REPORT TO THE CONGRESS

Problems In Paying For Services Of Supervisory And Teaching Physicians In Hospitals Under Medicare B-164031(4)

Social Security Administration

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

NOV. 17, 1971

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

B-164031(4)

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

This is our report on problems in paying for services of supervisory and teaching physicians in hospitals under Medicare. The Medicare program is administered by the Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

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

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

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D I G E S T

WHY THE REVIEW WAS MADE

Because of expressed congressional interest in the administration of Medicare payments to supervisory and teaching physicians in hospitals having programs in graduate medical education, the General Accounting Office (GAO) reviewed payments for the services of such physicians at six hospitals. Its reports on these hospitals previously were submitted to congressional committees. This report summarizes problems discussed in the individual reports.

Background

The Medicare health insurance program for Americans aged 65 and over provides two kinds of coverage. Part A covers hospital services and certain posthospital care. Part B covers physicians' services to individual patients. When a Medicare patient is hospitalized under the care of a physician, the patient may be entitled to both kinds of benefits.

Part B payments reviewed by GAO were made for the Social Security Administration (SSA) by paying agents--or carriers--under contract. The payments were made on a fee-for-service basis for services by specific physicians to specific patients.

Under this method of payment, a physician charges a fee for each service--a hospital visit, a consultation, or an operation--furnished to a patient. The Senate Finance Committee has estimated that total Medicare payments for teaching physicians' services could be more than $100 million annually.

Most of the other Medicare payments (for services at the hospitals) were made under part A by other SSA paying agents called intermediaries.

FINDINGS AND CONCLUSIONS

Problems in administration

As shown below problems existed in the administration of the fee-for-service method of making Medicare payments for the services of supervisory and teaching physicians.

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The problems do not concern the quality of medical care provided--described authoritatively as excellent--but they raise the question as to whether the traditional fee-for-service method of payment is suitable in many teaching hospitals under the program.

Questionable propriety of many physicians' charges

The hospitals' records showed that teaching physicians' services to individual patients (part B) had, in many instances, been provided only by residents and interns whose salaries were reimbursable as hospital services (part A). If reimbursement for the same services was made under parts A and B, Medicare would be paying for such services twice.

The Medical records reviewed by GAO at the six hospitals showed that

- --physicians named on the bills had provided about 18 percent of the number of services billed in their names,
- --supervisory physicians, other than the physicians named on the bills, had provided about 15 percent of the services, and
- --only residents and interns had provided the remaining 67 percent of the services. (See p. 17.)

Methods of providing and supervising medical care at certain teaching hospitals

The methods followed made it inherently difficult to establish an "attending" physician-patient relationship.

In about 45 percent of the cases where a supervisory physician was identified with a specific service billed to Medicare, the name of the supervisory physician shown on the medical records was different from the supervisory physician in whose name the service was billed. It was difficult therefore to establish the bona fide relationship of the attending physician to the patient necessary to qualify for fee-for-service payments under Department of Health, Education, and Welfare (HEW) regulations. (See p. 33.)

Problems in administering the dual (part A and part B) Medicare reimbursement system

Services of a teaching physician may be paid for as hospital services (part A) on the basis of costs and also under part B on the basis of fee-for-service. Because of difficulties encountered in the administration of this arrangement, payments at two of the hospitals exceeded the reimbursable Medicare costs by about $434,000. (See p. 38.)

Other problems

Often there was no indication that the patients had authorized payments to be made on their behalf for physicians' services. (See pp. 39 and 40.)

Certain Medicare payments, on the basis of customary or prevailing charges for physicians' services, were questionable because the carriers did not pay for similar services at those same hospitals for their own subscribers. (See pp. 42 and 43.)

In commenting on GAO's review of the medical records, the hospitals and medical schools usually took the position that:

--The absence of teaching physicians' notations in the medical records did not mean that the services were not provided or personally supervised by these physicians.

--Before April 1969 SSA did not require that bills for services of supervisory and teaching physicians be documented in the patients' medical records. (See p. 25.)

GAO noted that, when private doctors treated their own patients, their involvement was frequently shown in the hospitals' medical records. Also, at two of the hospitals where GAO reviewed payments made before and after implementation of the April 1969 guidelines, there was only slight improvement in the extent to which the medical records supported physicians' bills. At another hospital the affiliated medical school pointed out that the SSA recordkeeping requirements took too much of its physicians' time. (See pp. 26 to 32.)

Action taken by SSA and carriers

From April 1969 to April 1971, SSA issued instruction to its carriers to:

--Clarify the conditions under which part B payments could be made on a fee-for-service basis for the services of supervisory and teaching physicians in hospitals.

--Suspend payments where such conditions were not met.

--Determine, through audits by the carriers, whether over payments had been made.

SSA reported that, at one time or another, payments had been suspended at about 250 hospitals. (See pp. 45 and 46.) GAO believes that this is indicative of the difficulties inherent in administering a fee-for-service reimbursement system that is neither easily understood nor readily susceptible to effective controls.

In addition to the six hospitals included in GAO's review, SSA has identified six others where overpayments may have occurred. As of June 1, 1971, SSA had determined that overpayments totaling about $2.5 million had been made at four of the 12 hospitals and it was trying to collect the overpayments. SSA-directed audits were in process at six hospitals to determine the amounts of overpayments. (See p. 47.)

Legislative changes being considered

Legislation being considered by the Congress would change the basis of reimbursement for supervisory and teaching physicians from a fee-for-service basis (part B) to a cost-reimbursement basis (part A) except where

--the Medicare patients are bona fide private patients of the billing physicians or

--during the 2-year period ended December 31, 1967, and each year thereafter, all the hospital's patients were regularly billed on a fee-for-service basis and most patients paid the charges.

