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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D C 20548

NOV 13 1970

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Dear Mr. Chairman.
Long (Senate)

Pursuant to your request of May 7, 1970 (enc. II), we are submitting a report (enc. I) on our examination into Medicare payments made by Blue Shield of Florida, Inc (Blue Shield), for the services of supervisory and teaching physicians at Jackson Memorial Hospital, in Miami, Florida, which is a teaching hospital for the University of Miami School of Medicine (University). The supervisory and teaching physicians were on the faculty of the University, and some of them were also employed full time by the Veterans Administration (VA) at its Miami hospital which is also affiliated with the University. The Medicare payments discussed in this third report, submitted pursuant to your May 7 request, 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, which has contracted with various private insurance companies, such as Blue Shield organizations, to make benefit payments for physicians' services

Following is a summary of the information we obtained at the University and at Jackson Memorial Hospital relating to the points of interest specified in your letter of May 7 These matters are discussed in more detail on the cited pages of enclosure I

--For the 18-month period ended December 31, 1969, Blue Shield paid about $930,000 under part B of the Medicare program for the services of University physicians who were teaching the residents and interns in training at the hospital and who were also functioning as the physicians having overall responsibility for the medical care of indigent and certain paying patients The billings were made on a fee-for-service basis in the names of specific physicians for specific services provided to specific Medicare patients

--Included in these payments was about $100,000 for the services of University physicians who also were employed full time by

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the VA. Under VA regulations, VA hospitals and their medical staffs have been encouraged to become affiliated with medical schools Further, VA regulations have permitted full-time VA physicians to teach in educational institutions and to accept remuneration, provided that the teaching activity did not impinge on the physicians' responsibilities for the care and treatment of VA patients. Full-time VA physicians, however, could not assume responsibility for the continuing care of non-VA patients, although the assumption of such responsibility was required before payment for supervisory and teaching physicians' services could be made under part B of the Medicare program.

Because the Medicare payments for the services of full-time VA physicians appeared to be in conflict with either the VA or the SSA regulations, we brought the matter to the attention of these agencies Subsequently, VA, in a February 1970 clarification of its regulations, specifically prohibited its full-time physicians from rendering continuing care to Medicare or Medicaid patients or to bill for such services. Further, in March 1970 SSA ordered the suspension of Medicare part B payments for the services of full-time VA physicians in teaching hospitals. (See pp 4 to 6.)

--Our examination included a review of the hospital medical records relating to 65 Medicare patients on whose behalf 188 bills totaling about $52,000 had been submitted to Blue Shield. The bills in our sample covered 1,684 occasions of service. Our comparison of the services billed with the related medical records showed wide variations in the involvement by the physicians in whose names the services had been billed to Medicare.

For about half of the 188 bills reviewed, there was no evidence in the medical records that the physicians had been involved in providing or supervising any of the 733 services billed in their names with respect to particular Medicare patients, although,

in some cases, the bills covered several weeks of hospitalization. On the other hand the medical records related to about one third of the 188 bills reviewed showed that the physicians in whose names the bills had been submitted had been involved in providing all the 163 services billed in their names with respect to specific Medicare patients. Because the variations in documentation sometimes involved the same physicians, this suggested to us that the hospital's medical records may have provided a basis for measuring a physician's personal involvement in the services billed in his name with respect to a given patient.

In the majority of cases, the medical records showed that only residents and interns had provided the services Residents and interns are not authorized to bill on a fee-for-service basis under part B of the Medicare program, but a portion of their salaries is reimbursable to the hospital under part A of the Medicare program. If reimbursement for these services were made under both parts A and B, the Medicare program would be paying twice for the same services. (See pp. 7 to 12 )

--Of the 1,684 occasions of services included in the bills reviewed, 388 services had been provided after July 1, 1969. We reviewed the bills for these 388 services to ascertain the extent of compliance with the revised guidelines which SSA issued in April 1969 and which were sent to the University for implementation in June 1969. These revised guidelines set forth more clearly (1) the services which must be performed by a teaching physician to be eligible for part B payments on a fee-for-service basis and (2) the documentation required in the medical records to demonstrate the performance of such services.

We found that, for 70 percent of the services provided to Medicare patients on or before July 1, 1969, and for 57 percent provided after July 1, 1969, the hospital's medical records did

not show that the supervisory or teaching physicians in whose names the bills had been submitted had been involved in providing the services billed. The lack of documentation showing the involvement of the physicians named on the bills for services rendered after July 1, 1969, indicated to us that, except for anesthesiology and certain surgery charges, the University had not effectively implemented SSA's April 1969 guidelines. (See pp 7 to 10 )

--A portion of the salaries paid to University anesthetists at the hospital, who billed for services to Medicare patients under part B, was also included by the hospital in its claim for reimbursement under part A of the Medicare program. As a result, the hospital's claim for reimbursable Medicare costs was overstated by about $17,000 during the fiscal year ended September 30, 1969. SSA advised us that it would inquire into this matter and would recover any incorrect payments. (See pp. 33 and 34 )

--The University had 16 medical school departments, and each department billed separately for the services provided by the physicians on its faculty. University Medical Associates, Inc., was established in December 1967 by the University for the purpose of billing and collecting fees for services provided to Medicare patients by faculty physicians in the department of medicine The department of medicine received about 50 percent of the Medicare payments collected by the University during the 18-month period ended December 31, 1969. In other University departments Medicare payments were made to individual physicians who turned the money over to the University.

The Medicare payments to the University, whether collected by individual physicians or by University Medical Associates, were credited to the University's professional income plan accounts and, according to the plan, were used for paying faculty

salaries and for providing "financial support for the enrichment and development" of the University medical school. (See pp. 3 and 4.)

--Under part B of the Medicare program, the patient is responsible for a portion of the charges for physicians' services (deductible and coinsurance). The practices for billing Medicare patients for these deductible and coinsurance amounts varied among University departments. Some departments billed for the deductible and coinsurance amounts and others did not, not even in cases where the charges of more than one department involved the same patient.

The department of medicine, which received the largest amount of Medicare payments, billed about 1 percent of the deductible and coinsurance amounts. In contrast, the departments of surgery and anesthesiology billed about 98 and 44 percent, respectively, of the deductible and coinsurance amounts. In total, the University billed Medicare patients or their insurers for only $2,273, or 25 percent, of the $9,252 of deductible and coinsurance amounts applicable to the bills included in our sample and had collected only $1,225. (See pp. 35 and 36.)

--For 127 of the 188 bills we reviewed, the Medicare claim forms had not been signed by the patients, as was generally required by SSA regulations, but a Blue Shield official advised us that all Medicare patients were notified of the payments made on their behalf. (See pp. 37 and 38.)

--Information furnished by the University showed that, during the 18-month period ended December 31, 1969, the University billed in excess of $1 million to about 273 private insurers (other than Medicare), employers, and organizations, such as labor unions, for services provided by its faculty physicians. University officials advised us that practically all health insurance companies honored bills for services provided by its

teaching physicians. They advised us also that the same fee schedules were used for billing private insurers and the Medicare program. (See pp. 39 and 40.)

