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BY THE U.S. GENERAL ACCOUNTING OFFICE

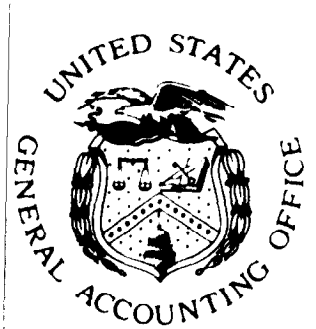
Report To The Secretary Of Health And Human Services

Need To Eliminate Payments For Unnecessary Hospital Ancillary Services

About 6 percent of the charges for ancillary services provided to a sample of Medicare beneficiaries at 16 hospitals represented unnecessary care. All of the unnecessary care was paid by Medicare because of the absence of effective medical necessity reviews.

Medicare's new prospective reimbursement system will provide an incentive for hospitals to eliminate unnecessary ancillary services. A remaining problem, however, is that the reimbursement rates under the new system are based in part on costs of providing unnecessary care. GAO recommends that HHS eliminate the cost of such care from the data base used to establish the rates.

GAO also noted that the Medicaid program was vulnerable to the payment for unnecessary ancillary services.



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

HUMAN RESOURCES
DIVISION

B-210564

The Honorable Margaret M. Heckler
The Secretary of Health and
Human Services

Dear Madam Secretary:

The Social Security Amendments of 1983 require that you establish a prospective reimbursement system for hospitals under Medicare. This report points out that the data on which the rates are to be based are inflated with the cost of providing hospital ancillary services which are medically unnecessary. We believe the data base should be purged of the cost of unnecessary care. While there is insufficient time to do anything about the data base to be used for the fiscal year 1984 and 1985 rates, the rates for fiscal year 1986 and beyond are far enough in the future to address the problem. This report contains a recommendation to you concerning this issue.

As you know, 31 U.S.C. 720 requires the head of a Federal agency to submit a written statement on action taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of this report. A statement is also to be submitted to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the above-mentioned Committees, the Senate Committee on Finance, the House Committee on Ways and Means, and the House Committee on Energy and Commerce; the Director, Office of Management and Budget; your Inspector General; the Administrator, Health Care Financing Administration; and other interested parties.

Sincerely yours,

Richard L. Fogel
Director

Contents

ABBREVIATIONS

DRG	diagnosis related group
EKGs	electrocardiograms
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
PRO	Peer Review Organization
PSRO	Professional Standards Review Organization
TEFRA	Tax Equity and Fiscal Responsibility Act

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY OF
HEALTH AND HUMAN SERVICES

NEED TO ELIMINATE PAYMENTS FOR UNNECESSARY HOSPITAL ANCILLARY SERVICES

D I G E S T

In fiscal year 1984, over $30 billion will be spent under Medicare and Medicaid for hospital ancillary services. These services are those which are incidental to an individual's hospitalization and include X-rays, laboratory tests, and drugs. Generally, they represent about 60 percent of the total charges for a hospital stay. Under Medicare and Medicaid, payment is to be made only for those services that are medically necessary.

At 16 hospitals, GAO arranged for Professional Standards Review Organizations to examine the medical necessity of ancillary services provided to Medicare beneficiaries. They found that about 6 percent of Medicare charges for ancillary services were unnecessary. The percentage of unnecessary care for laboratory, special services, and radiology was about 10 percent each. Physical therapy had the highest figure--32 percent (see pp. 7 and 8).

GAO found that all of this unnecessary care was paid by Medicare because of the absence of effective medical necessity reviews, i.e., an examination of medical records for assessing the reasonableness and medical necessity of the services provided (see p. 13).

The amount of unnecessary care can be sizable. For example, at one hospital where the percentage of unnecessary care was only 2.7, a random sample of Medicare claims disclosed $2,918 worth of unnecessary ancillary charges. Estimating the results of the sample findings to the hospital's universe of 1981 Medicare claims indicated that at least $255,000 in unnecessary care may have been incurred for that year (see pp. 9 and 10).

The Social Security Amendments of 1983 (Public Law 98-21), enacted on April 20, 1983, changed the way hospitals are to be reimbursed under Medicare. Starting in fiscal year 1984, hospitals will be reimbursed prospectively on the

basis of a flat rate established for each Medicare case. The rate paid generally would depend on how the case is classified by diagnosis related group (e.g., kidney transplant and coronary bypass) and where the hospital is located (see p. 15).

When a prospective reimbursement system is established, there will be incentives for hospitals to eliminate unnecessary use of ancillary services--the more unnecessary care eliminated, the greater the "profit" or reward for being efficient. A new problem with unnecessary ancillary services, however, is that the data base used to establish the prospective payment rates is inflated with costs incurred in providing unnecessary care.

The Social Security Amendments of 1983 require that Peer Review Organizations review the appropriateness of hospital services under the prospective payment system. GAO is recommending that, as part of these reviews, the review organizations examine and report on the medical necessity of hospital ancillary services. The results of these reviews should then be used to adjust the data base and prospective payment rates accordingly (see p. 18.)

Because the prospective payment system is to start on October 1, 1984, it is not practical to adjust the data base to be used for fiscal years 1984 and 1985. The Department of Health and Human Services, however, should have sufficient time to adjust the data base prior to establishment of the 1986 rates.

CHAPTER 1

INTRODUCTION

Hospital ancillary services are those services which are incidental to an individual's hospitalization. Generally they represent about 60 percent of the total charges of a hospital stay. Ancillary services include X-rays, laboratory tests, drugs, supplies, and physical and inhalation therapy.

