being reduced. If the charge exceeds the customary or prevailing charges, the computer will reduce the amount to be paid to the customary or prevailing charge, whichever is lower

The following examples illustrate how the general criteria on customary and prevailing charges are to be applied in reviewing claims and in making payments under part B of the Medicare program Assume that the prevailing charge for a specific medical procedure is $10 in a certain locality and that Doctor A customarily charges $8 for this procedure and that Doctor B customarily charges $12 50

1 If Doctor A's bill is $7 50, the reasonable charge would be limited to $7.50, since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and the prevailing charge for the locality

2 If Doctor A's bill is $8.50, the reasonable charge would be limited to $8 because that is his customary charge Even though his actual charge of $8 50 is less than the prevailing charge, the reasonable charge cannot exceed his customary charge

3 If Doctor A's bill is $8, the reasonable charge would be $8 because it is his customary charge and it does not exceed the prevailing charge for that locality

4 Doctor B's customary charge is $12 50 and he bills $12 50 The reasonable charge for Doctor B could not be more than $10, the prevailing charge in the area

In December 1968 the Secretary of Health, Education, and Welfare considered the adequacy of the premium of $4 for part B of the Medicare program This premium was continued in effect for the period July 1, 1969, to June 30, 1970, on the assumption that the level of reimbursement for physicians' fees would remain approximately at the December 1968 level To ensure this, HEW instructed Medicare carriers not to update a physician's profile beyond his established profile in effect during December 1968, except in very unusual situations Therefore, profile payment data used by CPS to evaluate the reasonableness of 1969 Medicare part B claims was compiled from claims submitted before 1969.

Prior to December 1968, CPS instructed its claim examiners to change single-patient visit procedure code 9014 to the multiple-patient visit procedure code 9018 whenever evidence indicated that a physician had seen more than one patient during the same visit even though the amount shown on the claim--based on code 9014--was greater than the physician's customary charge for a multiple-patient visit--based on code 9018 In these instances, however, the claim examiners were directed not to reduce the amount charged by the physician CPS did not return such claims to the physicians requesting that they correct the charges. CPS explained that the dollar amount was not changed because it was expected that, through the use of the computer, the

amounts to be paid would be reduced. Under the computer system, however, the physicians' profiles were established and updated on the basis of amounts billed rather than on the basis of amounts paid, the effect of which caused the physicians' multiple-patient visit profiles to be based on single-patient visit fees rather than multiple-patient visit fees. Since single-patient visits were generally billed and paid for at a higher amount than multiple-patient visits and because some physicians billed the higher amount for single-patient as well as multiple-patient visits, the input of such billing data into the computer system increased the maximum amount at which claims for the multiple-patient visits were paid.

In commenting on this matter (see app. II, p. 34), HEW agreed that the use of erroneous charges distorted the carriers charge data for multiple-patient visits. They pointed out, however, that the higher fees would not be erroneous in those instance where physicians had intended to increase their charges for multiple-patient visits or had decided to charge the same fee for multiple-patient visits as for single-patient visits.

In all instances which we examined, physicians had customarily charged less for multiple-patient visits than they had charged for single-patient visits. We doubt that a physician wishing to raise his charge for a multiple-patient visit would do so by billing his new charge to a single-patient visit code with the expectation that a claims examiner would change the code to a multiple-patient visit.

We discussed this matter with CPS officials, and in December 1969--after CPS had determined that multiple-patient visit profiles contained the same payment levels as the single-patient visit profiles--CPS acted to stop the overpayments. Until a new multiple-patient visit profile could be correctly established, CPS replaced the multiple-patient visit profiles with the profile data charges for routine office visits which CPS believed more nearly reflected the fees that should be paid for multiple-patient visits.

CPS officials informed us that the input of incorrect charges into physicians' multiple-patient visit profiles would no longer happen because claims changed manually were being coded so that the amount billed did not enter the profiles.

