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B-164031(4)
8-21-70

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

NEW RELEASED AUG 21 1970

B-164031(4)

Dear Mr. Chairman: Wilbur D. Mills -- Ways & Means

On March 9, 1970, representatives of the General Accounting Office appeared before the Ways and Means Committee in executive session to brief the Committee on our audit work with respect to the Medicare program. The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare, (HEW which) has entered into contracts with various private insurance companies--such as Blue Shield organizations--to make benefit payments for physicians' services under the Supplementary Medical Insurance Benefits for the Aged (part B) portion of the Medicare program. The matters we discussed before your Committee included our reviews at five hospitals concerning part B payments for the services of supervisory and teaching physicians.

On May 7, 1970, the Chairman of the Committee on Finance, United States Senate, requested (Russell B. Long.) that we furnish that Committee with individual reports on these reviews because the Committee would soon be considering legislative changes concerning Medicare payments to supervisory and teaching physicians. In connection with this request, Mr. William Fullerton of the staff of the Ways and Means Committee requested that we furnish similar reports to you.

The enclosure to this letter sets forth the results of our review of Medicare part B payments made by the Michigan Medical Service (Blue Shield) for the services of salaried supervisory and teaching physicians at Herman Kiefer Hospital in Detroit, Michigan. Following is a summary of the information obtained during our review at the Herman Kiefer Hospital. These points are discussed in more detail in the enclosure.

--For the 3-year period ended June 30, 1969, Blue Shield paid about $354,000 to the hospital under part B of the Medicare program for the services of salaried staff physicians at the hospital. The billings were on a fee-for-service basis in the names of specific physicians for specific services provided to specific Medicare beneficiaries. (See pp. 3 through 5.)

9-13-73 Note - GAO Director's list of reports issued for August 1970 shows that this report was sent to the Chairman, Senate Committee on Finance.

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--Our comparison of the claims paid by Blue Shield on behalf of selected Medicare beneficiaries with the hospital's medical records relating to these patients indicated that the records lacked the documentation required by SSA regulations to establish that the beneficiaries had an attending physician during their periods of hospitalization.

According to the hospital's medical records, the physician's name shown on the billings was the same as the physician involved in providing the services for only about 1 percent of the services billed. In most cases, the medical records contained no evidence that the services billed were provided, and, in the remaining cases, the records indicated that the services were provided either by other staff physicians or by residents in training at the hospital. (See pp. 6 through 10.)

--We estimate that, although Blue Shield paid the hospital about $354,000 during the 3-year period ended June 30, 1969, for the services of the hospital's salaried physicians, the hospital's costs of providing such services were only about $49,000. These costs had been eliminated from the hospital's claims for reimbursement for its costs of providing services to Medicare beneficiaries under the Hospital Insurance for the Aged (part A) portion of the Medicare program.

We estimate that, after subtracting the deductible and coinsurance amounts, totaling $14,000--which were payable by the Medicare patients--from the hospital's costs of $49,000, the Medicare payments received by the hospital exceeded its reimbursable costs by about $319,000 and thereby resulted in a substantial windfall or profit to the hospital and/or the city of Detroit. (See pp. 13 through 15.)

--The funds collected under the Medicare program were deposited by the hospital in a special escrow account with the city of Detroit which owns the hospital. The city planned to retain the portion of the payments equal to the physicians' salaries applicable to the care of Medicare patients and to distribute the

balance at the ratio of 12 percent to the city to cover its administrative expenses and 88 percent to a nonprofit corporation formed by the physicians at the hospital to promote medical research, patient care, and educational activities of the hospital. (See pp. 3 through 5.)

--Generally, only Medicare beneficiaries who had Blue Shield private insurance policies that supplemented their Medicare coverage were billed by the hospital for the deductible and coinsurance portions of the physicians' charges. Although Medicare beneficiaries did not approve individual claims as authorizing payments to be made on their behalf for the services of specific physicians, the hospital did obtain statements from the patients at the time of admission authorizing the assignment of payments for any charges later made by the hospital. Also, Blue Shield notified the beneficiaries of the payments made on their behalf. (See pp. 16 and 17.)

--The hospital's charges under part B of the Medicare program for physicians' services were based on certain Blue Shield fee schedules. (See p. 13.) We believe--and SSA and Blue Shield now agree--that the use of these fee schedules as a basis for billing for the services of these salaried physicians was not appropriate because the fees paid were not related to the physicians' compensation and related fringe benefits paid by the hospital. (See pp. 14 and 15.)

--Private insurance under medical insurance programs--as well as the Michigan State Medicaid program--paid for physicians' services at the Herman Kiefer Hospital on a fee-for-service basis; however, because of limitations on coverage, the private insurers were usually charged less than Medicare for a typical period of hospitalization. Patients who did not have private insurance or who were not covered by the Medicare or Medicaid programs were not charged for physicians' services. (See pp. 17 through 19.)

--After the issuance of SSA's April 1969 guidelines, which set forth more clearly the circumstances under which Medicare payments to supervisory and teaching physicians could be made, the hospital officials stopped billing under part B for surgical operations because they concluded that the part-time physicians supervising surgical procedures could not be considered as attending physicians as defined by the SSA guidelines.