--Because Blue Shield had not assured itself as to the University's compliance with SSA's April 1969 guidelines, SSA, in August 1969, requested Blue Shield to suspend all payments for services provided by University physicians. A Blue Shield audit completed in September 1969 disclosed that, for 74 percent of the services included in the audit, the involvement of the physicians in whose names the bills had been submitted could not be verified because there was no supporting documentation in the medical records.

In October 1969, Blue Shield advised University officials that the resumption of Medicare payments would depend upon compliance with certain minimum requirements which included recording the name, signature, or initials of the attending physicians in the medical records supporting the claims. Blue Shield notified the University in November 1969 that Medicare part B payments would be resumed for certain departments on the basis that immediate refunds would be made if a later audit revealed cases which did not meet the criteria set forth in SSA's April 1969 guidelines.

In April 1970, Blue Shield notified the University that its Medicare part B payments were being suspended again because another audit by Blue Shield had revealed that the required documentation for 47 percent of the services billed by the University could not be found in the medical records. Blue Shield, however, did not request the University to refund any of the Medicare payments In July 1970, Blue Shield advised us that it had not requested refunds because plans for additional audit work involving the use of statistical-sampling methods in determining the amounts of the refunds were still being developed in cooperation with SSA. (See pp 30 to 32.)

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

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

2 Some or all of the Medicare patients do not pay the deductible and coinsurance amounts related to the physicians' charges

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

We believe that this report will be of use to the Committee in its consideration of the teaching-physician provisions of House bill 17550 As stated above, the House bill provides that reimbursement for teaching-physicians' services under part B of the Medicare program be made on a cost-reimbursement basis when some or all of the Medicare patients do not pay the deductible and coinsurance amounts related to the physicians' charges

With regard to this provision, we noted that the practices for billing and collecting deductible and coinsurance amounts by the University for Medicare patients at the Jackson Memorial Hospital varied among its departments Some departments billed for the Medicare deductibles and coinsurance amounts and others did not, not even in cases where the charges of more than one department involved the same patient

Because the departments in the University medical school each billed independently for Medicare services and had different practices pertaining to billing for deductible and coinsurance amounts, we believe that the conditions provided in the House bill for billing on a fee-for-service basis may be burdensome to administer and could result in different reimbursement methods within the same institution For instance, if the University continues to permit some departments to require Medicare patients to pay deductible and coinsurance amounts and permits other departments to not require such payments, some departments may be eligible for reimbursement on a fee-for-service basis, whereas other departments may be paid on a cost-reimbursement basis

The matters discussed in enclosure I were presented to SSA, Blue Shield, and the University for review Their written comments were considered by us in the preparation of our report The University stated that notations in the patients' medical records indicating the involvement of the physicians in whose names the bills had been submitted had no relationship to whether the services were rendered and had no clear relationship to the quality of care provided The University stated also that, in its opinion, its faculty had provided the Medicare patients with the highest possible quality of patient care

Pursuant to arrangements with the Committee, copies of this report are being sent today to the Secretary of Health, Education, and Welfare and to the Commissioner of Social Security A similar report is being sent to the Chairman of the Committee on Ways and Means, House of Representatives

Sincerely yours,

Comptroller General
of the United States

Enclosures - 2

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

# GENERAL ACCOUNTING OFFICE

# EXAMINATION INTO

# MEDICARE PAYMENTS FOR SERVICES OF

# SUPERVISORY AND TEACHING PHYSICIANS AT

# JACKSON MEMORIAL HOSPITAL

# MIAMI, FLORIDA

## INTRODUCTION

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

Medicare provides two forms of health protection for eligible beneficiaries aged 65 and over. One form of protection--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. This protection is financed from a trust fund established through a social security payroll tax. Blue Cross of Florida, Inc., is the principal SSA contractor in Florida for making benefit payments under part A.

The second form of protection--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 July 1, 1970, the monthly premium was increased from $4 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 of Florida, Inc., is the SSA contractor for making part B benefit payments in Florida.

Payments on a fee-for-service basis for services provided by supervisory and teaching physicians at teaching hospitals are allowed by SSA regulations under part B. To qualify, 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 approved training programs are reimbursed to hospitals under part A of the program.

MEDICAL CARE AT JACKSON MEMORIAL HOSPITAL AND AFFILIATION WITH UNIVERSITY OF MIAMI

Jackson Memorial Hospital (JMH) in Miami, Florida, is a 1,250-bed, county-owned general hospital operated under a joint agreement between the Dade County Board of County Commissioners and the trustees of the University of Miami. JMH is a teaching hospital for the University of Miami School of Medicine (University) and provides facilities for private and staff patients. A staff patient is one who needs medical care but who is financially unable to pay for the care. The overall administrative direction of JMH is provided by a hospital director who is responsible to the Dade County Manager. Funds for JMH operations are derived from payments received from patients and third-party insurers and from county taxes.

The JMH medical staff consists of about 850 faculty members appointed by the University, of which about 150 are full-time departmental faculty members. About 45 members of the University's faculty were also identified as full-time employees at the Veterans Administration hospital in Miami. A staff of about 500 private physicians approved by the county commissioners also practice at JMH. Additionally, there are about 3,800 county employees, including residents and interns, on the JMH staff who assist in providing health care services at JMH.

In accordance with a January 1959 agreement between the University and Dade County, the University pays 25 percent of the salaries of the residents at JMH. Because these payments are made by the University, they are not eligible for reimbursement to either JMH or the University under part A of

the Medicare program. University officials advised us that, for the fiscal year ended May 30, 1971, these salary payments by the University would amount to about $500,000.

JMH provides a full range of medical services, including the usual services in medicine, surgery, obstetrics, gynecology, and pediatrics. For the fiscal year ended September 30, 1969, JMH reported that it had provided 374,421 patient-days of care, of which about 74,884 patient-days, or 20 percent, had been provided to Medicare patients. The cost of operating JMH during this same period was about $40 million.

University billing organizations

The University has 16 medical school departments, and each department bills Medicare, other third-party insurers, and/or patients separately for medical services provided by its full-time faculty physicians to Medicare and non-Medicare patients. A University Medicare patient is defined by the University as:

> "*** a patient with Medical Insurance (Part B) who is seen in the ambulatory or in-patient service at Jackson Memorial Hospital and, on inquiry, does not have or request a local licensed physician, or, if a specific physician is requested he or an alternate is unavailable."

The department of medicine, which received about 50 percent of the Medicare Part B payments collected by the University during the 18-month period ended December 31, 1969, established a nonprofit corporation (University Medical Associates, Inc.) in December 1967 for the purpose of billing and collecting fees for services provided to Medicare patients by faculty physicians in the department. Under this arrangement, bills were rendered in the names of the physicians, who had made assignments to the corporation, and Blue Shield made payments directly to the corporation. In the other University departments, Medicare payments were made to individual physicians who turned the money over to the University.