This report discusses the reasonableness and medical necessity of ancillary services paid under Medicare and Medicaid--over $30 billion will be paid for ancillary services in fiscal year 1984. The report also addresses the actions taken by the Health Care Financing Administration (HCFA) to prevent payment for unnecessary services. HCFA--which is under the Department of Health and Human Services (HHS)--is responsible for administering Medicare and Medicaid at the Federal level.

MEDICARE

Medicare is a health insurance program which covers most Americans who are age 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. The program is authorized under title XVIII of the Social Security Act and provides protection under two parts. Part A covers services of institutional providers of health care, primarily hospitals, skilled nursing facilities, and home health agencies. Part B, or the supplemental medical insurance program, covers primarily physician services.

Under Part A--which covers hospital ancillary services--an estimated $44.7 billion in benefit payments will be made in fiscal year 1984. Of this amount, $42.4 billion represents payments to the approximately 7,000 hospitals that participate in Medicare. The amount reimbursed for ancillary services is difficult to pinpoint; however, it generally represents about 60 percent of the total charges of a hospital stay. The estimated expenditures for ancillary services under Medicare in fiscal year 1984, therefore, is about $25 billion (60 percent x $42.4 billion).

HCFA administers Part A of Medicare with the assistance of various Blue Cross plans and commercial insurance companies such as Aetna Life and Casualty and Mutual of Omaha. These organizations--called Medicare intermediaries--make Medicare payments to hospitals on a reasonable cost basis. Hospitals are paid during their cost reporting years based on estimated costs. Final settlements are made retrospectively after the end of the hospital's cost reporting year; the amount of payment is limited to

costs found by intermediaries to be proper, reasonable, and related to patient care. A hospital's cost report is the basis for determining both allowable costs for furnishing services and the share of those costs which are attributable to Medicare.

For cost report periods beginning in fiscal year 1982, Medicare limited payments to hospitals for inpatient routine operating costs (room, board, and general nursing) to 108 percent of the average costs of similar hospitals, adjusted for local wage levels. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248) extended this limit to cover ancillary services. The limit for fiscal year 1983 was set at 120 percent of average costs. TEFRA also established a limit on the amount that a hospital could be paid per discharge. This limit was set at the prior year's cost per discharge inflated by the increase in the hospital market basket (an economic index designed to measure the increase in the cost of items hospitals buy) plus 1 percent.

The Social Security Amendments of 1983 (Public Law 98-21), enacted on April 20, 1983, changed the way hospitals are to be reimbursed under Medicare by establishing a prospective payment system. The amount a hospital will be paid is determined before the period in which the payments are made, and normally payments are not adjusted retrospectively to reflect actual costs. The prospective payment system will be phased in over 3 years beginning in fiscal year 1984, and eventually hospitals will be paid a uniform rate (adjusted to reflect local wage levels) established for each Medicare case. The rate paid will depend on how the case is classified by diagnosis related group (DRG) (e.g., kidney transplant and coronary bypass).

Public Law 98-21 repealed, for cost reporting years beginning in fiscal year 1984 and later, the Medicare limit on hospital operating costs contained in TEFRA but retained its rate of increase limit for fiscal years 1983-85. Public Law 98-21 also requires that the prospective payment rates be set at a level that will result in the same amount of payments in fiscal years 1984-85 as would have occurred with the TEFRA limits. Additional discussion on the new payment methodology is provided on page 15.

MEDICAID

Medicaid is authorized under title XIX of the Social Security Act and is a Federal/State program that pays for medical services provided to eligible low-income persons. States initiate, design, and operate their programs and HHS approves each State's plan which provides the basis for claiming Federal cost

sharing. Depending on the State's per capita income, the Federal Government pays 50 to 77 percent of Medicaid medical services costs.

For fiscal year 1984, total Medicaid expenditures are estimated to be $38.6 billion, of which $20.8 billion will be the Federal share. Total payments to hospitals for inpatient services are estimated to be $12.1 billion, about $7 billion of which is for ancillary services.

Because Medicaid is basically a State designed and administered program, the way the program operates varies. Regarding payments to hospitals, however, most State Medicaid programs use systems similar to Medicare's retrospective cost reimbursement system. Some States also use prospective payment systems with varying features. All States are required to establish procedures as may be necessary to guard against unnecessary utilization of services.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The Social Security Amendments of 1972 (Public Law 92-603) authorized HHS to establish independent Professional Standards Review Organizations (PSROs). PSROs are groups of physicians that review health care services provided under Medicare and Medicaid. Among other things, the amendments required PSROs to ensure that Federal funds are spent only for medically necessary services.

The Senate Committee on Finance recommended establishing the PSRO program as a partial solution to the dual problems of rising health care costs and the high incidence of medically inappropriate services rendered to Medicare and Medicaid patients. The Committee noted that the economic impact of the overutilization of services was significant. It also expressed concern over the effect that such overutilization had in terms of the health of the aged and the poor.

As of February 1983, there were 142 PSROs. They are funded through grants, and the program is administered by HCFA.

The Peer Review Improvement Act of 1982, subtitle C of title I of TEFRA of 1982 substituted the Peer Review Organization (PRO) program for the PSRO program. The new PROs will be organizationally similar to PSROs and will perform the same type of functions for Medicare and Medicaid. Despite these basic similarities, PROs are to differ from PSROs in several respects, including the following:

--Contracts will replace grants as the funding mechanism.

--PROs are to be statewide bodies, except where HHS decides that the anticipated volume of reviews justifies more than one PRO per State. At present, many States have multiple PSROs.

--Whereas PSROs are funded for 1 year, PROs will be funded for 2.