GAO believes that the proposed legislation, if enacted, will help resolve the major problems noted during its reviews. (See p. 53.)

Remaining potential problem area

Under the proposed legislation it would still be possible to pay for teaching physicians' services to their private patients at an institution on a fee-for service basis (part B) and also to pay for the same physicians' services to their nonprivate patients on the basis of costs (part A). Under these circumstances the difficulties in administering the dual Medicare reimbursement system would continue. (See p. 55.)

RECOMMENDATIONS OR SUGGESTIONS

If the proposed legislative changes are enacted, HEW should establish and maintain effective procedures for determining the proper amounts to be paid for supervisory and teaching physicians' services which are reimbursed on the basis of both costs and fee-for-service at the same institution. (See p. 55.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW advised GAO that it was aware of the potential continuing problem of administering the dual part A and part B reimbursement system for physicians' services and that it would deal with the problem by developing guidelines and instructions for implementing the new amendments, when they are enacted.

MATTERS FOR THE CONSIDERATION OF THE CONGRESS

As previously stated this report deals with legislation that currently is being considered by the Congress.

Contents

ABBREVIATIONS

AMA	American Medical Association
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration
VA	Veterans Administration

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As shown below problems existed in the administration of the fee-for-service method of making Medicare payments for the services of supervisory and teaching physicians.

The problems do not concern the quality of medical care provided--described authoritatively as excellent--but they raise the question as to whether the traditional fee-for-service method of payment is suitable in many teaching hospitals under the program.

Questionable propriety of many physicians' charges

The hospitals' records showed that teaching physicians' services to individual patients (part B) had, in many instances, been provided only by residents and interns whose salaries were reimbursable as hospital services (part A). If reimbursement for the same services was made under parts A and B, Medicare would be paying for such services twice.

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CHAPTER 1

PERTINENT FEATURES OF THE MEDICARE PROGRAM

Title XVIII of the Social Security Act (42 U.S.C. 1395-139511), effective July 1, 1966, established two basic forms of health protection for eligible beneficiaries aged 65 and over. One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services, as well as posthospital care in an extended-care facility or in the patient's home. Part A is financed by a special social security tax paid by employers and their employees and by self-employed persons. For fiscal years 1967 through 1970, benefit payments under part A amounted to about $15.7 billion, of which about $14.4 billion was for inpatient hospital services.

The second form of protection, designated as Supplementary Medical Insurance Benefits for the Aged (part B), is a voluntary program and covers physicians' services and a number of other medical and health benefits. Part B is financed, in part, from premiums collected from each participating beneficiary. The premiums are matched by equal amounts appropriated by the Congress. Effective July 1, 1971, the monthly premium was $5.60.

Under part B the beneficiary is responsible for paying for the first $50 for covered medical services in each year (the deductible). Medicare usually pays 80 percent of the reasonable charges for covered services in excess of $50 in each year; the remaining 20 percent of the reasonable charges is usually the responsibility of the beneficiary (coinsurance).

For fiscal years 1967 through 1970, benefit payments under part B amounted to about $5.7 billion; about 90 percent was for physicians' services.

USE OF INTERMEDIARIES AND CARRIERS TO HELP ADMINISTER MEDICARE

To administer Medicare benefits, the Congress authorized the Secretary of Health, Education, and Welfare to contract with public agencies or private organizations to pay (1) for

services provided by hospitals and other institutions and (2) for physicians' services.

The organizations making payments to hospitals and other institutional providers are called fiscal intermediaries and are nominated by the providers.

The principal intermediary is the Blue Cross Association which was nominated by the American Hospital Association. At December 31, 1970, the Blue Cross Association was the fiscal intermediary for about 90 percent of the 6,800 hospitals participating in the Medicare program. The remaining participating hospitals deal directly either with SSA or with nine other intermediaries.

SSA reimburses intermediaries for their administrative costs in making Medicare payments and for performing certain other functions under their contracts with the Secretary. For fiscal years 1967 through 1970, the intermediaries' administrative costs amounted to about $263 million.

The organizations making benefit payments for physicians' services are called carriers. Carriers were selected by SSA; at December 31, 1970, SSA had contracted with 48 carriers to pay part B benefits in specific specific geographical areas of the country.[1] Of these carriers, 33 were Blue Shield organizations, 14 were private insurance companies and one was a State agency. For fiscal years 1967 through 1970, SSA reimbursements to the carriers for their Medicare-related administrative costs amounted to about $416 million.

PAYMENTS FOR PHYSICIANS' SERVICES IN A HOSPITAL SETTING

Depending on the classification of the physician and and the type of services provided, payments for physicians'

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[1] The Travelers Insurance Company, operating under a contract with the Railroad Retirement Board, acts as the nationwide part B carrier for railroad-related beneficiaries and, accordingly, administers a small part of the part B Medicare program in the same geographical areas covered by the SSA carriers.

services provided in a hospital setting can be made either by intermediaries under part A or by carriers under part B.

Under part A hospitals are reimbursed by intermediaries for the reasonable costs of the services furnished to Medicare patients--including salaries paid to physicians who are residents and interns participating in training programs approved by the American Medical Association.[1] For those physicians not in training who are on a hospital's staff and who are salaried or otherwise compensated by the hospital, that part of their compensation for services other than direct patient care--such as teaching, administration, and supervision of technical personnel--is also reimbursable to the hospital under part A.