PAYMENT FOR PORTABLE X-RAY SERVICES

In accordance with CPS policy, payments for portable X-ray services[1] are limited to one equipment setup fee, although several patients might be X-rayed during the same nursing-home visit. We estimated, however, that overpayments of about $28,800 had been made during calendar year 1969 because CPS's claims-processing system was not adequate for detecting instances in which setup fees were charged for each patient X-rayed during multiple-patient visits. We were told by CPS officials that the setup fee payment policy had never been communicated to providers of X-ray services.

Claims-processing procedures applicable to portable X-ray services are similar to those for processing physician claims (see p. 13), that is, CPS has no effective means for routinely identifying--either prior to or after payment--X-ray claims which relate to multiple-patient visits CPS can detect multiple-equipment setup fees prior to payment only if all claims from a provider are received at CPS at the same time and are reviewed by the same claims examiner.

Our review of a random sample of 100 X-ray claims paid by CPS in February 1969 indicated that overpayments of about $2,400 were made We estimate that, on an annual basis, the overpayments would be about $28,800. An example of an overpayment follows

> Over a 10-month period, a provider submitted 57 separate claims showing charges of $24 for equipment setup and $15 for the patients' X-ray. He was paid $39 for each claim submitted--a total of $2,223. We found that charges for 35 of these setups represented setups for patients X-rayed on the same date at the same nursing home. Our analysis showed that this provider had been overpaid $840

In June 1970, we were informed by CPS officials that they had submitted a proposal to the Department of Health

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[1]Under Medi-Cal, X-ray services are payable only to physicians.

Care Services to install a new claims-processing system which would give CPS the capability to identify providers of portable X-ray services who were billing for multiple-equipment setup charges.

CONCLUSIONS

The cost of physician and other related provider services represents a significant portion of all Federal and State expenditures for the Medicaid and Medicare programs in California Therefore, weaknesses in the procedures for paying providers for services rendered to patients under these programs can result in substantial amounts of Federal, State, and local funds--which could be used for other worthy purposes under these programs--being spent unnecessarily.

The overpayments for 1969, which we estimated to be about $426,400, occurred because (1) physicians and providers of X-ray services had not been advised by CPS as to the correct way to bill for multiple-patient visits, (2) CPS's processing and payment system was not adequate to routinely identify multiple-patient visit claims, and (3) the Medicare physician payment profiles for multiple-patient visits were improperly developed from single-patient visit charges. Because of the manner in which CPS maintained and filed its claims data, it was not practicable to identify individual cases involving overpayments. For this reason we did not ask CPS to attempt to identify instances of overpayment and to seek recovery.

CPS has taken action to (1) instruct physicians as to the correct way to bill for nursing-home visits, (2) assure that only correct-charge data are included in physicians multiple-patient visit profiles, and (3) develop a claims-processing system capable of allowing identification of multiple equipment setup charges. These actions will, in all likelihood, reduce the incidence of future overpayments, however, the weaknesses which we noted can be partly attributed to HEW because it has not evaluated the adequacy of CPS's claims-processing system to ensure that the policy of paying reduced fees is being effectively followed

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

In those instances in which the States, their agents, or Medicare carriers have policies for paying reduced fees for multiple-patient visits, we recommend that HEW, in its program for monitoring Medicaid and Medicare activities, provide measures for determining compliance with such payment policies and take corrective action where warranted.

AGENCY COMMENTS AND ACTIONS

By letter dated December 11, 1970, the Assistant Secretary, Comptroller, HEW, furnished us with HEW and the California Department of Health Care Services comments on our findings and recommendations (See apps. II and III.)

HEW informed us that it concurred with our recommendation and was developing instructions to all Medicare carriers containing uniform guidelines for national application to assist in identifying multiple-patient nursing-home visits and in ensuring proper reimbursement for such services. Under these instructions, which will be issued shortly, it will be mandatory for all Medicare carriers to have a policy that provides for paying reduced fees for multiple-patient visits HEW also informed us that it would provide for appropriate monitoring and appraisal by the Social Security Administration to verify that such a policy had been established, that it was being effectively implemented, and that it conformed to national guidelines.