The 1983 Social Security Amendments also required that hospitals enter into a contract with the PRO covering its area as a precondition for receiving Medicare payments. Also, State Medicaid agencies may contract with PROs to review the medical necessity of Medicaid services.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to assess (1) the reasonableness and medical necessity of hospital ancillary services paid under Medicare and Medicaid and (2) the effectiveness of steps taken by HCFA and its intermediaries, PSROs, and the States to assure that payments under the programs are made for only reasonable and necessary care. Selected PSROs conducted for us on-site reviews of hospital records for Medicare discharges. We limited our records review to Medicare beneficiaries because Medicare payments for hospital ancillary services ($25 billion) far exceed the payments for these services under Medicaid ($7.3 billion). The PSROs selected were:

--Kern County PSRO, Inc., Bakersfield, California.

--Area XXIV PSRO, Los Angeles, California.

--Colorado Foundation for Medical Care, Denver, Colorado.

--Dade Monroe PSRO, Inc., Miami, Florida.

--Eastern Mass. PSRO, Inc., Cambridge, Massachusetts.

--New Hampshire Foundation for Medical Care, Durham, New Hampshire.

--South Carolina Medical Care Foundation, Columbia, South Carolina.

--Utah PSRO, Salt Lake City, Utah.

Eight PSROs were selected because we believed this was a manageable number and would permit us to achieve our objectives. Our selection criteria included (1) geographical dispersion (East, South, etc.), (2) rural or urban service area, (3) the PSRO's interest in the medical review of ancillary services and their willingness to participate, (4) views of HCFA officials, and (5) PSRO location relative to available GAO staff.

Each PSRO reviewed the medical records for about 50 Medicare discharges at each of two hospitals. The records contained information pertinent to the medical condition and treatment of the patients, as well as the hospital charges for the services provided.

A PSRO registered nurse made the initial medical review determinations, and PSRO physicians made the final determinations. The nurses and physicians used their judgment to determine whether such services were medically necessary.

To gain some insight into the relative value of the various ways that medical reviews can be made, we used two methods to select Medicare cases for review. One involves the use of random sampling, while the other method--which for the purpose of this report is called a "focused review"--involves a more discriminating way of selecting cases.

The focused review method was used by four PSROs at eight hospitals. Using Medicare ancillary charge data obtained from computer billing data provided by Medicare intermediaries (Blue Cross plans in Southern California, Colorado, and Florida), we developed normative ancillary charges by diagnosis. For example, knowing the average charges for laboratory services for a coronary bypass, those bypass cases with exceptionally high laboratory charges would represent high potential for overutilization. The data were used to select both hospitals and hospital case files for review based on high utilization of ancillary services. A further explanation of how this was done is included in appendix III.

For the random sampling method, eight hospitals were selected by four PSROs on the basis of a number of factors, including ancillary service utilization, size, and proximity to the PSRO. The case files were selected on a random sample basis. For comparison purposes, the random sampling method was done at one hospital where we used focused review.

To provide for consistency in the medical review and data collection by PSRO reviewers and to focus their attention on common problem areas, we developed a data collection instrument

with the assistance of PSRO #23 in Torrance, California (see app. I). PSRO #23 had experience with reviewing the medical necessity of ancillary services, and the instrument was based largely on the results of its work.

The instrument was field tested at a Los Angeles hospital by the Beverly Hills PSRO (Area 25) which found in a random sample of 61 claims that 22 percent of the charges for ancillary services were not covered under the Medicare program. Nine percent represented services which were not reasonable and medically necessary, while the other 13 percent were for services which did not meet various other program requirements. The major problem identified with the latter was the absence of a signed order by a physician authorizing the services provided. Despite the significance of these findings, i.e., no signed orders, this aspect was excluded from our review at the 16 hospitals because of our desire to focus the PSROs' attention on medical necessity issues.

After the instrument was developed, a workshop for all participating PSROs was held at PSRO #23 in Torrance. The purpose was to brief the PSROs on our review objectives and methodology, acquaint them with the use of the data collection instrument, and give them an opportunity to review actual case files which included some unnecessary care.

We discussed our findings with officials of HCFA's central office and obtained their comments, which are reflected in this report where appropriate. Our review was performed in accordance with generally accepted government auditing standards.

CHAPTER 2

UNNECESSARY CARE IS BEING PROVIDED

About 6 percent of the ancillary services reviewed by the PSROs were not reasonable or medically necessary.[1] The percentages of unnecessary care were about 10 percent each for laboratory, special services, and radiology. Physical therapy had the highest figure--32 percent.

Studies by HCFA, PSROs, the California Medicaid program, and others show similar percentages of unnecessary care. Other studies also show high percentages of ancillary services which do not meet various other requirements of the Medicare and Medicaid programs. A common problem in this respect is tests performed and billed with no signed physician orders.

The amount of unnecessary care can be sizable. For example, at one hospital where the percentage of unnecessary care was relatively low--2.7 percent--a random sample of Medicare claims disclosed $2,918 of unnecessary ancillary services. Estimating the results of the sample findings to the hospital's universe of 1981 Medicare claims amounts to at least $255,000 in unnecessary care for that year.

Some of the hospitals reviewed generally agreed with the PSRO findings, while others disagreed that the care provided was unnecessary. The hospitals that commented said that physicians are primarily responsible for the utilization of ancillary services because they order the services.

RESULTS OF REVIEWS

The PSRO reviews resulted in about 6 percent of the claimed ancillary services being determined as not medically necessary. The following table summarizes the PSRO findings.

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[1]The actual impact on Medicare outlays depends on hospital cost and Medicare caseload. Medicare reimburses hospitals on the basis of cost and not charges and generally hospital charges are greater than hospital costs. The amount of hospital costs that Medicare pays depends on the extent of hospitals' Medicare caseload; the greater the Medicare caseload, the greater Medicare's share of the hospitals' costs.