Under part B payments for physicians' services for direct patient care usually are made by carriers on the basis of reasonable charges (fee-for-service basis)--a fee is paid for a specific service to a specific patient.

Where physicians--other than residents and interns under an approved training program--are paid salaries by the hospital, part B payments may be made by the carrier to the hospital for the physicians' services to individual Medicare patients; in this case, the part of the physicians' salaries applicable to direct patient care should not be reimbursed to the hospital under part A.

PERTINENT HEW REGULATIONS

Because the Medicare law is silent regarding the precise methods for paying for the services of supervisory and teaching physicians who work in a hospital setting, HEW and SSA have issued various regulations and instructions on the subject. Two categories of regulations and instructions most germane to the subject are discussed below.

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[1] If training programs have not been approved, 80 percent of the salaries of interns and residents are reimbursed under part B on a reasonable cost basis.

Payments to supervisory and teaching physicians

Payments to supervisory and teaching physicians at teaching hospitals are authorized by HEW regulations under part B. HEW regulations,[1] issued on August 31, 1967, stated that, to qualify for payment on a fee-for-service basis, the physician must be the Medicare patient's attending physician and must either render services personally or provide "personal and identifiable direction to residents and interns" participating in the care of his patient.

In April 1969 SSA issued new and more comprehensive guidelines which were intended to clarify and supplement the criteria for making payment for the services of supervisory and teaching physicians. From June 1969 through April 1971, SSA issued numerous instructions which were intended to clarify the April 1969 guidelines. (See app. I.)

Payments to hospital-based physicians

HEW issued regulations in October 1966 providing for part B payments to hospitals for services to individual patients by physicians who are employed by, or receive compensation from or through, hospitals. To the extent that these hospital-based physicians are compensated for services other than direct patient care--such as teaching, administration, and supervision of professional or technical personnel--the cost is reimbursable to hospitals under part A.

HEW regulations provide, however, that the sum of the payments to hospitals under parts A and B be about equal to the amount of the physicians' compensation allocable to the Medicare program--except in certain circumstances where hospital charges for physicians' professional services to individual patients had been identified separately from the charges for other hospital services.

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

WHAT IS A TEACHING HOSPITAL?

The term "teaching hospital" has been defined by the Association of American Medical Colleges as any hospital where there is a program of graduate medical education (residents and interns) whether or not the hospital is related directly to a medical school.

The director of a prominent teaching hospital in New England has described the role of teaching hospitals in the following terms.

> "The primary function of the hospital regardless of the adjective used to designate its character, is the care of the sick and injured of the community. An additional responsibility of the teaching hospital is the conservation and expansion of knowledge through educational endeavor and scientific research. The teaching of medical students; the postgraduate training of interns and residents; the support of schools for nurses, dieticians, medical record librarians, physiotherapists, x-ray and laboratory technicians; the conduct of postgraduate 'refresher' courses for practicing physicians and teaching conferences open to all physicians on a regular basis; the publication of clinical experience and research findings and the further sharing of knowledge as visiting lecturer; all round out the activities of the teaching hospital and its staff. In such an environment of constant inquiry, high intellectual activity, repeated questioning of the conventional wisdom, constant scrutiny of established procedure, and with the rigorous application of the scientific method, the quality of patient care is likely to be optimal. Our country depends on such teaching hospitals for the setting of standards in the best care of the sick and for the provision of the all-too-scarce supply of well-trained doctors, nurses, dieticians, technicians, and so on. The urban, university-affiliated, teaching hospitals are our islands of excellence in medicine."

According to the American Medical Association (AMA), there are about 1,400 hospitals that have AMA-approved residency and/or intern programs, including about 135 which are operated by Federal agencies, such as the Department of Defense and the Veterans Administration.

During 1968 and 1969 about 1,000 teaching hospitals were participating in the Medicare program where part B billings could have been made for the services of supervisory and teaching physicians.

According to information furnished by AMA, the 1,000 hospitals and their affiliation with medical schools can be classified under the following categories.

Classification	Approximate number of hospitals
Hospitals owned by a medical school or both the hospital and medical school are owned by the same organization.	55
Hospitals used by a medical school as a major unit in the school's teaching program.	145
Hospitals used by a medical school to a limited degree in the school's teaching program.	135
Hospitals used by a medical school for graduate training programs only (i.e., residents and interns but not medical students).	90
Hospitals not formally affiliated with a medical school but have an AMA-approved resident or intern program.	575
Total	1,000

The AMA, in commenting on an approved internship program, stated:

> "A well-organized, effective educational program inevitably results in the improvement

of the quality of patient care in a hospital. In no way does it conflict with the hospital's primary function of providing adequate facilities for the scientific care of the sick and injured by a competent medical staff. For such an educational program, it is fundamental that the staff recognize its obligations to permit full utilization for teaching purposes of all patients, whether private or non-private, to whom interns are assigned."

What is the difference between a nonprivate and a private patient?

The director of a large university-owned hospital explained the distinction between a nonprivate (service) patient and a private patient as follows:

"Patients in the Hospital are designated as either service or private. Service patients enter the Hospital without a private physician, generally through our outpatient clinics, emergency room, or from a State mental or penal institution. These patients are provided care primarily by the house staff [residents and interns] under the supervision of one of the staff [supervisory and teaching] physicians. Private patients are admitted to one of these [staff] physicians who assumes primary responsibility for directing the care of the patient with the assistance of the house staff."

Officials of other teaching hospitals stated that they had only one class of patients or that they had made no distinction between service and private patients.