HEW informed us that compliance with policies established under the Medicaid program by the States would be determined by regional offices of the Social and Rehabilitation Service. HEW pointed out that primary responsibility for reviewing State Medicaid programs had recently been given to the Service's regional offices in order to facilitate monitoring activities and to promote faster corrective actions HEW stated that the scope of its new monitoring program required a closer relationship with State agencies and more frequent visits and reviews of State operations.

The California Department of Health Care Services advised HEW that it had issued instructions which should

effectively cope with the problem of payments to physicians for multiple-patient visits under the Medicaid program. The State expressed the view that, because the controls in the Medicare and Medicaid programs were inherently different, they became virtually ineffective when blended together with joint Medicare/Medicaid coverage. The State urged that action be taken at the Federal level to permit uniform policies and procedures for beneficiaries covered under both of these programs.

CHAPTER 3

PAYMENT POLICIES FOLLOWED IN OTHER STATES FOR MULTIPLE-PATIENT NURSING-HOME VISITS

We asked HEW officials about the payment policies applicable to physicians' claims for multiple-patient visits followed by other fiscal agents and carriers within HEW Region IX. These officials informed us that, in California, Oregon, Nevada, and Washington, there were 10 different policies for the payment of such claims. Each policy and its applicability to the Medicare and/or Medicaid programs within each of the four States is discussed below.

State	Paying agent	Description of policy	Medical program to which policy applies
California (Northern California) (note a)	CPS	Reimbursement is made at the rate for a home visit for the first patient and at a reduced rate for each additional patient seen during the same visit	Medicare/Medicaid
California (Southern California)	Occidental Life Insurance Company of California	Reimbursement is made at the same rate for each patient seen during multiple visits	Medicare
Nevada	Blue Shield	Reimbursement is made at the rate for a home visit for the first patient and at the rate for an office visit for additional patients seen	Medicaid
Nevada and Oregon	Aetna Insurance Company	If three or more patients are seen during the same visit, physicians are reimbursed at a reduced rate for each patient seen	Medicare
Oregon	State	Fee schedules are used The same fee is paid for all routine nursing home visits and no reduction is made for multiple visits	Medicaid
Washington	State and Blue Shield	Washington Physicians Service (Blue Shield) consists of 20 bureaus that follow the various policies listed below	Medicare/Medicaid
		Method 1 (11 bureaus) Reimbursement is made at the rate for an initial office visit for the first patient seen All others are treated as follow up office visits	
		Method 2 (five bureaus) Reimbursement is made at the single-visit rate for each patient	
		Method 3 (two bureaus) Reimbursement is made at one half of the single-visit rate for each additional patient during the same visit	
		Method 4 (one bureau) Reimbursement is made at the rate allowed for subsequent hospital calls	
		Method 5 (one bureau) Method 1 is used for so-called extended-care facility or nursing-home doctors, and method 2 is used for doctors making occasional visits	

[a]CPS processes and pays Medicaid claims for the entire State

HEW officials were of the opinion that the same degree of divergence existed nationwide as existed in their region.

Existing Medicare and Medicaid regulations do not provide any specific criteria or guidelines which can be followed uniformly by States' fiscal agents and carriers in establishing payment policies for multiple-patient visits. As shown above, HEW's allowing these States and paying agents to establish their own policies has resulted in higher payments of multiple-patients visits in some areas than in others.

HEW officials have told us that they do not generally issue specific payment guidelines because of the various ways in which medicine is practiced throughout the country and the effect that such guidelines would have on the practice of medicine. HEW officials stated, however, that the circumstances relating to medical services provided nursing home patients might require that special gudielines be issued.

HEW officials told us that they were looking into the need for establishing specific reimbursement guidelines under Medicare for physicians visits and had completed a study to determine (1) the diversity of policies that were used by carriers throughout the nation and (2) the feasibility of issuing uniform guidelines for national application in identifying multiple-patient nursing-home visits and proper payment for such services. Conversely, no such study had been made for Medicaid.