Funds received for services provided by full-time departmental faculty physicians became University property and were credited to departmental professional income plan accounts

which were used, in part, for paying faculty salaries and for providing "financial support for the enrichment and development" of the University medical school. University officials advised us that, during the 18-month period from July 1, 1968, through December 31, 1969, the University had collected at least $929,139 under part B of the Medicare program. The following table shows the amounts of Medicare collections reported by the medical school departments during this period. Information concerning the total amounts of Medicare collections by the University from July 1, 1966, through June 30, 1968, was not obtained.

| Department | Total | Period 7-1-68 to 6-30-69 | Period 7-1-69 to 12-31-69 |
|---|---|---|---|
| Anesthesiology | $115,999 | $ 79,360 | $ 36,639 |
| Dermatology | 39,495 | 28,722 | 10,773 |
| Family Medicine | 30 | 30 | - |
| Medicine | 486,853 | 325,060 | 161,793 |
| Neurology | 21,513 | 17,757 | 3,756 |
| Obstetrics-Gynecology | 32,554 | 23,472 | 9,082 |
| Ophthalmology | 65,805 | 40,948 | 24,857 |
| Orthopaedics | 29,574 | 18,162 | 11,412 |
| Otolaryngology | 37,438 | 14,761 | 22,677 |
| Pediatrics | - | - | - |
| Psychiatry | 3,037 | 2,166 | 871 |
| Radiology (note a) | - | - | - |
| Neurosurgery ) | 24,622 | 22,451 | 2,171 |
| Surgery--general) | | | |
| Thoracic and Cardiovascular | 6,346 | 6,346 | - |
| Urology | 65,873 | 38,340 | 27,533 |
| Total | $929,139 | $617,575 | $311,564 |

[a]Information on Medicare collections from this department was not available.

Of the $617,575 collected under part B of the Medicare program during fiscal year 1969, about $101,000, or about 16 percent, was applicable to the services of 17 full-time VA physicians who were also on the University faculty.

See p 6

## PERTINENT SSA REGULATIONS RELATING TO PAYMENTS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS, RESIDENTS, AND INTERNS AND VA REGULATIONS RELATING TO TEACHING ACTIVITIES OF FULL-TIME VA PHYSICIANS

The SSA regulations dealing with part B payments for professional services provided to Medicare patients by supervisory and teaching physicians were issued in August 1967.[1] Under these regulations, a charge can be paid under part B for the services of an attending physician who involves residents and interns in the care of his Medicare patients only if his services to the Medicare patient are of the same character in terms of responsibilities that are assumed and fulfilled as the services he renders to his other paying patients.

In April 1969, SSA issued new and more comprehensive guidelines which, according to SSA, were intended to clarify and supplement the criteria for making payments for services of supervisory and teaching physicians. SSA stated that the new guidelines had been found to be necessary because there had appeared to be a serious need for a better and more uniform understanding of the conditions under which such payments could be made.

According to SSA's April 1969 guidelines, teaching physicians, to qualify for reimbursement under the Medicare program, should assume full responsibility and control over the care of the patient at least during the specific period of the patient's hospitalization.

Under VA regulations, VA hospitals and their medical staffs have been encouraged to become affiliated with medical schools. Further, VA regulations have permitted full-time VA physicians to teach in educational institutions and to accept remuneration, provided that the teaching activity did not

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[1]The SSA regulations were published in February 1967 in the Federal Register as a proposed rule.

impinge on the physicians' responsibilities for the care and treatment of VA patients. The VA regulations dealing with outside activities of its full-time physicians provided, however, that the physicians may not assume responsibility for the continuing care of non-VA patient.

Because the Medicare payments for the services of full-time VA physicians at JMH appeared to be in conflict with either the VA or the SSA regulations, we brought the matter to the agencies' attention. Subsequently, VA, in a February 1970 clarification of its regulations, specfically prohibited its full-time physicians from rendering continuing care to Medicare or Medicaid patients or to bill for such services. Further, in March 1970 SSA ordered the suspension of part B payments for the services of full-time VA physicians in teaching hospitals.

## REVIEW OF MEDICAL RECORDS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS CHARGED TO MEDICARE PROGRAM

JMH's medical records relating to payments of about $38,000 for services furnished to 65 Medicare patients at JMH indicated that, except for anesthesiology and certain surgery charges, the majority of the services had been provided by residents and interns. Further, we noted instances in which the records did not contain any evidence that the physicians in whose names the services had been billed had been involved in any of the services billed during the period of the Medicare patients' hospitalization and that, according to the records, the medical care had been provided exclusively by the residents and interns at JMH. Residents and interns are not authorized to bill on a fee-for-service basis under part B of the Medicare program, but a portion of their salaries is reimbursable to the hospital under part A of the Medicare program. If reimbursement for these services were made under both parts A and B, the Medicare program would be paying twice for the same services.

We selected for review 188 bills which had been submitted and paid under part B applicable to 65 Medicare patients who were hospitalized at JMH for periods between July 1, 1968, and December 31, 1969. Our selection included bills for 20 patients who were hospitalized after July 1, 1969, to ascertain the extent of compliance with SSA's April 1969 revised guidelines concerning Medicare payments to supervisory and teaching physicians.

The following table summarizes, for the bills we reviewed, the types and number of services, the amounts billed by the University (including services by full-time VA physicians) and by private physicians, and the amounts allowed by Blue Shield.

| Type of service | Number of services | Amount billed | Amount allowed by Blue Shield |
|---|---|---|---|
| Medical services: | | | |
| Initial visits | 62 | $ 2,715 | $ 2,585 |
| Daily medical care | 1,387 | 19,977 | 19,334 |
| Consultations | 88 | 2,330 | 2,260 |
| Outpatient care | 17 | 233 | 188 |
| Other | 45 | 1,301 | 1,187 |
| Total medical | 1,599 | 26,556 | 25,554 |
| Surgical services: | | | |
| Surgery--operating room | 48 | 21,310 | 19,074 |
| Surgery--other | 2 | 25 | 25 |
| Anesthesiology | 35 | 4,011 | 3,951 |
| Total surgical | 85 | 25,346 | 23,050 |
| Total | 1,684 | $51,902 | 48,604 |
| Less deductibles and coinsurance | | | 10,432 |
| Total payments reviewed | | | $38,172 |

Private physicians at JMH billed for 227 of the 1,684 services and their charges amounted to about $7,500. The University and/or its faculty physicians billed for the remaining services.

JMH's medical records did not show any involvement by the attending physicians[1] in whose names the bills had been submitted in about 68 percent of the 1,684 services included in our sample. The following table shows, for the bills we

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[1]The term "attending physician" as used subsequently in this report excludes residents and interns and refers to University faculty physicians or private physicians who were entitled to bill on a fee-for-service basis under part B of the Medicare program.

reviewed, the types and number of services charged for and the percent of services for which the medical records did not show any involvement by the physicians in whose names the bills had been submitted.

| Type of service | Number of services reviewed | Medical record not showing involvement of attending physician named on bill | |
|---|---|---|---|
| | | Number | Percent |
| Initial visits | 62 | 39 | 63 |
| Daily medical care | 1,387 | 960 | 69 |
| Consultations | 88 | 54 | 61 |
| Outpatient care | 17 | 13 | 76 |
| Other medical services | 45 | 43 | 96 |
| Surgery--operating room | 48 | 16 | 33 |
| Surgery--other | 2 | 2 | 100 |
| Anesthesiology | 35 | 13 | 37 |
| Total | 1,684 | 1,140 | 68 |

In these cases, we found no evidence of the involvement of University physicians in about 75 percent of the services billed in their names, whereas evidence of the involvement of private physicians was lacking for about 25 percent of the services they billed for. Also the medical records did not show that any attending physicians had been involved in providing or supervising 1,032, or 61 percent, of the services. Furthermore, the medical records contained no evidence that 326, or 19 percent, of the services had been provided. Medical records showed that, in the majority of cases, residents, interns, and medical students had provided the services.