In August 1969 Blue Shield curtailed part B payments to 16 teaching hospitals in Michigan, including the Herman Kiefer Hospital, and scheduled audits of the hospitals to determine compliance with the SSA April 1969 guidelines. As of July 31, 1970, Blue Shield had not resumed payments to Herman Kiefer Hospital. (See pp. 10 and 11.)

--SSA, acting through the Department of Justice, entered into an agreement with the city of Detroit in July 1970 that would prevent the release of funds paid to the hospital and held in escrow by the city. SSA has advised us that it will take steps to recover any amounts incorrectly paid to the hospital. (See p. 5.)

On May 21, 1970, House bill 17550, entitled "Social Security Amendments of 1970," was passed by the House of Representatives. One of the provisions of the bill would change the basis of reimbursement for teaching physicians' services under part B of the Medicare program from a fee-for-service basis to a cost-reimbursement basis when the physicians' services are furnished in a setting containing either of the following circumstances:

--the non-Medicare patients, even when able to pay, are not obligated to pay the billed charges for physicians' services or

--some or all of the Medicare patients do not pay the deductible and coinsurance amounts related to the physicians' charges.

Under the bill, the cost reimbursement would be 100 percent of the reasonable costs of such services to the hospital or other medical service organization, including medical schools and thereby makes it

unnecessary for these institutions to obtain the deductible and coinsurance amounts from the individual Medicare beneficiaries.

We believe that this report will be of interest to your Committee because it presents an actual case comparing, in a hospital or institutional setting, the cost to the Medicare program of payments for physicians' services on a fee-for-service basis as opposed to payments on a cost-reimbursement basis. In this particular instance, the use of the fee-for-service method of paying the hospital for physicians' services resulted in charges to the program (excluding deductible and coinsurance amounts) of about $354,000. The hospital's costs relating to such charges (including deductible and coinsurance amounts) were about $49,000, or about 14 percent of the charges.

The matters discussed in the enclosure were presented to SSA, Blue Shield, and the hospital for review. Their written comments were considered by us in the preparation of our report.

We trust that the information contained in this report will be of assistance to your Committee.

Sincerely yours,

Acting Comptroller General
of the United States

Enclosure

The Honorable Wilbur D. Mills
Chairman, Committee on Ways and Means
House of Representatives

B-164031(4)
8-21-70

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

AUG 21 1970

B-164031(4) N6Th DETROIT

Dear Mr. Chairman: Long - Senate

Pursuant to your request of May 7, 1970 (enc. II), we are submitting a report (enc. I) on our review of Medicare payments made by the Michigan Medical Service (Blue Shield) for the services of salaried supervisory and teaching physicians at Herman Kiefer Hospital in Detroit, Michigan. These payments were made under the Supplementary Medical Insurance Benefits for the Aged (part B) portion of the Medicare program.

The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), which has entered into contracts with various private insurance companies, such as Blue Shield organizations, to make medicare benefit payments ~~for physicians' services under part B.~~ The payments to doctors are not in this report Come under the Supplementary

Following is a summary of the information obtained during our review at Herman Kiefer Hospital relating to the points of interest specified in your letter of May 7.

--For the 3-year period ended June 30, 1969, Blue Shield paid about $354,000 to the hospital under part B of the Medicare program for the services of salaried staff physicians at the hospital. The billings were on a fee-for-service basis in the names of specific physicians for specific services provided to specific Medicare beneficiaries. (See pp. 3 through 5.)

--Our comparison of the claims paid by Blue Shield on behalf of selected Medicare beneficiaries with the hospital's medical records relating to these patients indicated that the records lacked the documentation required by SSA regulations to establish that the beneficiaries had an attending physician during their periods of hospitalization.

According to the hospital's medical records, the physician's name shown on the billings was the same as the physician involved in providing the services for only about 1 percent of the services billed. In most cases, the medical records contained

no evidence that the services billed were provided, and, in the remaining cases, the records indicated that the services were provided either by other staff physicians or by residents in training at the hospital. (See pp. 6 through 10.)

--We estimate that, although Blue Shield paid the hospital about $354,000 during the 3-year period ended June 30, 1969, for the services of the hospital's salaried physicians, the hospital's costs of providing such services were only about $49,000. These costs had been eliminated from the hospital's claims for reimbursement for its costs of providing services to Medicare beneficiaries under the Hospital Insurance for the Aged (part A) portion of the Medicare program.

We estimate that, after subtracting the deductible and coinsurance amounts, totaling $14,000--which were payable by the Medicare patients--from the hospital's costs of $49,000, the Medicare payments received by the hospital exceeded its reimbursable costs by about $319,000 and thereby resulted in a substantial windfall or profit to the hospital and/or the city of Detroit. (See pp. 13 through 15.)

--The funds collected under the Medicare program were deposited by the hospital in a special escrow account with the city of Detroit which owns the hospital. The city planned to retain the portion of the payments equal to the physicians' salaries applicable to the care of Medicare patients and to distribute the balance at the ratio of 12 percent to the city to cover its administrative expenses and 88 percent to a nonprofit corporation formed by the physicians at the hospital to promote medical research, patient care, and educational activities of the hospital. (See pp. 3 through 5.)