CONCLUSIONS

We believe that the concept of paying a reduced fee for multiple-patient visits at a nursing home is sound and that it can be applied on a nationwide basis.

HEW should study the payment policies of the 52 States and jurisdictions that have Medicaid programs to determine whether there is a need for HEW to issue specific guidelines to States regarding payment for physicians' nursing-home visits under Medicaid. HEW should also coordinate the issuance of such guidelines with appropriate Medicare and

Medicaid officials within HEW to ensure that payment policies established under these programs do not conflict with each other.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that HEW make a study similar to the one completed under the Medicare program to determine the diversity of payment policies under the Medicaid program for physicians' visits and to ensure that guidelines for Medicaid and Medicare are coordinated.

We recommend also that the Administrator, Social and Rehabilitation Service, and the Commissioner, Social Security Administration, provide, in HEW's program for monitoring Medicaid and Medicare activities, ways to measure the implementation of HEW guidelines developed as a result of the studies and obtain corrective action where warranted.

AGENCY COMMENTS AND ACTIONS

In commenting on the above recommendations (see app. II), HEW stated that the Social and Rehabilitation Service would initiate a study of the diversity of existing payment policies under Medicaid with a view toward the issuance of national guidelines, that the study would be coordinated with the parallel study in the Medicare area, and likewise that the issuance of guidelines would be coordinated between the Medicare and Medicaid programs.

In connection with its monitoring activities, HEW expressed the opinion that, in view of the actions already taken by the Social Security Administration and the Social and Rehabilitation Service, these agencies had effective surveillance systems which could and would be used to assure compliance with guidelines governing payments for multiple visits.

HEW outlined the methods that it had taken and those that it intended to employ in monitoring the Medicare program, including the placement of systems technicians in each Social Security Administration (Bureau of Health Insurance) regional office to assist HEW representatives assigned to

the larger Medicare carriers and other regional office staffs in evaluating, on an ongoing basis, carriers' claims and data processing systems.

As previously noted (see p. 20), HEW also informed us that the responsibility for reviewing State Medicaid programs was recently redelegated from the HEW central office to Social and Rehabilitation Service regional offices and, as a result, HEW expected that State Medicaid activities would be monitored more frequently and more thoroughly than in the past and that corrective action would be initiated promptly.

We believe that the administrative actions taken or promised by HEW should, if effectively implemented, tend to bring about uniform policies for the payment of reduced fees for multiple-patient visits and appropriate monitoring and appraisal of compliance with such policies by the carriers, the States, or their fiscal agents.

CHAPTER 4

SCOPE OF REVIEW

Our review of payments to physicians and certain other providers visiting patients in nursing homes under the Medicare and Medicaid programs in California was directed toward evaluating the controls established by HEW, the State, and CPS in making payment for medical services. Our review consisted principally of examining into such controls in connection with the policies and practices followed by CPS in making payment for medical services provided nursing-home patients We reviewed the enabling legislation and examined procedures, records, and documents relating to the Medicare and Medi-Cal programs

Our work, including discussions with officials responsible for the various levels of administration of the programs, was done at HEW headquarters in Washington, D.C., and Baltimore, Maryland, HEW's regional office in San Francisco, California, State headquarters of the Department of Health Care Services in Sacramento, California, and CPS in San Francisco

Also, we visited 10 nursing homes located in Alameda, Fresno, Los Angeles, and Santa Clara Counties These counties were selected because they account for a significant portion of Medicaid expenditures Factors which we considered in selecting the nursing homes were their bed capacity and the number of Medicaid patients served We also reviewed records at each nursing home visited For the most part, the case files of Medicaid patients were selected from among those who were residing in the home at the time of our visit and covered transactions during calendar years 1968 and 1969

APPENDIXES

NUMBER AND AMOUNT OF OVERPAYMENTS DURING FEBRUARY 1969 FOR SINGLE-PATIENT VISITS AND PORTABLE X-RAY CLAIMS (note a)