We believe that, because Blue Shield transmitted SSA's April 1969 guidelines to the University on June 19, 1969, bills for attending physicians' services submitted after July 1, 1969, should have been supported by medical records containing evidence of the physicians' involvement, as required by the revised guidelines. The revised guidelines required that the performance of the services billed to Medicare be demonstrated, in part, by notes and orders in the

patients' records that had been either written by or countersigned by the attending physicians.

Of the 1,684 services, 1,346 were provided on or before July 1, 1969, and 338 were provided after July 1, 1969. For 70 percent of the services provided on or before July 1, 1969, and 57 percent provided after July 1, 1969, the medical records did not show that the attending physicians in whose names the bills had been submitted actually had performed or directly supervised the services billed to Medicare.

Considering that, for 57 percent of the services charged for after July 1, 1969, the medical records showed no involvement by the attending physicians named on the bills, we believe that, except for anesthesiology and certain surgery charges, the University had not effectively implemented the revised SSA guidelines.

For about one half of the 188 bills included in our sample, which represented about one third of the amounts allowed by Blue Shield, there was no evidence that the physicians in whose names the bills had been submitted had been involved in providing or supervising any of the 733 services billed, although in some cases the bills covered several weeks of hospitalization. In most cases, the records showed that the services had been provided by only the residents and interns.

For example, one patient in our sample was hospitalized for 31 days and Medicare was billed $560 for a medical work-up (initial visit), a consultation, a minor surgical procedure, and 30 daily hospital visits. The only evidence in the patient's medical record relating to the involvement of an attending physician was a statement of the morning report officer,[1] which showed that he had received the resident's initial report of the patient's admission.

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[1] A morning report officer at JMH is a full-time University faculty physician in the department of medicine who meets with the resident staff each morning to review hospital admissions or special problem cases.

The University billed for daily hospital visits in the name of a full-time VA physician, although the medical records did not indicate that he had ever seen the patient during the period of hospitalization. Also we noted that, although the University had billed for 30 daily hospital visits in the name of this physician, the physician's VA time and attendance report showed that he was at JMH only 3 days a week.

In other cases, the physicians in whose names the bills were submitted were identified in the medical records as having been personally involved in providing a portion of the services billed for in their names with respect to particular patients. For about one third of the 188 bills included in our sample, which represented about one third of the amounts allowed by Blue Shield, the physicians in whose names the bills had been submitted were identified in the medical records as having been involved in providing all the 163 services billed in their names with respect to specific Medicare patients.

We recognize that variances in the extent of involvement shown in the medical records may be attributed in part to variances in the documentation practices of individual physicians. Because the variations in documentation sometimes involved the same physicians, however, this suggested to us that JMH's medical records may have provided a basis for measuring a physician's personal involvement in the services billed in his name with respect to a given patient.

The University used JMH medical records as the basic source for preparing Medicare bills. These bills were usually prepared by a department secretary who determined whether the services shown in the patients' medical records were billable. Therefore we reviewed the medical records applicable to the 65 Medicare patients included in our sample to ascertain (1) whether the records showed that the services actually had been provided and (2) the extent to which the attending physicians in whose names the bills had been submitted had been involved in providing such services.

Because of the technical nature of the data being considered, the Public Health Service made a physician available to provide us with professional assistance in examining the medical records.

Our findings with respect to each type of medical and surgical service included in our review and pertinent comments of the Public Health Service physician are discussed in the following pages.

Initial visits

When a Medicare beneficiary was admitted to JMH and assigned an attending physician, the Medicare program was generally billed for an initial visit or medical work-up which consisted of developing a patient history and making a physical examination and a diagnosis. The charge for an initial visit was usually $50 by the departments of medicine and ophthalmology and $35 by other departments. We were advised by University officials that the difference in these charges was due to the time and procedures necessary in the examination and diagnosis of each patient's illness.

The number and type of medical personnel identified as having been involved in providing the specific services relating to initial visits are summarized in the following table. In most cases, more than one individual was identified as having been involved in providing the same service. Therefore the number of medical personnel identified with the services exceeds the number of services supported by physicians' notations.

| | Bill for services rendered | | |
|---|---|---|---|
| | Total | On or before 7-1-69 | After 7-1-69 |
| Number of services: | | | |
| Billed | 62 | 42 | 20 |
| Not supported by physician's notation | 1 | - | 1 |
| Supported by physicians' notations | 61 | 42 | 19 |
| Medical personnel identified with record of service: | | | |
| Attending physician: | | | |
| Same as identified on bill | 23 | 13 | 10 |
| Other attending physicians | 27 | 24 | 3 |
| Residents | 89 | 62 | 27 |
| Interns | 57 | 40 | 17 |
| Medical students | 6 | 6 | - |
| Total | 202 | 145 | 57 |

The service billed but not supported by a physician's notation was a duplicate charge which was not allowed by Blue Shield The 61 services supported by physicians' notations included charges for emergency room services to six patients and one daily hospital visit. The charge for the daily hospital visit was an error, because it was for the first day of hospitalization for which a charge for an initial visit was also made. After we brought this billing error to the attention of University officials, they advised us that a refund would be made to Blue Shield.

We questioned the charges for emergency room services to the six patients, because the medical records did not show that any attending physicians had been involved in these services and because most of the other patients included in our sample had been admitted to JMH through the emergency room and no charges for physicians' services had been billed to Medicare. Also we noted that the six charges for emergency room services had been made in the name of a full-time VA physician who, according to his VA time and attendance reports, had been on duty at the VA hospital for 5 of the 6 days for which bills had been rendered.

The chairman of the department of medicine advised us that the six charges for emergency room services had been made on the basis that a University physician had been assigned to the emergency room and had been involved in the patients' care, even though the medical records did not show his involvement. He stated also that some emergency room services had not been billed because the department did not have sufficient administrative capability to bill for all services and because Blue Shield had recommended that bills not be made for routine emergency room care.

In commenting on a draft of this report, the University advised us that physicians' emergency room charges, in addition to initial visit charges, were justified, because, the average length of stay in the emergency room prior to admission as an inpatient at JMH was about 8 hours, during which time considerable medical care would usually be required.