In June 1970, in testimony before the Senate Finance Committee, an official of the Association of American Medical Colleges described the delivery of medical care in teaching hospitals in the following terms.

"*** On any well-organized teaching service, the professional care provided to a single patient involves more than one physician. In the

teaching hospital, it is a team of physicians that cares for the patient, not a single practitioner, as envisioned by the [Medicare] law and regulations.

"The team usually consists of an attending faculty member, residents, and interns, and I would again add parenthetically that all these individuals on the team are licensed to practice medicine, the intern being an exception since his licensure is somewhat limited to his practice within the institution."

In summary the problems disclosed in our reviews involving supervisory and teaching physicians do not relate to the quality of medical care provided in teaching hospitals--which has authoritatively been described as excellent--but they raise the question as to whether the traditional fee-for-service method of paying for physicians' services is suitable in many teaching hospitals under the Medicare program.

CHAPTER 2

PRIOR REPORTS TO COMMITTEES OF THE CONGRESS

In April 1969 the Committee on Finance of the U.S. Senate requested us to make a review of Medicare payments to an association of supervisory and teaching physicians at a large midwestern hospital. In July and September 1969, we reported to the Committee that, according to the hospital's medical records, the professional services billed to Medicare on a fee-for-service basis in the names of supervisory and teaching physicians had been furnished, in almost all cases, by residents and interns in training at the hospital with only limited involvement of the supervisory physicians in whose names the services had been billed.

In May 1970 the Committee requested reports on our reviews of Medicare payments at five other teaching hospitals. The Committee was considering proposed legislation to change the basis of payment under Medicare for supervisory and teaching physicians from a fee-for-service basis to a cost-reimbursement basis under certain conditions. The Committee on Ways and Means of the House of Representatives also requested reports on these reviews. In line with the Committees' interest in this subject, our examinations were directed toward determining:

--The extent to which the services paid for by Medicare had been performed by (1) supervisory and teaching physicians and (2) residents or interns--as shown by the hospitals' medical records.

--The extent to which payments had been made for services provided by salaried and nonsalaried (volunteer) physicians and whether the hospitals or the physicians had been otherwise compensated by Medicare for such services.

--Whether Medicare patients had been billed for deductibles and coinsurance and whether the patients had requested that Medicare payments be made on their behalf.

--Whether other medical insurance programs or other patients had paid for physicians' services in amounts comparable to those paid by Medicare under comparable circumstances.

This report to the Congress summarizes the more significant problems discussed in the six separate reports to the cognizant congressional legislative committees.

PERTINENT DATA ON THE SIX TEACHING HOSPITALS REVIEWED

The six hospitals were all affiliated in some manner with medical schools and ranged in size from about 450 to 2,500 beds. Five of the hospitals were used by the medical schools as major units of the schools' teaching programs, which involved residents, interns, and medical students; one hospital had only a relatively small residency program related to thoracic (chest) surgery.

Five of the hospitals are owned and operated by county governments or by a city government. The sixth hospital is privately incorporated and serves both paying and nonpaying (service) patients of the community.

We reviewed samples of Medicare part B payments totaling about $85,500 made for services provided to 315 patients by supervisory and teaching physicians at six hospitals. These samples were selected from payments totaling $4.2 million which were identified as having been made for services rendered at the six hospitals. The period of time and the services for which the $4.2 million was applicable varied at the individual hospitals, depending on when the billing started, the types of service billed, the availability of financial records, and the periods covered by our reviews. On an annual basis, however, the part B payments averaged about $500,000 at each hospital and ranged from about $120,000 to $1.6 million.

At none of the six hospitals did the supervisory and teaching physicians usually retain the Medicare part B payments for the services billed by them or in their names. Generally the physicians were salaried employees of the hospitals or medical schools or were nonpaid volunteers who

had donated their time to supervise and teach residents and interns at the hospitals. Usually the physicians gave the money received from Medicare to the hospitals or the affiliated medical schools. In other words, although Medicare was billed for teaching physicians' services on a fee-for-service basis, this was not the method by which the physicians were compensated for services provided to the Medicare patients.

CHAPTER 3

PROBLEMS IDENTIFIED BY GENERAL ACCOUNTING OFFICE REVIEWS

Our reviews indicated the existence of serious problems in the administration of the fee-for-service method of making Medicare payments for the services of supervisory and teaching physicians. Although the six hospitals included in our reviews may not be representative of all teaching hospitals, these problems raised the question as to whether this traditional method of paying for physicians' services is suitable in many teaching hospitals under the Medicare program. The problems involved SSA, the intermediaries and carriers, as well as the hospitals, medical schools, or other organizations that were billing Medicare and stemmed from the difficulties in

- --supporting and verifying the propriety of physicians' fees charged under part B of Medicare because the hospitals' medical records showed that physicians' services paid for under part B had, in many instances, been provided only by residents and interns whose salaries were reimbursable as hospital costs under part A of Medicare,

- --establishing the attending physician-patient relationship necessary to qualify for payment on a fee-for-service basis under pertinent HEW regulations,

- --reimbursing for services of the same physician under both part A on the basis of costs and under part B on the basis of fee-for-service,

- --clearly establishing the required beneficiary liability to pay for the services because of the lack of the Medicare patients' involvement in the billing arrangements, and

- --establishing that the physicians' charges for the services were customary and prevailing because major health insurers--other than Medicare--did not pay for similar services.