Amount and Percent of Unnecessary Care by Type of Service

Service	Total charges reviewed	Unnecessary charges	Percent of unnecessary charges
Laboratory	$1,228,390	$ 95,940	7.8
Special services[a]	346,403	37,857	10.9
Radiology	277,430	23,910	8.6
Inhalation therapy	551,407	33,887	6.1
Physical therapy	92,178	29,767	32.3
Other[b]	1,549,185	10,297	0.7
	$4,044,993	$231,658	5.7

[a]Includes electrocardiograms (EKGs), electroencephalograms, computerized tomography, nuclear medicine, and telemetry.

[b]Includes pharmacy, medical supplies, blood administration, speech therapy, and occupational therapy.

The largest amount of unnecessary charges, $95,940, was for laboratory services which represented over one-third of the total unnecessary charges. Physical therapy had the highest unnecessary care rate--32 percent. The "Other" category, consisting mainly of pharmacy and medical supplies, had the lowest percentage of unnecessary care. According to one PSRO, it was impractical to review these services because of the lack of information contained in the case files and the high volume of low cost items. If the "Other" category had been excluded from the study, the overall percentage of unnecessary care would have been 9 instead of 6. Examples of the PSRO findings are shown in appendix II.

An analysis of the PSRO findings shows that urban hospitals and proprietary hospitals had on the average much larger percentages of unnecessary care. The 10 urban hospitals had an average unnecessary care rate of 6 percent while the 6 rural hospitals had a rate of 3 percent. The average rate for the 5 proprietary hospitals was 11 percent compared with 5 percent for the 11 other hospitals.

The percentage for services considered to be unnecessary for hospitals reviewed ranged from 0.3 to 18.7 percent of total ancillary charges. The Florida and California PSROs had the highest percentage while the Colorado PSRO had the lowest. The table below summarizes the review results by PSRO.

Amounts and Percent of Unnecessary Care at Hospitals Reviewed by PSROs

PSRO	First hospital Amount	First hospital Percent	Second hospital Amount	Second hospital Percent
California Area #24	$17,928	10.1	$13,457	7.4
Colorado	2,080	0.3	1,531	0.3
Dade Monroe, Florida[a]	44,407	18.7	17,875	14.5
Eastern Massachusetts	11,250	5.4	3,957	1.7
Kern County, California	79,382	9.2	26,168	8.2
New Hampshire	2,791	5.6	668	1.4
South Carolina	4,854	5.1	2,139	2.5
Utah	2,918	2.7	255	0.4

[a]The percentage for the first hospital represents an average of using both statistical sampling and focused review; the amount represents the sum of noncovered care identified using both methods of review. (See pp. 27 and 28.)

The Dade Monroe, Florida, PSRO by far had the highest percentage of unnecessary care. According to PSRO officials, that care includes ancillary services associated with unnecessary admissions and/or days of care (length of stay). While the PSRO recognized, for example, that an unnecessary admission does not rule out the possibility that some of the ancillary services may have nonetheless been necessary, it believed that the vast majority of the ancillary services were not needed. Furthermore, the amounts of unnecessary care noted in the table above do not include routine charges for unnecessary room and board which totaled $60,007 for the cases reviewed.

We believe a major reason the Colorado PSRO had low unnecessary care rates is that most of the case files selected using the focused review method were for critically ill patients and involved long stays. The PSRO physician advisor stated that determinations in such cases are difficult because of their complexity. They involve multiple diagnoses, overlapping treatments, and high cost therapeutic technology. This physician advisor said that if less extreme cases had been selected, the PSRO's findings would have been more significant.

The significance of the percentage of unnecessary care is best illustrated in hospitals where the statistical sampling method of review was used. Based on the unnecessary care rates we found, for nine hospitals an estimated $1.4 million in unnecessary ancillary services was provided to Medicare patients in 1981. The table below summarizes the estimated amount of unnecessary care for each hospital.

Hospital	Percent of unnecessary care	Unnecessary care estimated for the year (note a)
A	18.9	$ 945,890
B	2.7	254,725
C	1.7	51,312
D	5.1	42,851
E	5.6	28,047
F	1.4	26,672
G	2.5	22,061
H	0.4	2,729
I	5.4	(b)
Total		$1,374,287

[a]Sampling errors are stated at the 95-percent level of confidence. Error rates ranged from ±31 to ±80 percent. All projections are conservative in that they represent the lower or minus end of the range.

[b]The results were not projected because the sampling error was too great (in excess of 100 percent).

For a discussion and comparison of the statistical sampling and focused review methods, see appendix III.

OTHER STUDIES

Many officials believe that there is overutilization of ancillary services; however, a literature search as well as discussions with these officials indicated there were few studies to support these views. The available studies, nonetheless, corroborate the findings of this report.

The PSRO, intermediary, and Medicaid officials we talked to generally said that ancillary services were overused. Further, their estimates of such overuse ranged from 3 to 30 percent. The views of these officials are in line with two surveys conducted in 1979. In a national utilization review survey, hospital administrators ranked ancillary services utilization as a major problem area, with 27 percent responding that more than 5 percent of ancillary services in their institutions were unnecessary. At a conference on ancillary services review sponsored by the University Health Policy Consortium, a group of Federal and non-Federal health care experts estimated that 30 percent or more of all diagnostic tests were unnecessary.

In April 1982, a HCFA Office of Program Validation study of laboratory and radiology services at three Baltimore hospitals showed that 8.5 percent of the laboratory and 3.1 percent of the radiology services were not medically necessary. These findings were based on a review of services received by a sample of Medicare beneficiaries during the first 6 months of 1980.