--Generally, only Medicare beneficiaries who had Blue Shield private insurance policies that supplemented their Medicare coverage were billed by the hospital for the deductible and coinsurance portions of the physicians' charges. Although Medicare beneficiaries did not approve individual claims as

authorizing payments to be made on their behalf for the services of specific physicians, the hospital did obtain statements from the patients at the time of admission authorizing the assignment of payments for any charges later made by the hospital. Also, Blue Shield notified the beneficiaries of the payments made on their behalf. (See pp. 16 and 17.)

--The hospital's charges under part B of the Medicare program for physicians' services were based on certain Blue Shield fee schedules. (See p. 13.) We believe--and SSA and Blue Shield now agree-that the use of these fee schedules as a basis for billing for the services of these salaried physicians was not appropriate because the fees paid were not related to the physicians' compensation and related fringe benefits paid by the hospital. (See pp. 14 and 15.)

--Private medical insurance under insurance programs--as well as the Michigan State Medicaid program--paid for physicians' services at the Herman Kiefer Hospital on a fee-for-service basis; however, because of limitations on coverage, the private insurers were usually charged less than Medicare for a typical period of hospitalization. Patients who did not have private insurance or who were not covered by the Medicare or Medicaid programs were not charged for physicians' services. (See pp. 17 through 19.)

--After the issuance of SSA's April 1969 guidelines, which set forth more clearly the circumstances under which Medicare payments to supervisory and teaching physicians could be made, the hospital officials stopped billing under part B for surgical operations because they concluded that the part-time physicians supervising surgical procedures could not be considered as attending physicians as defined by the SSA guidelines.

--In August 1969 Blue Shield curtailed part B payments to 16 teaching hospitals in Michigan, including the Herman Kiefer Hospital, and scheduled audits of the hospitals to determine

Other hospitals audits

compliance with the SSA April 1969 guidelines. As of July 31, 1970, Blue Shield had not resumed payments to Herman Kiefer Hospital. (See pp. 10 and 11.)

--SSA, acting through the Department of Justice, entered into an agreement with the city of Detroit in July 1970 that would prevent the release of the funds paid to the hospital (and held in escrow by the city). SSA has advised us that it will take steps to recover any amounts incorrectly paid to the hospital. (See p. 5.)

On May 21, 1970, the House of Representatives passed House bill 17550, entitled "Social Security Amendments of 1970." One of the provisions of the bill would change the basis of reimbursement for teaching physicians' services under part B of the Medicare program from a fee-for-service basis to a cost-reimbursement basis when the physicians' services are furnished in a setting containing either of the following circumstances:

--the non-Medicare patients, even when able to pay, are not obligated to pay the billed charges for physicians' services or

--some or all of the Medicare patients do not pay the deductible and coinsurance amounts related to the physicians' charges.

Under the bill, the cost reimbursement would be 100 percent of the reasonable costs of such services to the hospital or other medical service organization, including medical schools and thereby makes it unnecessary for these institutions to obtain the deductible and coinsurance amounts from the individual Medicare beneficiaries.

We believe that this report will be of use to the Committee in its consideration of the teaching physician provisions of House bill 17550 because it presents an actual case comparing, in a hospital or institutional setting, the cost to the Medicare program of payments for physicians' services on a fee-for-service basis as opposed to payments on a cost-reimbursement basis. In this particular instance, the use of the fee-for-service method of paying the hospital for physicians' services

resulted in charges to the program (excluding deductible and coinsurance amounts) of about $354,000 during a 3-year period. The hospital's costs relating to such charges (including deductible and coinsurance amounts) were about $49,000, or about 14 percent of the charges.

The matters discussed in enclosure I were presented to SSA, Blue Shield, and the hospital for review. Their written comments were considered by us in the preparation of our report.

Pursuant to agreements with the members of the Committee staff, copies of this report are being sent today to the Chairman of the Committee on Ways and Means, House of Representatives; the Secretary of Health, Education, and Welfare; and other appropriate officials of the Department of Health, Education, and Welfare.

Sincerely yours,

Acting Comptroller General
of the United States

Enclosures

The Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate

GENERAL ACCOUNTING OFFICE

EXAMINATION INTO

MEDICARE PAYMENTS FOR SERVICES OF

SALARIED SUPERVISORY AND TEACHING PHYSICIANS

AT HERMAN KIEFER HOSPITAL

DETROIT, MICHIGAN

INTRODUCTION

The Medicare health insurance program was established under title XVIII of the Social Security Act (42 U.S.C. 1395), effective July 1, 1966. The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), which has entered into contracts with various insurance companies, such as Blue Cross and Blue Shield organizations, to make benefit payments under the program.

Medicare provides two forms of health protection for eligible beneficiaries aged 65 and over. One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services as well as posthospital care in an extended-care facility or in the patient's home. Payments for this protection are made from a trust fund financed through a social security payroll tax. Blue Cross is the principal organization in Michigan for making benefit payments under part A.

The second form--Supplementary Medical Insurance Benefits for the Aged (part B)--covers physicians' services. Part B benefits are paid from a trust fund financed through premiums paid by beneficiaries electing to participate and by matching contributions from Federal funds appropriated by the Congress. Effective April 1, 1968, the monthly premium was increased from $3 to $4; and, effective July 1, 1970, the premium was increased to $5.30. The beneficiary is

responsible for paying the first $50 for covered services in each year (deductible) and 20 percent of the reasonable charges in excess of the first $50 (coinsurance). Blue Shield is the organization for making part B benefit payments in Michigan.