DIFFICULTIES IN SUPPORTING THE PROPRIETY OF PHYSICIANS' FEES

According to the hospitals' medical records, in a majority of cases reviewed by us, the services billed in the names of supervisory and teaching physicians had been provided only by residents and interns. Excluding those services for which there was a lack of any notations by medical personnel, the medical records at the six hospitals showed that, overall:

--The physicians named on the bills were involved in providing about 18 percent of the number of services billed in their names.

--Supervisory physicians, other than the physicians named on the bills, were involved in providing about 15 percent of the services.

--Only residents and interns had been involved in providing the remaining 67 percent of the services.

It is important that the billings to Medicare for supervisory physicians be supported by documentation evidencing their involvement in providing the services because Medicare payments for residents' and interns' services are not authorized on a fee-for-service basis; their salaries, however, are reimbursable as hospital costs under part A of the program. If reimbursement for these services were made under both parts A and B, Medicare would be paying twice for the same services.

In testimony before the Senate Finance Committee in June 1970, the president of the Association for Hospital Medical Education described the following situation, which is typical of those noted during our reviews.

> "The services rendered to 'institution patients' have usually been rendered by residents and interns in training under the general supervision of the assigned full-time and/or part-time staff doctor, 'supervisory physicians.' They assume medical and legal responsibility for the care rendered. There have been instances when the

care rendered by house staff--residents and interns--to these 'institutional patients' who are Medicare beneficiaries has been reimbursed under part A which we believe is appropriate, and where reimbursement for the same services has been sought by a supervisory physician under part B, who is also paid under part A. Clearly this is double reimbursement and it is unequivocally wrong." (Underlining supplied.)

Comparison of bills with medical records

The type and number of occasions of services, the amounts billed and the amounts allowed by the carriers for services provided the 315 Medicare patients covered by our samples of payments of about $85,500 selected from total payments of $4.2 million at the six hospitals are summarized below:

Summary of Amounts Billed, Allowed and Paid by Type of Service

Type of service	Occasions of service	Amounts billed	Amounts allowed
Inpatient services			
Initial medical care	251	$ 8,105	$ 7,145
Daily visits	5,553	46,208	45,072
Surgery	144	46,146	42,077
Consultations	151	4,163	3,887
Other medical and other surgical services	286	4,962	4,536
Anesthesiology	51	5,221	4,989
Radiation therapy	115	2,300	2,300
Total inpatient services	6,551[a]	$117,105[a]	$110,006
Outpatient services	107	1,173	1,065
Total	6,658	$118,278	$111,071
Less: Amount of patients' responsibility (coinsurance and deductible amounts)			25,529
Total Medicare payments			$ 85,542

[a]At one of the six hospitals, 11 of the 65 Medicare patients included in our sample had private physicians who had participated in the care of the 11 patients. Included in the billings reviewed were billings by these private physicians consisting of 227 occasions of service and charges of about $7,500.

The difficulty in supporting the billings for teaching physicians' services on the basis of evidence in the hospitals' medical records are discussed below for the more typical types of services billed.

Initial medical care

At all six hospitals the Medicare program usually was billed for initial medical care (initial visits) provided to nonsurgical patients on the first day of hospitilization. Initial visits generally consisted of developing a patient's history and making a physical examination and a diagnosis. Charges for an initial visit ranged from $15 at one hospital to $50 at another.

According to the hospitals' medical records for the 251 initial visits

--the physicians named on the billings, in addition to the residents and interns, were involved in providing about 27 percent of the services billed;

--supervisory physicians, other than the ones named on the billings, were involved in providing about 24 percent of the services;

--only residents and interns were involved in providing the remaining 49 percent of the services.

The extent of the support for the charges, as shown in the medical records, varied widely among the hospitals. For example, at one hospital, the records indicated that the physicians named on the billings or other supervisory physicians had been involved in providing initial medical care in about 80 percent of the cases sampled. At two other hospitals the records indicated that the physicians named on the billings were involved in providing initial medical care in about half of the cases for which charges were made. At the remaining three hospitals, the supervisory physicians named on the billings were involved in providing about 7 percent of the services billed.

Daily visits

At all six hospitals the Medicare program usually was billed for follow-up visits for each day of hospitilization, unless such care was covered under the fees billed for surgery. In some instances, however, the surgical fees were supposed to include the preoperative and postoperative care, yet additional fees for daily visits also were submitted and, in our opinion, incorrectly paid by the carriers. Charges for daily visits ranged from $4 at one hospital to $15 at another.

The hospitals' medical records showed that, for about 2,000 of the 5,553 daily visits, notations had not been made in the records by any of the physicians, including the residents and interns, to indicate that they had seen the patients; therefore we could not determine who provided the services or whether the services had been provided at all. Included in the 2,000 unsupported charges for daily visits were charges for 16 visits on days when the patients were not in the hospitals.

About 1,300 of these 2,000 unsupported daily visit charges related to a long-term tuberculosis hospital where the average length of a patient's stay was about 90 days and where notations by any of the physicians supporting the daily visit charges usually were not made.

For the 3,553 visits that were supported by physicians' notations, the medical records showed that (1) at three hospitals only residents and interns had provided about 95 percent of the services billed, (2) at one hospital the named physicians were identified with about 17 percent of the services billed, and (3) at another hospital the named physicians were involved in about 30 percent of the services billed.

At the last hospital, however, there were wide variances regarding the involvement of the named physicians with Medicare patients. The medical records showed that, for some Medicare patients, the named physicians had been involved in virtually all of the services billed in their name whereas, for other Medicare patients, all of the daily

visits recorded had been made by residents and interns with no involvement of the physician in whose name the services had been billed.