	Single-patient visit claims (procedure code 9014)	Portable X-ray claims (procedure code 7477)
NUMBER OF CLAIMS PAID	14,716	781
NUMBER OF CLAIMS OVERPAID:		
Estimate	8,958	109
Sampling error	1,198	50
AMOUNT OF OVERPAYMENTS:		
Estimate	$27,326	$2,413
Sampling error	$5,672	$1,135

[a]GAO's estimates were developed from random samples of claims paid under these procedure codes during February 1969. The number of sample claims were as follows: procedure code 9014--138 claims--and procedure code 7477--100 claims. Sampling errors are stated at the 95-percent confidence level. Thus, there is only a 1 in 20 chance that the estimates derived from the sample would differ by more than the amount shown from an examination of all claims.

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

DEC 11 1970

Mr. John D. Heller
Assistant Director, Civil Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Heller:

The Secretary has asked me to respond to the draft report on GAO's review of Overpayments By The Medicare and Medicaid Programs For Physician and X-ray Services Provided To Patients In Nursing Homes In California. Enclosed are the Department's comments on the findings and recommendations in your report. We have also enclosed a copy of comments submitted by the Department of Health Care Services, State of California.

We appreciate this opportunity to comment prior to issuance of the final report. We also appreciate your continuing interest in helping us improve Medicare and Medicaid administration.

Sincerely yours,

for James B. Cardwell
Assistant Secretary, Comptroller

Enclosures

OVERPAYMENTS BY THE MEDICARE
AND MEDICAID PROGRAMS FOR PHYSICIAN
AND X-RAY SERVICES PROVIDED TO
PATIENTS IN NURSING HOMES IN CALIFORNIA
(GAO Draft Report Transmitted June 22, 1970)

The draft audit report presents a factual picture of overpayments by the California Physicians Service (CPS) under both the Medicare and Medicaid programs for physician and x-ray services provided to patients in nursing homes. It is generally consistent with findings of the Social Security Administration (SSA) and the Social and Rehabilitation Service (SRS) on these points.

Comments submitted by the Department of Health Care Services, State of California indicate that the State has issued instructions to CPS, in its capacity as Medicaid fiscal agent, to cope with the problems discussed by GAO

Coordination between the Medicare and Medicaid programs' payment policies and guidelines, to the full extent feasible, is highly desirable and is being undertaken. As indicated in our response below to recommendation 2, provision has been made for ongoing liaison and coordination between SSA and SRS. However, there are fundamental differences between the Title XVIII and Title XIX programs, and the provisions of law under which they operate These differences have an impact, for example, on the extent to which the Federal government may exercise direct centralized control over the methods used to establish levels of benefit payments under the two programs. The differences also limit to some degree the extent to which uniform guidelines, policies, and approaches to the resolution of problems may be developed. Our position in response to the GAO recommendations therefore cannot be entirely uniform with respect to actions taken or planned under Title XVIII and Title XIX by SSA and SRS.

Our comments on the three recommendations are as follows

1. Recommendation In those instances where the States, their agents, or Medicare carriers have established policies for paying reduced fees for multiple patient visits, we recommend that, in HEW's program for monitoring Medicaid and Medicare activities, the Secretary, HEW, provide measures designed to determine compliance with such payment policies and to effect corrective action when warranted.

We concur in this proposal. SSA is in the process of developing instructions to all Medicare carriers containing uniform guidelines for national application in identifying multiple-patient nursing home visits and reimbursing properly for such services Under these instructions, it will be mandatory for all Medicare carriers to have a policy for paying reduced fees for multiple patient visits. SSA will provide for appropriate monitoring and appraisal to verify that such a policy has been established, that it is being effectively implemented, and that it conforms to the national guidelines mentioned above, which will be issued shortly. (As indicated in response to recommendation 2, SRS is initiating a study which will include the feasibility of uniform guidelines for Medicaid.)