Due to increasing concern about the escalating cost of ancillary services, during 1982 the California Department of Health Services, which administers the State's Medicaid program, conducted medical reviews of ancillary services at 12 hospitals. Teams of physicians and nurses at the hospitals evaluated the medical necessity of the services before payment was made. They denied payments for an estimated 5 percent of the services for a program savings totaling $371,479. The major problems were unnecessary laboratory, radiology, inhalation therapy, and physical therapy services.

In 1980 and 1981, PSRO #23 in Los Angeles conducted ancillary services reviews in three hospitals. For a 7-1/2-month period, payment was denied for $181,000, or 6.4 percent of the ancillary services billed for reimbursement. Over half of the denied charges were unnecessary laboratory, radiology, and inhalation therapy services. In addition, the payment denials resulted in changes in physician practices as the average denied amount dropped from over $500 per claim during the first several months of the review at the worst hospital to under $100 near the end.

As the result of an investigation by HCFA's Office of Program Integrity, Blue Cross of Southern California initiated medical reviews of all claims submitted by four hospitals. The focus was on inappropriate admissions and lengths of stay; however, about 1 percent of the ancillary services were denied at two of the hospitals.

Finally, two PSROs that became aware of our study advised us of the problems they had identified concerning ancillary services. The Rhode Island PSRO found that 86 percent of the 1981 Medicare and Medicaid claims sampled at 15 hospitals had one or more services which had been improperly ordered, delivered, or billed. This represented an average of $41 per claim in noncovered charges. The Northern Louisiana Medical Review Association found that 39 percent of the Medicare and Medicaid claims sampled at 16 hospitals included one or more services which had not been ordered by a physician. Also, 13 percent of the claims had one or more services that had been billed but not delivered.

While the issues the Rhode Island and Louisiana PSROs disclosed do not directly address the reasonableness and medical

necessity of the services, we believe they underscore the loose controls over the proper utilization of the services. Furthermore, we identified similar problems at a Los Angeles hospital where we tested our review methodology and data collection instrument (see p. 6).

COMMENTS ON OVERUTILIZATION

We provided the specific findings of the PSRO reviews to all the hospitals and requested their comments in writing. The hospitals' responses were mixed--some agreed with the PSRO determinations, while others generally disagreed that the care provided was unnecessary. Although given the opportunity, those that disagreed provided little information to rebut the PSRO findings.

Most hospital officials said that the physicians are primarily responsible for overutilization because they order the services and that the hospital does not attempt to dictate medical practice.[2] Beyond this, the officials offered few opinions on the underlying causes of overutilization.

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[2]With the establishment of Medicare's prospective reimbursement system, hospitals will now have an incentive to eliminate or reduce unnecessary ancillary services (see p. 18).

CHAPTER 3

MEDICAL NECESSITY REVIEW IS VIRTUALLY NONEXISTENT

PSROs, Medicare intermediaries, and State Medicaid agencies, with few exceptions, have not routinely reviewed the reasonableness and medical necessity of hospital ancillary services. Because of the absence of medical reviews, all of the unnecessary care identified by the PSROs during our review (see ch. 2) was paid by Medicare intermediaries. The main reason that medical reviews have not been made is the lack of funding.

When a prospective payment system for Medicare is established, there will be an incentive for hospitals to reduce the unnecessary use of ancillary services. A new problem with unnecessary ancillary services, however, is that the prospective payment rates will be based on the prior costs incurred by hospitals, including the costs associated with unnecessary care.

EXTENT OF ANCILLARY SERVICES REVIEW

PSROs, Medicare intermediaries, State Medicaid agencies, and HCFA have all had some role in assuring that Medicare and Medicaid pay for only those ancillary services that are reasonable and necessary. Individually and collectively, however, little has been done, primarily because of the lack of funds. The best indicator of the inadequacy of the actions taken is that all of the unnecessary services identified by the PSROs in our review were paid for under the Medicare program.

PSRO review

In recent years, PSROs have had the lead role in reviewing hospital services. Of the eight PSROs in our review, however, only one assessed the medical necessity of ancillary services as part of its regular review activities. While the PSROs had agreements with the Medicare intermediaries and State Medicaid agencies which stated the PSROs had responsibility for hospital review, the PSROs primarily concerned themselves with reviewing hospital admissions and length of stays, which is consistent with the thrust of the PSRO program since its inception. The main reason cited for not reviewing ancillary services was the lack of funding. Moreover, before ancillary services reviews can be conducted, HHS has to approve the PSRO for this function and fund it.

The Kern County PSRO was the only one of the eight PSROs with an ongoing review of ancillary services, but the scope of

its review was limited. Based on profiles developed on the use of 30 different ancillary services, the PSRO targeted for medical review physicians who appeared to be overusing services. This was done at only 6 of the 12 hospitals under the PSRO's jurisdiction because responsibility for medical review had been delegated to the other 6 hospitals.[1] Furthermore, at any given time, the PSRO generally selected for review only one or a few physicians and their use of one particular procedure. For example, a physician might be reviewed if he or she routinely ordered multiple blood gases without first checking the results of previous tests.

The PSRO relied heavily on the physicians' willingness to modify practices to correct overuse problems. According to the PSRO director, if more aggressive action was taken, such as denying payment for unnecessary care, the PSRO might damage its relationship with the physicians and the hospitals. The PSRO could not describe the financial impact of its approach on overutilization because such data were not available. The PSRO director stated that a much more comprehensive study of ancillary services could be done if more funding was available.

Medicare intermediaries and State Medicaid agencies

While PSROs have the lead in the review of ancillary services, intermediaries and Medicaid agencies can use computer edits or screens to identify claims representing potentially unnecessary ancillary services. Claims that exceed the edits are subjected to manual review, usually by a nurse or physician. None of the Medicaid agencies in the States covered by our review had any such edits, but two Medicare intermediaries did--Blue Cross/Blue Shield of Connecticut and Blue Cross of Southern California.