Surgery

At all six hospitals the Medicare program was billed for surgical procedures which usually required the use of the hospitals' operating rooms. Our samples of payments included 144 charges for operations. We found that one operation had not been performed and that one operation had been charged and paid for twice.

The August 1967 HEW regulations provided that:

> "In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician."

For the 142 operations actually performed, the hospitals' records indicated that the physicians named on the billings had been present during about 58 percent of the operations and that, in about 22 percent, other supervisory physicians had been present during the operation. For the remaining 20 percent, however, the hospitals' records did not show that any supervisory physician was present during the surgery which was performed by residents.

Wide variations existed among the six hospitals regarding the extent that their medical records supported the professional fees for the surgical procedures. For the payments included in our samples, the medical records at one hospital showed that the physicians named on the billings had been present for all the surgical procedures whereas the medical records at another hospital did not show that any supervisory physician was present at 60 percent of the procedures.

The findings of our reviews of the medical records at the six hospitals relative to the presence of supervisory physicians during the operations for which Medicare was billed are summarized in the following table.

Hospital	Total operations covered in our samples of payments	Medical records showed: Number of supervisory physicians present: Same as named on billing	Number of supervisory physicians present: Other	Supervisory physician not present: Number	Supervisory physician not present: Percent of total operations
A	13	13	-	-	-
B	14	4	5	5	36
C	49	32	15	2	4
D	20	10	7	3	15
E	28	20	-	8	29
F	18	3	4	11	61
Total	142	82	31	29	20

Surgical procedures for which Medicare was billed but for which the hospitals' records did not show that a supervisory physician was present included prostate operations, leg amputations, and cataract extractions.

Consultations

Our samples of payments included 151 charges for consultations at five of the six hospitals. A consultation was billed when a department (e.g., medicine) received medical advice from another department (e.g., surgery) or from a subspecialty within the same department. Charges for consultations ranged from $7 to $50.

Our samples of payments at three of the five hospitals pertained to 155 patients and included charges for 25 consultations. The hospitals' medical records showed that

--the physicians named on the billings had been involved in 72 percent of the consultations and

--other supervisory physicians had been involved in 20 percent of the consultations.

In other words, at these three hospitals, more than 90 percent of the consultations in our samples of billings were supported by supervisory physicians' notes in the medical records.

In contrast, our samples of payments at the other two hospitals which pertained to 140 patients included charges for 126 consultations. For about 65 percent of the charges, the hospitals' medical records (1) showed that consultations had been provided only by residents but did not indicate the involvement of the named physician or of any other supervisory physician or (2) did not show that consultations had been provided.

Hospital and medical school comments

The hospitals, the medical schools, or other billing entities were afforded the opportunity to review and comment on the drafts of our reports to the congressional committees.

In commenting on our findings that the medical records did not support the professional fees charged to Medicare, these organizations usually took the position that:

--The absence of supervisory physicians' notations in the medical records did not mean that the services were not provided or personally supervised by them.

--SSA, before the issuance of its April 1969 guidelines, did not require that billings to Medicare for supervisory and teaching physicians be supported by documentation in the hospitals' medical records of patients.

A medical school affiliated with one of the governmental hospitals advised us, in part, that:

"It is our studied opinion that our faculty have provided these patients with the highest 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 fully documented in the patients' medical records. It is a common practice to enter notes in the patient's chart when a doctor feels, for medical reasons, that a notation should be in the chart. This 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 to your attention 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 ***."

One county hospital commented as follows:

"We now have reviewed the clinical records of the patients identified to us as those audited by your staff. ***

"Regrettably, our review of the aforementioned clinical records does not enable us to refute the findings reported *** that our Medical Staff has not documented in the clinical records that they provided all of the services for which bills were rendered. This does not mean that the services were not rendered. It does mean, however, that our Medical Staff cannot confirm by means of the clinical records that the services were rendered.

"The conclusion indicated *** that the professional services for which Medicare billings were rendered 'generally had been furnished by residents and interns and not by an attending physician' is considered erroneous by our Director of Medicine and our Director of Surgery."

We acknowledge that the absence of a notation in the medical records does not conclusively prove--in all instances--that a service directly involving a supervisory physician had not been rendered to a patient. We believe, however, that the comments by the hospitals and medical schools raised two important questions which were relevant to the basic issue of whether, under the Medicare program, the fee-for-service method of payment is suitable for many teaching hospitals, namely:

1. Is the involvement of private doctors in the treatment of their own private patients in a hospital teaching setting usually shown in the hospitals' medical records of the patients?

2. Did SSA's April 1969 guidelines which specifically require that medical records contain documentation in

support of billings to Medicare for services furnished by supervisory and teaching physicians provide satisfactory solutions to the problems of unsupported and questionable billings at these hospitals?

What did the hospitals' medical records show for private Medicare patients?

At two hospitals we obtained some data indicating that hospital medical records did reflect the services provided to private patients by their own private doctor.

At the privately owned hospital, there were two distinct classes of patients--private patients and service patients. The private patients were admitted by physicians on the hospital's medical staff and normally were housed in private and semiprivate accomodations at the hospital. The service patients normally were housed in the hospital wards and generally were unable to pay the hospital charges and related professional fees.

For comparative purposes we reviewed the hospital's medical records of 42 Medicare nonsurgical service patients and of six Medicare nonsurgical private patients. For the nonsurgical services billed on behalf of the private Medicare patients, the hospital's medical records showed that--in addition to the services provided by residents and interns--the physicians named on the billings had been involved personally in about 65 percent of the services charged for. In contrast, for the nonsurgical services billed on behalf of the Medicare service patients, the hospital's medical records showed that the physicians named on the billings were involved in only about 4 percent of the services billed in their names.