Of the 61 services supported by physicians' notations, we found evidence that the attending physicians named on the

bill had been involved personally for only 23 services. For 27 additional services, the medical records showed the involvement of attending physicians other than those in whose names the bills had been submitted. The medical records showed, however, that, of the 27 services provided by physicians other than those identified on the bills, 23 services had been provided by attending physicians acting in the capacity of morning report officers.[1] The only evidence relating to the morning report officers' involvement included in the medical records for these 23 services were statements that they had received residents' initial reports of the patients' admissions to JMH. This limited involvement does not appear to be consistent with the physician-patient relationship necessary to qualify for Medicare payments on a fee-for-service basis. For the remaining 11 of the 61 services in our sample, the medical records showed that the services were provided only by residents and interns.

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[1]See footnote, p. 10.

Daily medical care

After a Medicare patient's first day in JMH (which was usually covered by the charge for an initial visit), the University generally billed for follow-up visits for each day of hospitalization, except in some instances in which the charges for such services were included in the fees billed for surgery.

The University and private physicians billed Medicare for 1,387 follow-up visits relating to 52 of the 65 patients included in our sample. The charge for a follow-up visit was usually $15 by the department of medicine, $7 by the department of orthopaedics, and $10 by most other departments.

Our findings regarding the review of medical records supporting charges for daily follow-up visits made on or before and made after July 1, 1969, are summarized in the following table. For many daily follow-up visits, the records showed that more than one person had been involved in making the visits. Therefore the number of medical personnel identified with the services exceeds the number of services supported by physicians' notations.

| | Bills for services rendered | | |
|---|---|---|---|
| | Total | On or before 7-1-69 | After 7-1-69 |
| Number of services | | | |
| Billed | 1,387 | 1,118 | 269 |
| Not supported by physician's notations | 290 | 242 | 48 |
| Supported by physicians' notations | 1,097 | 876 | 221 |
| Medical personnel identified with record of service | | | |
| Attending physicians | | | |
| Same as identified on bill | 427 | 319 | 108 |
| Other attending physicians | 53 | 44 | 9 |
| Residents | 379 | 324 | 55 |
| Interns | 610 | 481 | 129 |
| Medical students | 72 | 72 | - |
| Records not signed or signature not identifiable | 9 | 5 | 4 |
| Total | 1,550 | 1,245 | 305 |

The medical records did not show that any physicians had made 290 of the 1,387 daily follow-up visits which had been billed. At the time that 10 of these 290 visits were supposed to have been made, the patients were not in JMH. University officials advised us that refunds would be made to Blue Shield for these charges.

The Public Health Service physician assisting us in the review of the medical records commented that the attending physician who had made a note of each hospital visit was the exception rather than the rule and that such notes generally were not considered necessary.

Regarding the charges for daily visits by attending physicians for each day of hospitalization, some of the full-time VA physicians assigned to the department of medicine advised us that their ward duties at JMH, where they were involved in teaching and in the care of Medicare and non-Medicare patients, consisted of 2-hour tours of duty three times a week and that the University paid them $25 for each tour. According to University officials, before June 1969 attending physicians' rounds in the department of medicine were normally made 3 days a week.

The University received SSA's April 1969 guidelines in June 1969. We were advised by a responsible University official that, beginning in June 1969, supplemental daily ward rounds, except for Sunday, were made by the University's full-time faculty. These rounds, however, were not necessarily made by the attending physicians in whose names the services were billed.

In commenting on a draft of this report, the University pointed out that the assigned attending physicians were "responsible for the care of the patients seven days a week."

We believe that the question of charging Medicare for daily visits solely on the basis that physician has the legal responsibility for the care of a patient in a teaching setting had been previously considered and rejected by a cognizant legislative committee of the Congress. The Committee on Ways and Means, House of Representatives, in its report (H. Rept. 91-1096) on House bill 17550 entitled "Social Security Amendments of 1970" which was passed by the House on May 21, 1970,

and which, if enacted, would restrict Medicare payments on a fee-for-service basis to supervisory and teaching physicians under certain circumstances, stated, with respect to the congressional intent at the time the original Medicare act was being considered, that:

> "*** it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients--that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid."

Consulations

The various University departments billed Medicare for consultations when one department received medical advice from another department or from a subspecialty within the same department. Medicare was billed for 88 consultation visits relating to 28 of the 65 patients included in our sample. The charge for an initial consultation was usually $35, and the charge for a follow-up consultation was usually $15. In 10 instances, however, charges of $50 were billed for consultations and these charges were allowed by Blue Shield.

The number and type of medical personnel identified as having been involved in providing the specific services relating to consultations on or before and consultations after July 1, 1969, are summarized in the following table. In some cases more than one person was identified as having been involved with the services provided. Therefore the number of medical personnel identified with the services exceeds the number of services supported by physicians' notations.

| | Billings for services rendered | | |
|---|---|---|---|
| | Total | On or before 7-1-69 | After 7-1-69 |
| Number of services: | | | |
| Billed | 88 | 71 | 17 |
| Not supported by physician's notation | 17 | 17 | - |
| Supported by physicians' notations | 71 | 54 | 17 |
| Medical personnel identified with record of service: | | | |
| Attending physicians: | | | |
| Same as identified on bill | 34 | 21 | 13 |
| Other attending physicians | 6 | 4 | 2 |
| Residents | 40 | 35 | 5 |
| Interns | 3 | 3 | - |
| Medical students | 4 | 4 | - |
| Total | 87 | 67 | 20 |

JMH medical records supporting the services billed to Medicare showed that, for 17 of the 88 consultations billed, notations had not been made by any physicians or nurses to indicate that physicians had been involved in providing the services. Most of the 17 unsupported charges for consultations were submitted by the department of medicine. The billing secretary in the department advised us that, in some cases, she had received oral instructions from physicians to bill for consultations although there were not any corresponding notes in the patients' medical records.

Most of the bills for consultation services for which the medical records did not identify the involvement of attending physicians also were submitted by the department of medicine. The billing secretary in the department advised us that, in these instances, the consultations had been billed in the names of the attending physicians of the appropriate services, such as hematology, who had been designated as available to provide consultation services at the time the services had been provided.

In commenting on this lack of documentation to support the bills, the University advised us that every subspecialty service in the department of medicine had assigned faculty consultants who were responsible for reviewing all recommendations of the subspecialty residents.

Outpatient care

There were 17 services provided at the JMH outpatient clinic to nine patients during the 2 weeks before and after their periods of hospitalization for which Medicare was billed $233.

JMH medical records did not contain notations by any physicians supporting two of the 17 outpatient services. The remaining 15 services were supported by physicians' notations, but in only four instances were the attending physicians in whose names the services were billed identified as having been involved in providing the services. There were four visits for which the records showed that other attending physicians had been involved in providing the services. The medical records for the remaining seven outpatient visits which were

supported by physicians' notations identified residents and interns as having been involved in providing the outpatient care.

Other medical services

The University and private physicians billed Medicare for special procedures, such as lumbar punctures, bone marrow studies, and Foley catheter insertions, provided to patients during their hospitalization. Charges ranging from $10 to $100 were billed for 45 of these other medical services relating to 28 patients included in our sample. Of these 45 services, 43 were billed in the names of University physicians and two were billed by the patient's private physician.