Payments to supervisory and teaching physicians

Payments to supervisory and teaching physicians at teaching hospitals are allowed by SSA regulations under part B. To qualify for payments, the physician must be the Medicare patient's attending physician, and either render services personally or provide personal and identifiable direction to residents and interns participating in the care of the patient. The salary costs of hospital residents and interns under an approved training program are reimbursed to the hospital under part A of the program.

Payments to hospital-based physicians

When physicians are employed by or receive compensation from or through a hospital, SSA regulations provide for payments to the hospital for physicians' services to individual Medicare patients under part B. To the extent that these hospital-based physicians are compensated for services other than direct patient care, such as teaching, administration, and supervision of professional or technical personnel, the reasonable cost is reimbursable under part A. However, SSA regulations provide that the sum of payments under parts A and B should be about equal to the amount of the physicians' compensation and related fringe benefits allocable to the Medicare program.

MEDICAL CARE AND FINANCIAL ARRANGEMENTS AT HERMAN KIEFER HOSPITAL

The city of Detroit operates the 550-bed Herman Kiefer Hospital. The hospital is devoted almost entirely to treating patients with tuberculosis. Services such as general

medical care, pathology, radiology, and surgery are provided to patients who usually are residents of Wayne County, Michigan.

In Michigan, the county in which a person resides is responsible for providing medical care to tuberculosis patients. The city is reimbursed principally by Wayne County for the costs of operating the hospital. The county, in turn, is reimbursed by Blue Cross under part A for the costs of providing care to Medicare patients.

During the 3-year period ended June 30, 1969, the hospital employed an average of about 19 full- and part-time staff physicians and six medical residents. The latter were participating in American Medical Association-approved training programs, principally involving thoracic (chest) surgery. In addition, about 100 voluntary medical consultants were available on an as-needed basis. For the fiscal year ended June 30, 1969, the hospital's operating expenses totaled about $7.7 million. About 10 percent of the patients treated at the hospital were Medicare patients.

The hospital billed Blue Shield directly for physicians' services to Medicare patients in the names of salaried staff physicians who were generally the physicians in charged of the ward or department in which the services were provided. All staff physicians at the hospital were city employees and were paid an annual salary. As a condition of their employment, the physicians were precluded from billing and retaining for their own use any funds received from their treatment of patients in the hospital. Services provided to Medicare patients by consultants were not billed.

Payments under part B were made to the hospital which deposited the funds in a special escrow account with the city of Detroit. As discussed below, these funds have been held in this account pending distribution to a hospital research and development corporation and to the city of Detroit.

In April 1968 the physicians at Herman Kiefer Hospital formed a nonprofit corporation entitled "Herman Kiefer Hospital Research and Development Corporation." The stated purposes of the corporation were:

--to promote, develop, and generally assist in medical research in the hospital,

--to purchase equipment for such research,

--to stimulate and encourage research studies by staff members, residents, and interns,

--to extend and develop the hospital's facilities both for patient care and for the professional education and advancement of staff members, interns, residents, and fellows,

--to purchase supplies and equipment in connection with the medical education program of the hospital and to pay for the expenses of staff members, interns, residents, and fellows of the hospital for attendance at medical and other scientific meetings for such educational purposes,

--to promote and advance in all manners the level of patient care in the hospital, and

--to provide the necessary funds for accomplishing these purposes.

Payments under part B were first received by the hospital in January 1967 and related to services provided from the inception of the Medicare program in July 1966. As of January 28, 1970, the special escrow account had a balance of about $398,000, of which about $354,000 was received through June 30, 1969.

Until May 15, 1970, the city had refused to release any of the funds to the research and development corporation until such time as it could get assurance that the validity of payments received for physicians' services would not be questioned in future audits. Although such assurance had not been received, the city agreed in early 1970 to start releasing the funds on a scheduled basis. Subsequently, on May 15, 1970, the city released $50,000, of which $44,000 was paid to the corporation and $6,000 was paid to the city's general fund. The city planned to release an additional $100,000 a month starting on June 15, 1970, until the special

escrow account was depleted. Of these funds, the city had planned to transfer to its general fund an amount equal to the physicians' salaries applicable to the care of Medicare patients and to distribute the remaining funds at a ratio of 12 percent to the city to cover its administrative expenses and 88 percent to the research and development corporation.

However, on May 26, 1970, Blue Shield and SSA officials requested that the city make no further payments to the corporation until an audit of the Medicare payments could be completed by Blue Shield. As a result of this request, the city's deputy health commissioner on June 8, 1970, recommended to the city controller that further payments from the escrow account be suspended for a period of 90 days. Further, in July 1970, SSA, acting through the Department of Justice, entered into an agreement with the city of Detroit that would prevent the release of Medicare funds paid to the hospital and held in escrow by the city.