While the two Blue Cross plans made some attempt to identify unnecessary services, their edits did not appear to be very effective. Blue Cross of Southern California said that the screens were not very effective because the screen parameters are so high that few claims ever exceeded them. To illustrate, the screens identify for review claims where

--total ancillary charges constitute at least 75 percent of the total claim and

--physical, speech, inhalation, or occupational therapy charges exceed $200 for certain diagnoses for which these services should not normally be provided.

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[1]PSROs delegate review activities to hospitals which they find willing and able to perform this function.

Further, only a 20-percent sample of processed claims is screened, and this is limited to the 43 hospitals which are not under PSRO jurisdiction--about 16 percent of the 273 hospitals submitting Medicare claims to the intermediary.[2]

Blue Cross of Connecticut did not have any data on payment denials resulting from its edits. Blue Cross officials told us, however, that they did not believe the edits were very effective.

HCFA activities

Two of the more significant activities undertaken by HCFA are the funding of PSRO special initiative projects and a contractor study of ancillary utilization.

During 1980 and 1981, HCFA spent over $3 million to develop a methodology for ancillary services review by funding over 150 PSRO demonstration and special initiative projects. According to a HCFA official, however, the projects were short term and HCFA did not conduct any systematic followup or evaluation to identify any effective approaches that may have been developed.

HCFA also budgeted $582,568 during 1980 through 1982 for a study designed to explain why the use of ancillary services varies greatly from one hospital or area to another. The study, which was expected to be completed in September 1982, was discontinued because of cost overruns.

PROSPECTIVE REIMBURSEMENT

TEFRA required the Secretary of HHS to develop a legislative proposal for Medicare payment to hospitals on a prospective basis. A proposal was sent to the Congress in December 1982 and served as the focal point for debate on prospective payment which culminated in the system mandated by the Social Security Amendments of 1983 (Public Law 98-21), approved April 20, 1983.

Major features of the system mandated by the Congress include the following:

--Prospective reimbursement rates are to be established for DRGs.

--For each DRG, a total of 20 rates are to be established--a national urban and rural rate and an urban and rural rate for each of nine census regions.

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[2]The intermediary assumed responsibility for the review of 43 hospitals because of the absence of a PSRO where the hospitals were located.

--Over a period of 4 years, cost-based reimbursement will be phased out while the national DRG rates are phased in to replace the regional DRG rates. HHS is also required to study the need for the urban/rural differential.

--The rates are to be based on allowable costs.

--For fiscal years 1984 and 1985, increases in the rates are to be limited to the increase in an index designed to reflect changes in hospital operating costs plus 1 percent.

--For fiscal year 1986 and beyond, rate increases are not tied to any formula, but in updating the rates, the Secretary of HHS must consult with a commission selected by the Office of Technology Assessment. Also, the Secretary is to recalibrate the DRGs to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. The Secretary is to take into account costs necessary for the efficient and effective delivery of medical appropriate and necessary care.

To ease the transition to the new prospective system, as well as to the national rates, the following reimbursement schedule has been established.

	Percent of payment to hospital based on		
Fiscal year	Cost	Census region DRG rates	National DRG rates
1984	75	25.0	0
1985	50	37.5	12.5
1986	25	37.5	37.5
1987	0	0	100.0

To develop the rates, HCFA plans to use three data bases--(1) "MEDPAR," (2) hospital cost reports, and (3) Medicare discharge file. MEDPAR is a 20-percent sample of bills from Medicare beneficiaries discharged from short-stay hospitals. The file includes diagnosis and surgical data and charges by ancillary services department. Medicare hospital cost reports contain an audited source of hospital costs. The discharge file is a source of the number of Medicare cases treated by a hospital during a given calendar year. For the fiscal year 1984 and 1985 rates, HCFA plans to use calendar year 1981 data.

In its 1984 budget, the administration did not request any funding for the PRO program. According to the administration, utilization review would not be as necessary under a prospective payment system. In contrast, the Social Security Amendments of 1983 incorporate provisions to strengthen the PRO role under the prospective payment system.

Under the amendments, as a condition for Medicare payment, hospitals are required to enter into a contract with the PRO covering its area if one has been designated. Among other things, the legislation specifies that PROs will review the validity of diagnostic information provided by hospitals, the completeness, adequacy, and quality of care provided, and the appropriateness of admissions and discharges. With respect to ancillary services, HHS officials said that PRO reviews will emphasize quality of care or underutilization of services.

To provide assurances of funding, the amendments also require that the amount allowed for PRO review generally be no less than the amount expended during fiscal year 1982 adjusted for inflation. The amendments also provide direct payments from the Medicare trust fund.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATION

CONCLUSIONS

The percentages of unnecessary ancillary charges we found at most of the 16 hospitals reviewed were substantial. Moreover, all of the unnecessary care identified was paid by Medicare.

With the impending establishment of a hospital prospective payment system for Medicare, there will be an incentive for hospitals to reduce the unnecessary use of ancillary services. Hospitals will be paid a flat rate by diagnosis and will have an incentive to keep their costs below these rates. To the extent that hospitals keep their costs lower than the rates, they will realize a "profit."

A problem with the prospective payment system is that the payment rates are based on data generated from the old cost-based system. The baseline data used to establish the prospective rates are inflated with the cost of unnecessary ancillary services. To provide a sound base for establishing rates, the cost of unnecessary care should be removed from the data base.