The number and type of medical personnel identified as having been involved in providing the specific services on or before and after July 1, 1969, are summarized in the following table. In some cases, more than one person was identified as having been involved in providing the service. Therefore the number of medical personnel identified with the services exceeds the total number of services billed.

| | Bills for services rendered | | |
|---|---|---|---|
| | Total | On or before 7-1-69 | After 7-1-69 |
| Number of services: | | | |
| Billed | 45 | 33 | 12 |
| Not supported by physician's notation | 14 | 13 | 1 |
| Supported by physicians' notations | 31 | 20 | 11 |
| Medical personnel identified with record of service: | | | |
| Attending Physicians: | | | |
| Same as identified on bill | 2 | 2 | - |
| Other attending physicians | 1 | 1 | - |
| Residents | 13 | 8 | 5 |
| Interns | 14 | 10 | 4 |
| Medical students | 1 | 1 | - |
| Records not signed or signature not identifiable | 2 | - | 2 |
| Total | 33 | 22 | 11 |

On the basis of our review of JMH medical records prepared by physicians and nurses, we could not determine, for 14 of the 45 other medical services billed, that any physicians had been involved. Such services may have been provided by nurses or other technical personnel. For the 31 other medical services which were supported by physicians' notations, the records showed only two services in which the attending physician in whose name the services had been billed had been involved.

There was one service in which an attending physician other than the physician in whose name the bill was submitted was involved. Medical records for the remaining 28 services which were supported by physicians' notations generally identified residents and interns as having been involved in providing the services.

Although the bills submitted by the University stated in some instances that Foley catheters had been inserted by the physicians, the Public Health Service physician who assisted us in our review commented that the insertion of a Foley catheter was routinely performed by residents, interns, or nurses.

Blue Shield officials advised us in January 1970 that they had stopped allowing charges for certain procedures, including the insertion of Foley catheters, which were a routine part of patient care and which were covered by payments for hospital visits.

Surgical services

The University and private physicians billed Medicare for 50 surgical procedures involving 31 patients included in our sample. JMH's operating rooms were used for 47 of these procedures. Two minor procedures were performed in the patient's hospital rooms, and one bill was a duplicate charge of $175, for which Blue Shield had allowed $135. University officials advised us that a refund was made to Blue Shield after we brought this matter to their attention.

Our review of the JMH reports on the operations and the patients' medical records for the 49 surgical procedures that had been performed showed that:

--Twenty-eight procedures had been performed by the attending physicians in whose names the bills had been submitted.

--Four procedures had been performed by residents, but the attending physicians named on the bills had been present during the surgery.

--Four procedures had been performed by attending physicians other than the physicians named on the bills.

--Eleven procedures had been performed by residents, but attending physicians other than the physicians named on the bills had been present during the surgery.

--Two procedures had been performed by residents before July 1, 1969, and there was no evidence of attending physicians having been present during the surgery.

Medicare was billed for 51 instances of postoperative care provided by University surgeons on four of the 31 patients for which Blue Shield allowed about $330. On the basis of the fee criteria used by the University and published by the Florida Medical Association, Inc., the postoperative care should have been included as part of the basic charges for

surgery. Therefore it appears that the Medicare program should not have been charged for these services. Furthermore, the surgeons in whose names the bills for these services had been submitted were not identified in the medical records as having provided any of the postoperative care, which was generally provided by residents.

An example of these charges is a bill for $800 submitted by a physician in the department of urology for a transurethral resection of the prostate. The charge for this procedure was based on a relative-value study used by the department, which showed that the customary follow-up care was included in the charge for the surgery. The period of follow-up care established for this procedure by the Florida Medical Association was 90 days. The department of urology billed Medicare $70 for 7 days of follow-up care, however, and Blue Shield allowed the charge.

In commenting on a draft of this report, Blue Shield advised us that a separate, additional charge for postoperative care was customarily made for complications or nonroutine care and that such charges were traditionally allowed. Blue Shield stated that, if routine follow-up care had been paid for, it had been paid in error. Our review of the medical records indicated that the care had been routine because the patients' discharge summaries stated that there had been no complications.

Anesthesiology services

The University's department of anesthesiology based its fees on a relative-value study by the Florida Society of Anesthesiologists, Inc. The amounts billed for anesthetic services included the usual preoperative and postoperative visits, administration of anesthesia, and monitoring of essential functions plus the administration of fluids, blood, and medications required.

Anesthetic services, for which the Medicare program was billed $4,011, had been rendered to 23 of the patients included

in our sample. Blue Shield allowed $3,951 for 35 anesthetic services, including an instance in which the same service was billed twice, which resulted in a $100 overcharge. University officials advised us that, after we brought the matter to their attention, a refund had been made to Blue Shield for this overcharge.

JMH's medical records, including the anesthetic and surgery reports, relating to the 34 anesthesiology services that were performed showed that:

--In 22 instances, the attending physicians in whose names the services had been billed had been involved.

--In 10 instances before July 1, 1969, attending physicians other than the physicians named on the bills had been involved.

--In two instances before July 1, 1969, residents and interns had provided the services, and there was no evidence that attending physicians had been involved.

Because the medical records showed that residents and interns also had been involved in providing the anesthetic services and because the records did not always indicate the nature or the extent of the attending physicians' involvement or whether the attending anesthetists actually had been present in the operating room when anesthesia had been administered, the University provided us with the following statement defining the role of the attending physician in the department of anesthesiology.

> "The method of practice in the Department of Anesthesiology complies fully with the letter and spirit of *** [SSA's April 1969 guidelines]. That is, the services rendered to all Medicare patients are identical to that furnished to other paying private patients. We see and examine the patients preoperatively, confirm or revise the proposed anesthetic management and personally supervise the administration of the anesthetic so that the quality of care is the same as for other private patients. ***

> "Regardless of the experience of the resident, he is never left entirely alone. The attending physician is present in the operating room for a large part or all of each case, makes frequent visits throughout the procedure, and is immediately available at all times."

Regarding the differences between the names of attending physicians shown on the bills and the names of attending physicians shown in the medical records before July 1, 1969, University officials advised us that the physicians in the department of anesthesiology had practiced as a group and that bills had often been submitted in the name of the department's chairman.

University comments on our review of medical records

In commenting on a draft of this report, the University stated, in part, that:

"Our immediate reaction to this report is that it is a very detailed statistical analysis of information in patients' medical records, rather than a study of the very excellent medical care rendered to patients covered under the Medicare Insurance Program."

* * * * *

"It is our studied opinion that our faculty have provided these patients with the highest possible quality of patient care. It is well recognized in the medical community that participation of attending physicians in the care of their private patients is not always documented in the patients' medical records. It is a common practice to enter notes in the patient's chart when the doctor feels, for medical reasons, that a notation should be in the chart. The activity of note writing has no relationship to whether a service was rendered to a patient and it has no clear relationship to the quality of patient care that is delivered."

* * * * *

"We would also like respectfully to call your attention to the fact that the method or methods of providing documentation in the medical records in any of the intermediary letters or any other material published by the Social Security Administration have not required the degree of note writing that the report describes. Furthermore, verbal efforts to query Social Security Administration in an attempt to establish definite guidelines have always resulted in indefinite and ambiguous statements."