We estimate that the portion of physicians' salaries applicable to the care of Medicare patients amounted to about $49,000 for the period July 1966 through June 1969. (See p. 13.) Therefore, if the $354,000 received by the hospital for the treatment of Medicare patients through June 1969 had been released, the funds would probably have been distributed as follows:

	Total	City of Detroit	Research and development corporation
Physicians' salaries	$ 49,000	$49,000	
Administration (12%)	37,000	37,000	
Corporation (88%)	268,000		$268,000
Total part B payments	$354,000	$86,000	$268,000

REVIEW OF MEDICAL RECORDS FOR
BILLINGS FOR SERVICES OF
SUPERVISORY OR TEACHING PHYSICIANS

Our comparison of the hospital's billings for physicians' services under part B applicable to 20 Medicare beneficiaries with the hospital's medical records applicable to these patients indicated that the records lacked the documentation required by SSA regulations to establish that the patients had an attending physician during their periods of hospitalization.

SSA regulations, issued on August 31, 1967, described the circumstances under which payments would be made for services furnished by supervisory or teaching physicians as follows:

> "(b) Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. *** The carrying out by the physician of these responsibilities would be demonstrated by such action as: Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress."

In April 1969, SSA issued revised guidelines to set forth more clearly the circumstances under which payments for services of supervisory or teaching physicians may be made and the documentation required to support such payments. Some of the more important provisions are as follows:

"The physician[1] must be the patient's 'attending physician.' This means he must *** render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients."

"[1]The term 'physician' does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff."

* * * * *

"3. Performance of the activities *** must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician."

We randomly selected 20 medicare patients from whom payments of $7,386 had been made, and we compared the billed services with the patients' medical records and hospital reports. The billings had been submitted by the hospital from February 10, 1967, through July 10, 1969.

The type and number of services, as well as the amounts billed by the hospital and allowed by Blue Shield, for the 20 beneficiaries are summarized below.

Type of service	Occasions of service	Amount billed	Amount allowed by Blue Shield
Daily medical care	1,810	$ 8,502	$8,424
Surgery	15	1,579	1,198
Total	1,825	$10,081	$9,622
Less deductibles and coinsurance payable by beneficiaries			2,236
Total payments reviewed			$7,386

Hospital administrative and medical personnel confirmed our findings relating to our review of the medical records. In addition, because of the technical nature of the data, Blue Shield made a physician available to provide professional assistance to us in examining the medical records. Our findings are discussed below.

Daily medical care

Upon admission to Herman Kiefer Hospital and assignment to a ward, a patient receives a physical examination and medical diagnosis, and a record of his medical history is prepared. Thereafter, while hospitalized, the patient receives whatever medical care is deemed necessary. Under Medicare part B, a billing was made for medical care for each day a patient was hospitalized. Since January 1, 1967, the first day of care was billed at $25, days 2 through 7 at $9, days 8 through 21 at $5, and all subsequent days at $4.

The hospital billings for the 20 patients showed that the hospital had billed Blue Shield $8,502 for 1,810 days of care. From the hospital medical records (doctors' orders, progress notes, and nurses' notes), we found evidence that, on 385 days, the patients were seen by a hospital staff physician but that the name of the physician shown in the medical records was the same as the name of the attending physician shown on the billings for only 22 of these days (about 1 percent of the occasions of service billed). The medical records showed that, on 114 other days, care was rendered by resident physicians in training but that countersignatures or other evidence of direction by supervisory physicians were absent. For the remaining 1,311 days, we did not find any documentation to confirm that services had been rendered to the patients.

The Blue Shield physician assisting us reviewed the medical records of nine of the 20 patients and concurred with our findings, as summarized below.

	Total	Medical records reviewed by Blue Shield physician and GAO	Medical records reviewed by GAO only
Occasions of service:			
Total billed	1,810	882	928
Not supported by physicians' notations	1,311	599	712
Supported by physicians notations	499	283	216
Medical personnel identified with record of service:			
Attending physicians:			
Same as identified on billings	22	-	22
Other attending physicians	363	176	187
Residents	114	107	7
Total	499	283	216

Hospital officials agreed that there was a lack of documentation to support the part B billings but emphasized that daily care was rendered by the staff physicians. The medical director stated that medical records were for use by the physicians in seeing that a patient recovered from his illness. He said that physicians were not bookkeepers and, thus, were not required to document every task they performed. He emphasized that, before the Medicare program was initiated, the hospital's recordkeeping practices were acceptable to the health insurance companies and that, after the program was initiated, Blue Shield had instructed the hospital to follow its existing practices.

Surgery

Herman Kiefer Hospital which specializes in thoracic (chest) surgery has an American Medical Association-approved resident training program offering this specialty. The hospital is affiliated with Wayne State University in Detroit and has contracts with three physicians who, on a part-time basis, instruct residents and perform or assist in the surgery. Eight of the 20 patients included in our review had been billed for 15 operations for which physicians' fees of $1,579 were charged to Medicare under part B.

The hospital's medical records which were reviewed by us and by the Blue Shield physician showed that, of the 15 operations:

--five operations, for which charges of $468 were billed, had been performed by residents, and there was no documentation to show the presence of a staff physician when the operations took place; and

--one operation, for which a charge of $54 had been billed, had been scheduled but was not performed.

After SSA issued clarifying instructions in April 1969, officials at Herman Kiefer Hospital reconsidered their billing practices for surgery and concluded that the part-time physicians in charge of surgery could not be considered attending physicians. Therefore, the hospital officials concluded that, effective August 1969, no charges would be billed under part B for future surgical procedures.