Because the prospective rates are to be in place on October 1, 1983, little can be done to purify the data base used in establishing the rates for fiscal years 1984 and 1985. However, the law establishing the prospective payment system requires HHS to recalibrate DRGs for fiscal year 1986 to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. For fiscal year 1986, HHS is also required to adjust the DRG payment rate using a factor which takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care. We believe that to fulfill these requirements HHS should implement procedures to assure that unnecessary ancillary services are not included in the data bases used for recalibration and payment rate updating. Medicare law includes a mechanism which can be used to fulfill this responsibility--that mechanism is PROs.

The prospective payment law requires hospitals to have agreements with PROs to review the quality and necessity of services provided to Medicare beneficiaries. HHS officials told us that the initial emphasis of PROs with regard to ancillary services will be toward quality of care; that is, toward ensuring that the incentive provided by prospective payment to cut costs does not result in the provision of fewer services than are necessary. We believe the PRO reviews should also include reviews

to determine whether unnecessary ancillary services are still being provided. If they are, the information developed under the expanded review could be used to adjust the payment rates. If the reviews show that hospitals no longer provide unnecessary ancillary services, we would know that the incentives of the prospective system worked for ancillary services as intended. In either case, the information gained by the expanded review would be useful and worthwhile.

The Medicaid program is also vulnerable to the payment of unnecessary ancillary services. As with the Medicare program, there were virtually no controls to detect Medicaid payments for unnecessary care. Further, a California Medicaid review of 12 hospitals provided results nearly identical to the findings of this study. Because the scope of our work did not include an examination of the medical necessity of ancillary services provided to Medicaid recipients, we are not making any recommendations regarding the Medicaid program. However, we believe that HCFA, in its review of State Medicaid plans, should evaluate the adequacy of State controls over the provision of ancillary services.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to require PROs to review and report on the medical necessity of hospital ancillary services and use the results as necessary to adjust the data base which will be used to establish the prospective payment rates for future years starting in fiscal year 1986.

APPENDIX I

DATA COLLECTION INSTRUMENT FOR ON-SITE MEDICAL REVIEWS

PHYSICIAN REVIEWER COMMENTS ON REASONABLENESS AND MEDICAL NECESSITY OF ANCILLARY SERVICES

Patient Name _____

Medical Record No. _____

Hospital _____

Nurse Reviewer _____

Physician Reviewer _____

Ancillary Services	Unit Price	Dates of Service: Questioned by nurse	Dates of Service: Disallowed by Physician	Units disallowed: Unnecessary	Units disallowed: Duplicated	Units disallowed: Overused	Units disallowed: Not Done	Total amount disallowed
1. INTENSIVE/ CORONARY CARE								
2. BLOOD ADMINISTRATION								
3. PHARMACY (specify)								
_____								
_____								
RADIOLOGY								
4. Chest x-ray								
5. Upper G.I.								
6. Oral Cholecystogram								
7. Skull x-ray								
8. Bone Series								
9. Abdominal x-ray								
10. Other (specify)								
_____								
_____								

APPENDIX I

Ancillary Services	Unit Price	Dates of Service: Questioned by nurse	Dates of Service: Disallowed by Physician	Units disallowed: Unnecessary	Units disallowed: Duplicated	Units disallowed: Overused	Units disallowed: Not Done	Total amount disallowed
LABORATORY								
11. Prothrombin Time								
12. Electrolytes								
13. BUN/Creatinine								
14. CBC								
15. Arterial Blood Gases								
16. Cultures and/or Sensitivities								
17. Urinalysis								
18. Biochem or Liver Panel								
19. Enzymes								
20. Blood Sugars								
21. VDRL								
22. Blood Type & Crossmatch or screen								
23. Other (specify)								
CENTRAL SUPPLIES								
24. IV Solutions								
25. IV Supplies								
26. Other (specify)								
PHYSICAL THERAPY								
27. Gait Training								
28. Hot Packs								
29. Massage								

APPENDIX I

Ancillary Services	Unit Price	Dates of Service: Questioned by nurse	Dates of Service: Disallowed by Physician	Units disallowed: Unnecessary	Units disallowed: Duplicated	Units disallowed: Overused	Units disallowed: Not Done	Total amount disallowed
30. Evaluation								
31. Other (specify)								
OCCUPATIONAL THERAPY								
32. Specify								
SPEECH THERAPY								
33. Specify								
INHALATION THERAPY								
34. IPPB								
35. Oxygen								
36. Other (specify)								
OTHER								
37. Ct Scan								
38. EKG or EEG								
39. Echocardiogram								
40. Pulmonary Function								
41. Nuclear Medicine								
42. Other (specify)								
43. TOTAL ANCILLARY SERVICES								
44. NON-ANCILLARY SERVICES (specify)								

EXAMPLES OF PSRO FINDINGS

BY TYPE OF ANCILLARY SERVICE

LABORATORY

A diagnostic test is a procedure or an examination which provides information for assessing a medical condition or identifying a disease. While the $95,940 of unnecessary laboratory tests represented dozens of different diagnostic tests, electrolytes, biochemical panels, and arterial blood gases accounted for almost half of the unnecessary laboratory charges. The following are examples:

--Electrolyte tests totaling $850 were ordered every 4 to 6 hours and continued despite the fact that all 50 showed normal results.

--Biochemical panels involving about $2,000 were ordered daily for almost 2 months, even though the initial results were normal.

--Biochemical panels were ordered every other day during a 45-day period when every week would have been adequate; unnecessary charges--$1,377.

--Multiple arterial blood gases were given daily for a 60-day period when every other day would have been sufficient; unnecessary charges--$2,852.

SPECIAL SERVICES

The special services category includes computerized tomography head scans, nuclear medicine, telemetry, and pulmonary function studies. We also included EKG and electroencephalogram services. Two examples follow:

--Telemetry services involving a daily charge of $100 were given for an 8-day period when the initial 3 days would have been sufficient.