As indicated by the footnote on page 19, at one county hospital 11 of the 65 Medicare patients in our sample had private physicians who had participated in their care during their hospitalization. Our comparison of the charges billed by these private physicians with the hospital's medical records showed that--in addition to the services provided by residents and interns--the private physicians had been involved personally in about 75 percent of the services billed. We noted, however, that, for the services billed in the names of the medical school faculty members assigned to the patients, the medical records showed the faculty physicians had been involved in only about 25 percent of the services billed in their names.

Did SSA's guidelines specifically requiring documentation solve the problem?

SSA's April 1969 guidelines focused the attention of the Medicare carriers, the hospitals, and the affiliated medical schools on the existence of the problems involved in the payments for the services of supervisory and teaching physicians; in our opinion, however, these instructions did not result in timely and permanent solutions to the problems of unsupported bills.

At three[1] hospitals included in our review, our samples of Medicare payments included payments made before and after the dates in June and July 1969, when, we believe, the hospitals and the affiliated medical schools should have implemented SSA's April 1969 guidelines. These guidelines specifically required that bills for supervisory and teaching physicians' services be supported by medical records containing evidence of the physicians' personal involvement in the services billed.

At two of the hospitals, the SSA carriers had (1) suspended Medicare payments for supervisory and teaching physicians' services in August 1969 pending implementation of SSA's guidelines and (2) resumed or partially resumed payments 2 or 3 months later on the assumption that such implementation had been made effective.

During our reviews at these two hospitals, however, we noted that only slight differences had resulted from SSA's revised instructions in either the billing practices or the documentation supporting the billing physicians' charges. For example, at one hospital, for 97 percent of the nonsurgical services provided before and for 94 percent of the nonsurgical services provided after the date that, we believe,

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[1] At the other three hospitals such a comparison could not be made because at the time of our field reviews, Medicare payments had been suspended. At one of the hospitals, payments were resumed in November 1970, and, at the other two hospitals, the suspensions were still in effect in September 1971.

SSA's April 1969 documentation requirements should have been implemented, the medical records did not show that the supervisory physician in whose name the services had been billed had been involved in providing such services.

At the second hospital, for 70 percent of the services billed before and for 57 percent of the services billed after the date that we believe that SSA's April 1969 documentation requirements should have been implemented, the medical records did not show that the supervisory physician in whose name the services had been billed had performed or directly supervised the services.

On the basis of these findings, we concluded that SSA's guidelines for supporting the bills had not been effectively implemented at these two hospitals. In May 1970 and April 1970, respectively, the carriers again suspended Medicare payments for supervisory and teaching physicians' services at these hospitals; such payments were not fully resumed until February 1971 and January 1971.

At the third hospital, the SSA carrier had (1) suspended Medicare payments for supervisory and teaching physicians' services in August 1969 pending implementation of SSA's April 1969 guidelines and (2) resumed payments about 2-1/2 months later.

At this hospital we noted that, after the effective date of SSA's guidelines, there (1) was increased documentary evidence of the supervisory physicians' involvement in the services billed to Medicare and (2) were some changes in certain physicians' billing practices which had the effect of reducing the Medicare charges for the nonsurgical services by about 35 percent. These changes involved reductions in the number of charges for daily visits and in the number of minor medical and surgical services billed to Medicare.

Although the affiliated medical school at the third hospital had taken steps to implement SSA's requirements, the dean of the medical school pointed out that, in an academic setting, payments for teaching physicians' services on a fee-for-service basis were almost impossible to administer and audit. The dean stated, in part, that:

"When the Medicare health insurance program was established under Title XVIII of the Social Security Act, it was done so with little thought being given to the mode of delivering health care other than a one to one relationship, namely one physician dealing with a single patient. In an academic medical center setting, medical care is provided through a team approach. It matters not whether the patient is a private patient paying his own bill, a private patient whose bill is paid in total or in part by some third party mechanism, be it a private insurance company or some government program, or if the patient is indigent. This is generally conceded to be the most effective means of providing care to insure optimum quality of care. In such a system, the medical record is almost always more extensive than in the case of a private physician's record in a community hospital. The record is intended to document the condition of the patient and his progress and not to document the role played by the responsible physician. It is this difference that has caused so much of our problem in auditing the patient record."

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"It is unfortunate that our faculty members spend as much as two hours per day when they are on-service just to provide the documentation that is required if they are to be entitled to bill for their services. This adds nothing to the care of the patient and indeed takes up a very appreciable amount of a physician's time that should be devoted to patient care.

"I recognize that it is absolutely essential that we abide by the rules and regulations governing the program and we are doing so. None of us will countenance any misrepresentation of facts or unappropriate billing for services rendered. I do hope, however, that a program can be worked out that will better accomodate the situation in an academic medical center."

* * * * *

"The present legislation and guidelines make it almost impossible to administer and audit the Medicare program in an academic medical center setting."

In our opinion, the dean's comments are germane to the basic issue of whether there is a viable alternative to the traditional fee-for-service method for paying for physicians' services under Medicare--particularly in an institution where residents and interns are extensively involved in providing day-to-day patient care and where the personal involvement of a teaching physician in the care of a particular patient may range from extensive to virtually none.