SRS has implemented a new monitoring and liaison program with the State agencies by each of the SRS/MSA Regional Offices with the cooperation of the Washington Central Office. Under this new program, primary responsibility for reviewing the State program has been given to SRS Regional Offices in order to facilitate monitoring activities and promote faster corrective actions. The scope of the new programs requires a closer relationship with the State agencies along with more frequent visits and detailed reviews of State operations. The monitoring reviews will tend to be comprehensive in the beginning phases but will later develop into more intensive reviews of troublesome areas such as those noted in this report. In addition, SRS will follow through on all deficiencies reported by GAO and the HEW Audit Agency. Concerning the deficiency commented on in this recommendation, SRS will, of course, give special follow-up review of corrective actions promised by the State.

2. Recommendation That a study be undertaken to determine the diversity of payment policies under Medicaid for physicians' visits and that issuance of guidelines in this area be coordinated between the Medicaid and Medicare programs.

We agree with this recommendation and SRS will undertake such a study

We have made provisions for ongoing liaison and coordination between SRS and SSA Thus, the SRS study will be coordinated with the parallel study in the Medicare area which, as noted on page 29[1] of GAO's report, had already been undertaken by SSA and is now complete. Likewise, issuance of guidelines will be coordinated between the Medicare and Medicaid programs.

3. Recommendation That the Secretary direct the Administrator, SRS, and Commissioner, SSA, to provide, in HEW's program for monitoring

GAO note The page numbers referred to in these comments are applicable to GAO's draft report

Medicaid and Medicare activities, steps designated to measure the extent to which HEW guidelines have been implemented and to obtain corrective action where warranted.

In view of actions already taken by SSA and SRS, we do not think such a directive is necessary. SSA has been continually assessing the effectiveness of its surveillance activities and seeking ways to make them more effective. As an outgrowth of this continuing evaluation, SSA has placed onsite representatives at all of the larger Medicare carriers and intermediaries. It is the responsibility of the onsite representative to study in depth all facets of the carrier's claims processing activities and to evaluate compliance with SSA regulations and directives. This is accomplished through case review at various stages of the process as well as interviewing personnel, evaluating training guides and oral directions given to personnel, and analyzing written procedures and policies.

In addition, a systems technician has been placed in each SSA Bureau of Health Insurance (BHI) regional office. These technicians will assist onsite representatives and other regional office staff in evaluating on an ongoing basis carriers' claims and data processing systems

The above techniques employed by SSA for the surveillance of carrier activities are in addition to contract performance reviews by specially trained SSA teams, the use of quantitative operating standards and required periodic reports from carriers to measure performance, introduction of test claims into carrier systems, and other measures to monitor carrier performance.

With regard to the review of Medicaid administration, primary responsibility for reviewing State programs was recently shifted, as mentioned in our comments on recommendation number 1 above, to SRS regional offices. As a result of this change, SRS expects to be able to monitor State Medicaid activities more frequently and more thoroughly than in the past and to initiate corrective action promptly.

In summary, both of the responsible administrative agencies have effective surveillance systems, which can and will be used to assure compliance with guidelines governing payments for multiple visits.

* * * * *

In addition to our comments on the recommendations, SSA had a comment on the audit findings on pages 21 and 22[1] of the draft report which

GAO note The page numbers referred to in these comments are applicable to GAO's draft report

we want to include These findings relate to the way the California Physicians' Service (CPS) recorded data for developing computer records of customary and prevailing charges by physicians. (Under the provisions of law governing Medicare administration, the reasonableness of a physician's charge is screened and evaluated on the basis of the customary charge made by the physician for the service and prevailing charges in the locality for similar services.)

The report indicates that the carrier's Medicare reasonable charge screens for procedure code #9018 (routine home visit, multiple visit) were distorted. This occurred where physicians reported services rendered in multi-patient situations under code #9014 (routine follow-up home visit, single patient) and also charged higher fees than their customary charges for multiple visits. The carrier did correct erroneous codings on such claims, but failed to ascertain whether the higher than customary charges made by the physicians in the multiple visit situations were also erroneous. SSA agrees that the use of these charges, where they were erroneous, did distort the carrier's charge data for procedure #9018.