--EKGs ($37 each) were repeated six times when only two were considered medically necessary.

RADIOLOGY

The major radiology service disallowed by the PSRO physicians was chest X-rays. Two examples of the disallowed care are:

--Chest X-rays were ordered daily even after the first chest X-ray was normal and no new reasons were documented to indicate a need for additional testing.

--Three chest X-rays were given on the day of admission when only one was needed.

INHALATION THERAPY

About 6 percent of inhalation therapy services claimed were unnecessary. The medical director of one PSRO said the services primarily represented intermittent positive pressure breathing[1] given to surgical patients who did not need it or could have received incentive spirometry instead.[2] Also, another common problem was therapy treatments that were continued beyond the point of benefit to the patient. The medical director attributed the overuse to physicians' lack of familiarity with the proper use of inhalation therapy technology as well as the absence of "stop orders" once treatment had begun.

The following are examples of the cases in which overuse was found:

--A patient received inhalation therapy services amounting to $2,076 even though he did not exhibit any symptoms relating to a respiratory diagnosis.

--Intermittent positive pressure breathing treatments amounting to $518 were given to a patient when incentive spirometry could have been given at a much lower cost.

PHYSICAL THERAPY

About 32 percent of the physical therapy services claimed by the hospitals was unnecessary. Two reasons given by one PSRO for the unnecessary care were that (1) patients did not require

---

[1]Intermittent positive pressure breathing involves the use of a mechanical ventilator to supply air or oxygen to assist the patient in breathing.

[2]Incentive spirometry, which is less expensive and in many cases more effective, encourages breathing by having the patient blow into a container that records the amount of air blown out, that is, the harder you blow the higher a ping-pong type ball rises in a column.

the level of care provided by a physical therapist and (2) treatments were given even when no further progress was possible. Further, the PSRO said these problems could have been avoided with proper planning and evaluation before and during the course of treatment. Two examples follow:

--A physical therapist was used to assist the patient on brief walks at a charge of $294 even though "all she needed was her husband to walk her."

--All physical therapy treatments, amounting to $8,461, were considered medically unnecessary because the patient did not have a valid diagnosis for the services, and moreover, the patient was not responding to treatment.

DESCRIPTION AND COMPARISON OF REVIEW METHODS

Two methods of review were used in our study--focused review and statistical sampling. The following describes and compares them.

FOCUSED REVIEW

This approach involves a targeting methodology based on a computer analysis of over 1 million fiscal year 1981 Medicare claims from Blue Cross organizations in Southern California, Florida, and Colorado. The method compared the utilization patterns of hospitals with norms and identified aberrant patterns for further review. Thirty broad diagnostic groups were used which accounted for about half of Medicare claims submitted by the hospitals. For each diagnostic group, normative information was developed for 11 ancillary service categories. For example, for an individual that has an inguinal hernia without complications, we identified the norm of practice in terms of the charges for each ancillary service.

Once the norms based on the general diagnostic group had been established, the individual utilization patterns which represented aberrant or high utilization were targeted for individual case review by PSROs. Eight hospitals were selected which ranked among the top 20 percent in terms of high utilization of ancillary services in their PSRO area. A list of claims from hospitals which exceeded the norms were provided to the four PSROs doing the focused review. The PSROs selected about 50 of these claims for medical review.

Generally the PSROs selected cases with high charges but excluded long stays and deaths because they were more likely to involve complex medical problems which would account for the high ancillary charges. However, the Denver PSRO selected its cases strictly on the basis of high laboratory and inhalation therapy charges. As a result, the selections involved mostly critically ill and long-stay patients and few services were questioned.

STATISTICAL SAMPLING

The second approach involved statistical sampling. A random statistical sample of claims was selected from among the universe of 1981 Medicare claims at nine hospitals. The PSROs then reviewed individual medical records and based on their findings, the results of the sample review were estimated for the universe of Medicare claims.

APPENDIX III

The relative sampling error at the 95-percent level of confidence was high, generally ranging from 31 to 80 percent. The reason for the high sampling error was the large degree of variability in the findings among the individual claims. To be on the conservative side, we used the lower or minus end of the range of error in the projections (see p. 10).

COMPARISONS OF THE METHODS

A comparison of the two methods shows that the overall percentages of unnecessary care were similar--6 percent using the focused method and 5 percent using the statistical sampling method. The dollar amounts of unnecessary care identified using the focused method were about 3-1/2 times higher than the unnecessary care found in the randomly selected claims. This is partly because the claims selected using the focused method involved higher dollar amounts.

To gain some insight into the relative cost/benefit of the two methods of review, the cost of PSRO physician and nurse review time was tracked. While there are other costs involved in conducting reviews, the cost of the review time is probably the most significant variable. Because of higher utilization, the focused review generally takes longer than reviewing cases selected at random, many of which may involve relatively low ancillary service utilization. The costs of transportation, travel time, report preparation, and general overhead would generally represent fixed cost regardless of review method, and per diem cost, if any, generally would be a function of the amount of review time. The table below compares the costs and benefits of each.

Comparison of Cost/Benefit Ratios

	Focused review	Statistical sampling unprojected
Cost of review	$ 12,591	$ 7,427
Unnecessary care	182,215	49,443
Cost/benefit ratio	1:14.5	1:6.7

The table shows that the cost/benefit ratio for focused review is about double that of the results of statistical sampling.

At one hospital we used both methods of review and the results were comparable. Using statistical sampling, the amount

and rate of unnecessary care were $20,613 and 18.9 percent; for focused review the amount and rate was $23,794 and 18.5 percent. The cost/benefit ratio for statistical sampling and focused review was 18.4 and 23.9, respectively.

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