* * * * *

"We would also like to add, at this point, that we feel the medical schools have been placed at a great disadvantage by the fact that the Federal Government allowed a period of over three years to elapse prior to conducting a comprehensive audit of the type which has just been recently completed and which is now being undertaken by Social Security Administration."

*  *  *  *  *

"In conclusion, we would like to state that whereas your report is critical of lack of documentation in the patients' medical records, it makes no mention of the quality of medical care which we rendered to our patients. We respectfully submit that we have discharged our obligations to our patients by the quality of medical care that we have provided."

We did not review the medical records applicable to selected Medicare patients for the purpose of making evaluations of the quality of care provided by or under the supervision of the University physicians at JMH. Our review was designed to determine the extent to which the medical records indicated that University or private physicians had been involved in providing the specific services for which bills had been submitted to Blue Shield in their names.

Regarding the University's comment that the participation of attending physicians in the care of their private patients not always was documented in the patients' medical records, our analysis of the doctors' bills included in our sample showed that evidence of the involvement of private physicians was lacking in JMH's medical records for about 25 percent of the number of services the physicians had billed for, whereas JMH medical records showed no evidence of the involvement of University physicians for about 75 percent of the number of services billed in their names. (See 9.)

With regard to the University's comment that "the activity of note writing has no relationship to whether a service was rendered to a patient," we acknowledge that the absence of a note might not, in all instances, mean that a service had not been rendered to a patient. About 80 percent of

the number of services included in our sample, however, were for daily medical care. As pointed out on page 17, University physicians in the department of medicine, prior to June 1969, usually made ward round 3 days a week as attending physicians; however, a charge of $10 or $15 was generally made for each day of a patient's hospitalization. It seems to us that the lack of a notation as to the rendering of services by the physician in whose name the bill had been submitted on those days he did not normally see the patient would have a relationship to whether the service had been provided.

University comments on Medicare payments for services of full-time VA physicians

In commenting on the VA regulation dealing with the outside activities of its full-time physicians (see p 5), which provided that such physicians may not assume responsibility for the continuing care of non-VA patients, University officials advised us that it was their understanding that "continuing patient care" referred to the services provided before and after hospitalization, in addition to the services rendered while the patient was in the hospital An official of the VA Central Office, however, advised us that continuing patient care meant that a physician would accept responsibility for the needs of a patient over a period of time He stated that the key to this definition was that the physician would be personally responsible for a patient if he made a diagnosis of the illness, treated the patient, and planned the course of treatment

The foregoing services were among the services for which the University had billed the Medicare program in the names of the full-time VA physicians, although, as indicated by the example on pages 10 and 11, it was questionable whether the physicians were personally involved in providing such services.

Also, in February 1970 VA specifically prohibited its full-time physicians from billing the Medicare program for the continuing care of patients, and in March 1970 SSA ordered the suspension of part B payments to full-time VA physicians in teaching hospitals (See p 6.)

SUSPENSION OF MEDICARE PART B PAYMENTS TO THE UNIVERSITY

In June 1969, SSA had requested the organizations making part B payments (carriers) to suspend payments to teaching hospitals where the carriers were not assured that such payments were in accordance with SSA's April 1969 guidelines Near the end of June 1969, Blue Shield representatives met with University officials to discuss actions taken by the University to comply with the requirements of SSA's April 1969 guidelines which had been furnished to the University in mid-June. Blue Shield, at that time, advised the University that noncompliance would result in the suspension of Medicare payments

On July 7, 1969, the acting dean of the University requested that all medical school departments notify him by July 15, 1969, of actions taken to ensure compliance with the guidelines. In general, responses to the acting dean's request acknowledged an understanding of SSA's April 1969 guidelines and a willingness to comply with the requirements stated therein

Because Blue Shield had not assured itself as to the University's compliance with the requirements, in August 1969 SSA requested Blue Shield to suspend all Medicare part B payments for services provided by University physicians In September 1969, after it completed an audit, Blue Shield reported that, for 74 percent of the services included in the audit, the involvement of the physicians in whose names the bills had been submitted could not be verified because there was no supporting documentation in the medical records

In October 1969, Blue Shield advised University officials that the resumption of Medicare payments would depend upon compliance with certain minimum requirements which included recording the names, signatures, or initials of the attending physicians in the patients' medical records supporting the claims Blue Shield officials advised us that, in their opinion, their communications with the University faculty as to SSA billing requirements for teaching physicians were not effective until that time

Blue Shield notified the University in November 1969 that Medicare payments would be resumed for certain departments on the basis that immediate refunds would be made if a later audit revealed cases which did not meet the criteria specified in SSA's April 1969 guidelines

In April 1970, Blue Shield notified the University that its Medicare payments were being suspended again because a March 1970 audit by Blue Shield revealed that 47 percent of the services billed by the University could not be verified by documentation in the medical records. Blue Shield, however, did not request the University to refund any of the Medicare payments.

In July 1970, Blue Shield advised us that such refunds had not been requested because the plans for additional audit

work involving the use of statistical-sampling methods for determining the amounts of the refunds were still being developed in cooperation with SSA.

DUPLICATION OF HOSPITAL AND UNIVERSITY REIMBURSEMENT FOR ANESTHESIOLOGY SERVICES

A portion of the salaries paid to University anesthetists at JMH for services provided to indigent staff patients was included by JMH in its claim for reimbursement under part A of the Medicare program. The services of these anesthetists to Medicare patients were also billed by the University under part B of the Medicare program. As a result, JMH's claim for reimbursable Medicare costs was overstated by about $17,000 during the fiscal year ended September 30, 1969.

SSA instructions pertaining to reimbursement of hospital costs under part A provide that the portion of compensation to physicians for medical or surgical services involving direct patient care be eliminated from allowable cost reimbused under part A.

During the fiscal year ended September 30, 1969, salaries of about $99,000 were paid by JMH for medical and administrative services provided by 13 physicians in the department of anesthesiology. These physicians were also affiliated with and salaried by the University.

JMH determined that 90 percent of the amount paid to anesthetists was for services rendered to indigent staff patients, which patients did not include patients who had Medicare part B insurance or other patients who were able to pay for the physicians' services. These anesthetists, however, also rendered services to Medicare patients covered under part B and for which the University billed the Medicare program.

On the basis of JMH's determination that 90 percent of the salaries paid to anesthetists was for staff patient care, $89,268 should have been eliminated from the total allowable costs under part A of Medicare. Our review of JMH's cost records and its claim for reimbursement showed that only $7,728 of the $89,268 had been eliminated, which resulted in an $81,540 overstatement of JMH's allowable costs, part of which was allocated to the Medicare program. JMH claimed 20.73 percent of the $81,540, or about $17,000 of unallowable cost, under part A of the program.

JMH officials confirmed that the allowable costs had been overstated by $81,540 due to an oversight but advised us that an adjustment would not be made until a final cost settlement was made with Blue Cross of Florida, which made payments under part A of the program.