Actions taken to implement SSA's April 1969 guidelines relating to payments to supervisory and teaching physicians

The April 1969 guidelines, according to SSA, were intended to clarify and supplement the criteria for making payments for services rendered by supervisory and teaching physicians. SSA stated that new guidelines were necessary because of an apparent serious need for a better and more uniform understanding of conditions under which payments could be made.

Blue Shield received the revised guidelines in May 1969 and distributed them to the hospitals in the State of Michigan on June 30, 1969. In August 1969 Blue Shield curtailed Medicare part B payments to 16 teaching hospitals in Michigan, including Herman Kiefer Hospital, and subsequently scheduled audits at the hospitals to determine whether they were complying with the new guidelines. As of July 31, 1970, Blue Shield had not resumed part B payments to Herman Kiefer Hospital.

In commenting on a draft of this report, Blue Shield stated that the portion of the report dealing with the adequacy of documentation supporting the fees charged by the hospital under part B was irrelevant. Blue Shield stated, as discussed on page 15, that it agreed with our conclusion that the fee-for-service reimbursement method used--for supervisory and teaching physicians--was inappropriate and that the hospital-based-physician method, which would have related the Medicare reimbursement to the physicians' compensation by the hospital, should have been used.

We do not agree that the foregoing portion of the report is irrelevent to a discussion of Medicare payments on a fee-for-service basis to supervisory and teaching physicians because, for about a 3-year period, the hospital billed and Blue Shield paid about $400,000 under part B of the Medicare program on that basis. We believe that, irrespective of any misunderstandings by the hospital and Blue Shield as to the appropriate method of reimbursement under the SSA regulations, the hospital's medical records lacked the documentation required by SSA regulations concerning payments to supervisory and teaching physicians to establish that the individual Medicare patients had an attending physician during their periods of hospitalization.

The superintendent and the medical director at Herman Kiefer Hospital said that the SSA regulations prior to the issuance of the April 1969 revised guidelines were vague as to what hospital records and procedures were inquired. They stated that, consequently, hospital officials had worked closely with Blue Shield in 1966 to establish acceptable procedures and data systems for Medicare billing purposes.

Hospital officials stated that, in view of this coordination and approval by Blue Shield, they had assumed that their medical records and billing procedures were in compliance with the Medicare regulations.

In commenting on a draft of this report, the hospital superintendent stated that:

> "The report seems to be a fair report of what has happened although it does not put enough emphasis on why we billed the way we did. The intermediary [Blue Shield] understood what we were doing, endorsed our action, and even suggested ways to implement it."

EXTENT TO WHICH PAYMENTS UNDER PARTS A AND B FOR PHYSICIANS' SERVICES EXCEEDED HOSPITAL COSTS

We estimate that the hospital's charges for physicians' services under part B of the Medicare program exceeded its reimbursable costs of providing such services by about $319,000 for the 3-year period ended June 30, 1969, and thereby represented a windfall or profit to the hospital and/or the city of Detroit.

If physicians are employed by a hospital (hospital-based), SSA requires that charges for their services should be about the same as the compensation paid to the physicians by the hospital, including fringe benefits. The hospital-based-physician reimbursement method was not followed by the Herman Kiefer Hospital, even though the physicians were employed by the hospital. Instead, the hospital established fee schedules for various services which resulted in charges under part B that far exceeded the proportionate share of the physicians' compensation and fringe benefits related to providing direct patient care to Medicare patients.

Staff physicians and consulting physicians at the hospital, as part of their work agreements, authorized the hospital to bill and collect fees for services they provided to Medicare patients. The hospital's business office prepared the Medicare billings. The amounts were based on fee schedules in the Michigan Blue Shield Physician's Manual. However, these fees were not related to the hospital's compensation to the physicians for the services.

For the 3-year period ended June 30, 1969, the Herman kiefer Hospital was paid about $354,000 under part B for services of its physicians to individual Medicare patients. We estimate that the salary and fringe benefit costs to the hospital for these services totaled only about $49,000. Our estimate of the costs of $49,000 is based on the data used by the Herman Kiefer Hospital in preparing its Medicare part A cost statements for fiscal years 1967 through 1969.

In preparing these statements, the hospital officials reviewed the activities of the physicians and allocated their salary and fringe benefit costs to various accounts. One of

these accounts contained the allocated costs applicable to direct patient care which was deducted from the amounts claimed under part A. For the 3-year period, the hospital allocated $500,800, or about 40 percent of its physicians' salary and fringe benefit costs, to this account. This represented the costs to render services to patients in the hospital for a total of 550,282 patient days. Herman Kiefer Hospital, therefore, incurred an average cost of $0.91 a patient-day for direct patient care rendered by its staff physicians.

According to the hospital's part A cost statements, during the period July 1966 through June 1969, the hospital rendered services to Medicare patients for a total of 53,781 patient-days. Therefore, on the basis of the average daily cost of $0.91, the hospital incurred costs of about $49,000 in rendering direct care to Medicare patients by its staff physicians. We believe that, consistent with the Medicare reimbursement method for hospital-based physicians, this amount should have been the basis for computing the physicians' charges for the treatment of Medicare patients.