However, the higher than customary charges were not necessarily always erroneous. There were no doubt instances where the higher fees were the charges the physicians actually intended to make, e.g., where physicians had decided to increase their charges for procedure #9018 above the previously established customary level or where they had decided to begin charging the same fee for procedure #9018 (multiple visit) as for procedure #9014 (single visit). Under Medicare regulations on the development of reasonable charge screens, carriers are expected to use data on the actual charges made for a service, regardless of whether the charges were higher or lower than the previously established customary and prevailing levels

As SSA sees it, therefore, the problem in regard to reasonable charges under Medicare for nursing home visits is not simply one or proper data recordation. There is a need to superimpose upon screens which reflect actual charges, other limitations based on a concept of inherent reasonableness. Thus, even if many physicians became accustomed under Medicare to make the same charges in single and multiple nursing home visit situations, the proposed guidelines SSA is about to issue will nevertheless provide for a differential in the allowable charges under Medicare. The screens to determine reasonable charges will not depend on the charges physicians have made for nursing home visits, but rather, on their charges for house calls and routine follow-up office visits. This deviation from screens based on the actual charges made for the services in question will be justified because it is inherently reasonable to relate single patient nursing home visits to house calls, and multiple visit situations to routine follow-up office visits.

STATE OF CALIFORNIA—HUMAN RELATIONS AGENCY RONALD REAGAN Governor

DEPARTMENT OF HEALTH CARE SERVICES
714 P STREET
SACRAMENTO CALIFORNIA 95814

July 30, 1970

Miss Gene Beach
Associate Regional Commissioner
Medical Services Administration
Social and Rehabilitation Services
Department of Health, Education and Welfare
50 Fulton Street
San Francisco, California 94102

Dear Miss Beach

Thank you for providing an opportunity to review and comment on the draft report by the United States General Accounting Office on overpayments by the Medicare and Medicaid programs for physician and X-ray services provided to patients in California nursing homes.

Concerning payment to physicians for multiple nursing home visits, we have issued fiscal intermediary instructions (see attachments 1 and 2) [See GAO note] which should effectively cope with this problem Our latest fiscal intermediary instruction limits payment for routine nursing home visits to the value of a routine office visit unless the physician indicates on the billing form that the claim is for the first or only patient visited

As for portable X-ray services, clarification is needed Under the Medi-Cal program, portable X-ray services in nursing homes are payable only as physicians' services (see attachment 3) [See GAO note] Independent X-ray laboratories or X-ray technologists do not qualify as Medi-Cal providers However, they do qualify under Medicare Accordingly, Medi-Cal participates in payment (by coinsurance, and deductible when applicable) for their services to beneficiaries covered by both programs

This disparity, and confusing overlapping of payments and program rules, illustrates the need for better coordination of the two programs In addition, the controls in these programs are inherently different, and become virtually ineffective when blended together in cases with joint Title XVIII and Title XIX coverage. Title XVIII relies to a considerable degree on its coinsurance and deductible features, to help control utilization and costs. This significant feature is not operative when Title XIX adds its coverage; conversely, California's Title XIX controls such as prior authorization and payment ceilings become generally inoperative when services are provided to beneficiaries covered by both programs.

GAO note These attachments have been considered in preparation of our final report but have not been reproduced here.

Accordingly, we urge that action be taken at the Federal level to permit single administration of both Medicare and Medicaid programs, with uniform policies and procedures, for beneficiaries covered by both of these programs. We believe this would result in more effective administration, better controls, and lower costs for both programs

We will be pleased to discuss this concept in greater detail with you and other representatives of the Department of Health, Education and Welfare.

Sincerely,

Earl W. Brian

EARL W. BRIAN, M.D.
Director

Attachments

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present

U S GAO Wash , D C