We believe that SSA and Blue Cross should follow up on this matter and should inquire into prior years' determinations of reimbursable hospital costs to ascertain whether similar overstatements had occurred. SSA has advised us that it will inquire into this matter and will recover any incorrect payments.

## PATIENTS' INVOLVEMENT IN PAYMENTS MADE ON THEIR BEHALF

Our review showed that, in most instances, Medicare patients had not been billed for deductible and coinsurance amounts for the services billed in the names of University physicians and had not signed the appropriate claim forms. Blue Shield had, however, appropriately notified the patients of the payments made on their behalf.

### Patients generally not billed for deductible and coinsurance amounts

The 65 Medicare patients included in our sample were billed for only $2,273, or 25 percent, of the $9,252 of deductible and coinsurance amounts applicable to services billed in the names of University physicians. Of the amount billed, only $1,225 was collected.

The patient, under part B of the Medicare program, is responsible for the first $50 for covered medical services in each year and also for 20 percent of the reasonable charges for covered services in excess of $50 in each year. These amounts, which are payable by the patient or by others on his behalf, are generally referred to as the deductible and coinsurance amounts.

The practices of billing Medicare patients for deductible and coinsurance amounts varied among University departments. Some departments billed for the deductible and coinsurance amounts and others did not, not even in cases where the charges of more than one department involved the same patient. For example, a patient in our sample was not billed for $103 of deductible and coinsurance amounts by the department of medicine, but, for the same period of hospitalization, this patient was billed for deductible and coinsurance amounts of $196 and $67 by the departments of surgery and anesthesiology, respectively.

The following table shows, for each University department, the total deductible and coinsurance amounts applicable to the bills we examined, the amounts billed, and the amounts collected.

| Department | Deductible and coinsurance | | |
|---|---|---|---|
| | Total amount | Amount billed | Amount collected |
| Anesthesiology | $ 747 | $ 328 | $ 224 |
| Dermatology | 41 | 38 | - |
| Medicine | 4,189 | 57 | 57 |
| Neurology | 311 | 226 | - |
| Neurosurgery | 14 | 14 | - |
| Obstetrics-Gynecology | 606 | - | - |
| Ophthalmology | 829 | 515 | 515 |
| Orthopaedics | 459 | 282 | - |
| Otolaryngology | 775 | 140 | 140 |
| Radiology | 60 | 60 | - |
| Surgery--general | 477 | 465 | 279 |
| Urology | 744 | 148 | 10 |
| Total | $9,252 | $2,273 | $1,225 |

Reasons given by the University departments for not billing Medicare patients for the deductible and coinsurance amounts were that many patients would not pay and for other patients, the payments would have been hardships. University officials advised us that in such instances the costs of billing the patients would have been more than the amounts that would have been collected.

Patients generally did
not sign billing documents

SSA regulations dealing with Form SSA-1490, which is usually used to bill for a physician's services, require that, generally, the patient sign the form requesting the payment of benefits to him or to others on his behalf When a physician accepts an assignment of a Medicare claim from a patient, which authorizes that the payment be made directly to the physician, the patient's signature provides evidence that the patient has made the assignment and that he recognizes the right of the physician or organization to request payment on his behalf

Of the 188 bills we reviewed, only 61 had been signed by the patients and 17 had been signed by others on their behalf The 110 other bills had not been signed, and Blue Shield therefore did not have any evidence that the patients had authorized direct payment to the physicians or that the patients recognized the right of the physicians or designated billing organizations to request payment

The 17 bills signed by persons other than the patients were signed by hospital or University billing personnel or by the physicians who had charged for the services. Of the 110 bills not signed, 103 bills stated that the patients' signatures were "on file," six bills stated that the bills were not signed because the patient was deceased or was unable to sign, and one bill did not contain any explanation.

University officials advised us that they had not received instructions concerning patients' signatures on Medicare bills prior to the receipt of a letter in March 1970 from Blue Shield, which stated that, in accordance with recent instructions from SSA, the patient's signature must be obtained and that the notation "signature on file" would no longer be acceptable.

Most of the Medicare part B bills submitted by the department of medicine were submitted improperly on Form SSA-1554, a billing form intended to be used only when a hospital has a billing arrangement with its physicians under which the hospital collects the physicians' charges for patient care

The University advised us that Form SSA-1554 had been used on the advice and at the recommendation of Blue Shield. Blue Shield's response was that the use of Form SSA-1554 had been instituted originally to control and identify bills from the JMH outpatient clinic but had been replaced with Form SSA-1490 bills when the Blue Shield computer system capability became available

Patients notified of payments made on their behalf

We were advised by Blue Shield officials that Blue Shield had furnished Medicare patients with explanation of benefits forms showing each of the payments made on their behalf to University physicians. These forms identified the individuals or organizations to which the payments were made, the place and date of the services provided, and the charges allowed by Blue Shield. The explanation of benefits form also advised the patient of the amount of the $50 deductible that had been applied and of the amount of coinsurance payable and provided the patient with an opportunity to question any payments made on his behalf for services that may not have been provided.

## BILLS TO OTHER INSURERS AND ORGANIZATIONS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS

Information furnished by the University, which we did not verify, showed that the University medical school departments had billed in excess of $1 million to about 273 private insurers (other than Medicare); employers; and other organizations, such as labor unions, during the 18-month period ended December 1969 for services provided by its faculty physicians. The number and amounts of non-Medicare bills by each of the departments are shown in the following table.

| University department | Number of claims | Number of insurers billed | Amount billed |
|---|---|---|---|
| Anesthesiology | 830 | 28 | $ 114,519 |
| Dermatology (note a) | - | - | - |
| Family medicine (note a) | - | - | - |
| Medicine | 814 | 100 | 143,241 |
| Neurology | 42 | 17 | 21,048 |
| Neurosurgery | 4 | 3 | 1,100 |
| Obstetrics-Gynecology | 567 | 70 | 171,270 |
| Ophthalmology (note b) | 186 | 73 | 408,800 |
| Orthopaedics (note a) | - | - | - |
| Otolaryngology | 120 | 40 | 28,940 |
| Pediatrics | 17 | 10 | 2,647 |
| Psychiatry | 94 | 48 | 91,408 |
| Radiology (note a) | - | - | - |
| Surgery--general and plastic | 301 | 95 | 61,979 |
| Thoracic and Cardiovascular (note c) | 50 | 26 | 60,170 |
| Urology | 509 | 114 | 171,475 |
| Total | 3,534 | 624[d] | $1,276,597 |

[a]Billing information was not furnished by department.

[b]Information furnished by department on bills submitted during a 3-month period was projected to the 18-month period.

[c]Information for this department represents bills for only 14 months.

[d]This number represents about 273 different private insurers, employers, and other organizations.

University officials advised us that practically all health insurance companies honored bills for services provided by its teaching physicians. They advised us further that only one private insurer did not honor such claims.

Representatives of 11 of the 12 departments which furnished information on amounts billed to private insurers stated that, in general, the same fee schedules had been used without regard to the organization responsible for payment.

We reviewed a limited number of bills submitted to private insurers by the department of medicine and noted that for like services the fees charged to private insurers were identical to the fees charged to Medicare.

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,

Chairman