Under part B, the beneficiary and the Medicare program each are responsible for paying a portion of physicians' reasonable charges--the beneficiary pays for the first $50 (deductible) and for 20 percent (coinsurance) of the remaining reasonable charges and Medicare pays for the balance. On the basis of nationwide Medicare statistics, the beneficiaries' and the program's portions of Medicare billings were about 28 percent and 72 percent, respectively, during the 3-year period ended June 30, 1969. Therefore, we estimate that, of the costs of $49,000 incurred by the hospital in providing care by its physicians to Medicare beneficiaries, only about $35,000, or 72 percent, were reimbursable costs under part B, or $319,000 less than the amounts paid under part B by Blue Shield.

Hospital officials indicated to us that, since the inception of the Medicare program, they had held various meetings with Blue Shield personnel in an effort to become familiar with the requirements for obtaining reimbursement under Medicare. Hospital officials stated that, since Blue Shield apparently had approved what they were doing, they assumed that the hospital had been complying with Medicare requirements.

In commenting on a draft of this report, Blue Shield agreed with our position that the SSA regulations concerning reimbursement for the services of hospital-based physicians (see p. 2) applied to the conditions as we reported them with respect to the Herman Kiefer Hospital but pointed out that there were mitigating circumstances influencing its actions during the period when 280 hospitals in Michigan were being evaluated for payments for the professional services of their physicians.

Blue Shield stated that (1) the definition of a "hospital-based physician" was generally considered to apply solely to such specialists as radiologists, pathologists, and anesthesiologists and (2) although Blue Shield had the ultimate responsibility for determining the proper method of payment for services rendered to Medicare beneficiaries by hospital-based physicians, the part A intermediary (Blue Cross) also had a responsibility to provide Blue Shield with cost and reimbursement data from which the appropriate payment mechanism could be selected.

SSA, in commenting on a draft of this report, also agreed with our views as to the proper method of reimbursement for the physicians employed by Herman Kiefer Hospital and advised us that it would take steps to recover any amounts incorrectly paid to the hospital.

BENEFICIARY INVOLVEMENT

The Medicare beneficiary is responsible for paying a portion of part B charges and for signing appropriate forms authorizing the physician or hospital to bill Blue Shield for the remaining charges. The beneficiary, in turn, is entitled to receive from Blue Shield appropriate notice of payments made on his behalf. Our review at Herman Kiefer Hospital showed that the beneficiaries' portion of part B charges had been paid only to the extent that the charges were covered by insurance plans which supplemented their Medicare coverage. Further, the patients did not sign appropriate authorizations for the physicians or the hospital to bill Blue Shield but did receive notifications from Blue Shield of payments made on their behalf.

Extent to which beneficiaries paid for deductibles and coinsurance under part B

As discussed on page 7, the charges allowed by Blue Shield under part B on behalf of the 20 patients included in our review totaled $9,622. Of this amount, $2,236 was not reimbursable by Blue Shield under part B because it represented the deductible and coinsurance amounts that were the responsibility of these beneficiaries.

Eight of the 20 patients had a Blue Cross-Blue Shield complementary insurance plan which supplemented Medicare benefits. Under the complementary plan, Blue Shield had reimbursed the hospital for $711 of the $2,236. The remaining $1,525 of deductibles and coinsurance had not been paid at the time of our review and, because of the hospital's policy of not billing patients (see p. 19), will probably never be paid. Of the 12 patients without complementary insurance, hospital records indicated that six might have been qualified for benefits under the State Medicaid program. The hospital, however, did

not bill the Medicaid program[1] for deductibles and coinsurance of $796 applicable to the six patients.

Beneficiary approval of part B billings

None of the 20 patients included in our review approved individual bills submitted by the hospital under part B authorizing payments to be made on their behalf to specific physicians. Instead, the hospital required patients, at the time of admission, to sign the following statement authorizing the assignment of payments for any charges later made by the hospital:

> "I assign payment for the unpaid charges to the physician(s) for whom the hospital is authorized to bill in connection with its services."

Notification to beneficiaries of part B payments

SSA regulations require organizations making benefit payments under part B to furnish each Medicare beneficiary with an explanation identifying the individuals or organizations receiving payments, the place and date of the services, and the charges allowed. This gives the beneficiary an opportunity to question any payments for services that may not have been furnished. We found that Blue Shield had furnished the required explanations to Medicare patients at Herman Kiefer Hospital.

EXTENT TO WHICH PAYMENTS--OTHER THAN MEDICARE--ARE NORMALLY MADE FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS

In our limited review at Herman Kiefer Hospital, we did not obtain complete details on the billing practices followed

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[1]The State Medicaid program has paid fees for the services of salaried physicians at Herman Kiefer Hospital. The hospital deposited these payments in a special escrow account with the city of Detroit. As of January 28, 1970, the account had a balance of about $69,000.

prior to and after initiation of the Medicare program. We found, however, that Medicare paid more for physicians' services than was paid by non-Medicare patients covered by private insurers, primarily because of limitations on coverage in the private insurance policies.

The average length of stay at Herman Kiefer Hospital by all patients, including Medicare beneficiaries, during the 3-year period ended June 30, 1969, was about 90 days. Wayne County had arranged for the hospital to bill Medicare for physicians' services--mostly for daily medical care. The billings were computed on a sliding scale from $25 for the first day to $4 for every day after the 21st day in the hospital. Wayne County, on the other hand, billed private insurance carriers a flat fee of $6 a day, up to a maximum of 30 days, or $180 for physicians' daily medical care. Consequently, for a patient confined to the hospital for the average stay of 90 days, Medicare part B would have been billed $425 and other insurance companies would have been billed $180, computed as follows:

	Medicare		Other insurance companies	
Days in hospital	Rate	Amount	Rate	Amount
1	$25	$ 25	$6	$ 6
2 thru 7	9	54	6	36
8 thru 21	5	70	6	84
22 thru 30	4	36	6	54
31 thru 90	4	240	-	-
		$425		$180

Although county officials did not explain the basis for the $6-a-day billing, they advised us that private insurance companies would not pay in excess of this amount. Records were not readily available to enable us to determine the amount of billings to private insurance companies for physicians' services and the extent to which such billings were paid.

As of March 23, 1970, there were 286 patients at the Herman Kiefer Hospital, of whom the hospital's records showed that:

--192 had no Medicare or private medical insurance,

--13 had both Medicare and a Blue Cross-Blue Shield plan that supplemented their Medicare benefits,

--1 had both Medicare and other private medical insurance,

--52 had Blue Cross-Blue Shield private medical insurance, and

--28 had other private medical insurance.

As discussed on page 16, the Blue Cross-Blue Shield complementary insurance plan, which supplemented Medicare for persons aged 65 and over, paid the deductible and coinsurance portions of charges for physicians' services applicable to Medicare patients who had such supplementary coverage. However, as shown above, most patients had no medical insurance protection.

Wayne County officials advised us that patients who did not have private insurance or who were not covered by the Medicare or Medicaid programs were not charged for physicians' services because they did not believe that they had sufficient authority to make such charges under Michigan legislation. Act 314 of the 1927 Public Acts of Michigan, as amended, designates the county in which a person resides as the unit of government responsible for the cost of providing treatment to tuberculosis patients. The act also indicates, however, that the county may have had authority to bill patients who were financially able to pay for physicians' services. The act states that:

"Person who is financially able to reimburse or pay county for treatment should be required to do so, the county only having to pay for treatment of those who are unable to reimburse it.

"Although patient *** is liable to county for care, if able to pay, such person cannot be compelled to turn over hospital insurance funds to state or county, except by procedure incident to suit, such as garnishment or attachment."

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

May 7, 1970

The Honorable
Elmer B. Staats
Comptroller General
of the United States
Washington, D. C.

Dear Mr. Staats:

I understand that your office has been making reviews of Medicare payments for the services of supervisory and teaching physicians at five hospitals which are similar to the review made at the request of this Committee of Medicare payments to supervisory and teaching physicians at Cook County Hospital in Chicago, Illinois. I also understand that your Office contemplates issuing an overall report to the Congress presenting the findings, conclusions, and recommendations developed in connection with the reviews at the five hospitals.

On May 4, 1970, the Committee on Ways and Means of the House of Representatives announced that, in connection with its consideration of amendments to title XVIII of the Social Security Act, it had proposed certain restrictions with respect to payments under the supplementary medical insurance (part B) portion of the Medicare program to supervisory and teaching physicians.

This Committee will soon consider legislative changes concerning Medicare payments to supervisory and teaching physicians. In connection with this work, would you please furnish to this Committee individual reports of these reviews.

Although it will not be necessary for you to develop overall conclusions and recommendations relating to this information, the material furnished to this Committee should at least cover the following points with respect to the payments made on behalf of selected Medicare beneficiaries:

1. The extent that the services paid for were furnished by the supervisory or teaching physician in whose name the services were billed, by other attending physicians, or by residents and interns, as shown by the hospitals' medical records. Also, information as to any changes in billing or record-keeping practices since the implementation of Social Security's April 1969 guidelines relating to such payments.

2. The extent to which payments made from Medicare (part B) funds represented payments for services of physicians whose compensation may have also been reimbursed in part to the hospitals under the hospital insurance (part A) portion of Medicare. For those physicians who were not compensated by the hospitals, information as to their medical school affiliations and the bases for their compensation by these institutions would be helpful.

3. Information as to whether the individual physicians bill for claimed services or whether the billing is done by the hospital or some other organization, and information as to the disposition of such funds obtained from part B of the Medicare program. For example, are the payments retained by the physician or are they turned over to the hospital, medical school, or some other organization.

4. Whether: (a) the Medicare patients were billed for and subsequently paid the deductible and coinsurance portions of the Medicare charges, (b) the patients signed the appropriate claims forms requesting that Medicare payments be made on their behalf, and (c) the patients received "explanations of benefits" or other notification of the payments made on their behalf.

5. Information as to the basis for arriving at the amounts of "reasonable charges" for the services paid for.

6. Information as to whether any other medical insurance programs or other patients regularly made payments for services provided by the supervisory and teaching physicians at the hospitals in amounts comparable to those paid from Medicare funds under comparable circumstances.

7. Information as to the steps taken by the hospitals and the carriers to obtain compliance with SSA's April 1969 guidelines concerning payments to supervisory and teaching physicians, including actions taken to suspend or recover payments.

8. Any other pertinent information which you believe would be helpful to this Committee in its consideration of the subject.

Although there is no need to obtain formal advance comments from the Department of Health, Education and Welfare, the Committee has no objection to your Office discussing the matters covered in the reports with appropriate officials of the Department.

With every good wish, I am

Sincerely,