Agency comments

In commenting on the difficulties encountered in supporting the propriety of physicians' charges, HEW indicated that our findings at these three hospitals may not have been representative of the ultimate overall effect of SSA's April 1969 guidelines. (See app. II.) HEW pointed out that, after April 1969, there had been considerable improvement in the medical record documentation supporting the billings in the names of supervisory and teaching physicians, as evidenced by the fact that, as of September 1971, payments had been resumed at all but 22 of the 250 hospitals where Medicare payments for such services had been initially suspended. (See ch. 4.)

We do not disagree with HEW that our findings at these hospitals may not have been typical of the ultimate overall effect of the April 1969 guidelines. On the other hand we question whether compliance with medical record documentation requirements specifically for the purpose of supporting Medicare billings necessarily means that the fee-for-service method of paying for physicians' services is suitable in many teaching hospitals because of the need for maintaining continuous surveillance and enforcement of such requirements to ensure the propriety of the payments. In other words, if such medical record documentation is not usually provided by the physician in the normal course of treating his Medicare patients, some other payment mechanism which is more susceptible to effective controls appears to be desirable from the standpoint of both the physicians and the paying organizations.

DIFFICULTIES IN ESTABLISHING AN ATTENDING PHYSICIAN-PATIENT RELATIONSHIP IN SOME TEACHING SETTINGS

Our comparisons of the part B billings for physicians' services with the medical records of the hospitals revealed difficulties in establishing the attending physician-patient relationship necessary to qualify for payment on a fee-for-service basis under HEW regulations.

Available background material relating to HEW's August 1967 regulations, the language of the regulations, as well as later SSA guidelines and instructions placed particular emphasis on the requirement that, in order to bill part B of Medicare, the physician who involves residents and interns in the care of his Medicare patients be the patient's attending physician and render personal and identifiable medical services to the patient that are of the same character as his services to his other paying patients.

One of HEW's considerations which led to the promulgation of the August 1967 regulations was the concern that, unless provision was made for paying supervisory and teaching physicians on a reasonable charge or fee-for-service basis under part B, physicians who customarily admitted their private patients to teaching hospitals would withdraw their Medicare patients from the hospitals' educational programs under which residents, interns, and medical students learn by participating in the care of the physician's private patients.

The August 1967 regulations emphasized the attending-physician concept and also stated that there would be situations when part B payments on the basis of reasonable charges (fee-for-service) would not be applicable because the medical needs of a patient and the development of the resident's professional competence would make it inappropriate for a teaching physician to become involved personally in treating the patient to the extent required by the regulations.

The April 1969 guidelines--which, according to SSA, were intended to clarify and supplement the criteria for making payments for the services of supervisory and teaching physicians--further emphasized the attending-physician

concept by providing that a fee under part B would be authorized only when

--the physician, in fact, functioned as the Medicare patient's attending physician and personally rendered identifiable services to the patient which were documented in the hospital's medical records;

--the physician's services were of the same character as those rendered to his private patients;

--the physician was recognized by the patient as his private physician and was responsible for the continuity of the patient's care at least throughout the period of hospitalization; and

--the physician had full personal control over that part of the care for which charges were submitted.

Comparisons of Medicare part B billings with the medical records at the six hospitals showed that, in about 45 percent of the cases where a supervisory physician was identified with a specific service billed to Medicare, the supervisory physician shown on the medical record was different from the supervisory physician in whose name the service was billed.

We believe that this situation occurred because (1) the supervisory physicians in a particular department or ward practiced as a group and/or (2) the supervisory physicians served specific or intermittent tours of duty which were not necessarily related to a particular Medicare patient's period of hospitalization. It was difficult, therefore, to establish the bona fide attending physician-patient relationship contemplated by HEW regulations. Examples of such difficulties follow.

1. At one county hospital which relied on a large voluntary staff to help supervise the medical care provided, the hospital's director described the delivery of patient care by the supervisory physicians, the residents, and the interns in the following terms.

"Now, I'd be the first to say that the vast majority of our voluntary staff members, those who come in voluntarily and contribute their time, that there would be difficulty in the patient identifying just exactly which of those men were their personal physician; it is unlikely that a vast majority of our patients could do that. [note 1] Nevertheless, by virtue of the organized programs which we have, it is possible for three of four of these voluntary staff physicians, backed up by full-time staff physicians, to come in and supervise the residents, one being present at the time to check the initial examination of the patient and the initial plan of treatment, and, perhaps, another one being present at the time that the patient undergoes a therapeutic procedure, such as an operation or the like, and I believe this is at the present time an acceptable physician-patient relationship in the teaching setting with interns and residents, but it is going to be increasingly under scrutiny and it may be more difficult to document to the satisfaction of all parties concerned."

2. At the privately owned hospital, supervisory physicians in the section of the hospital for service patients had specified monthly tours of duty during which they supervised and taught residents and interns. Because the supervisory physician's tour of duty did not necessarily coincide with the period of the patients' hospitalization, the physicians could not be responsible personally for the continuity of care for all the patients in the section during their entire periods of hospitalization.

For example, our samples included payments for one Medicare patient who was hospitalized from October 29 to November 16, 1968. Medicare was billed in the name of the supervisory physician on duty during October for daily visits

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[1]The director indicated in a separate statement to us that, in the case of the full-time salaried staff, more patients were aware of the role of the supervisory physician in their care, although they still identified the intern or resident as their doctor.

at $10 each up to and including November 16, even though his tour of duty ended October 31.

After we brought this situation to SSA's attention, SSA issued instructions in August 1970 pointing out that, in the foregoing circumstances, the supervisory physician could not properly be considered the patient's attending physician for Medicare billing purposes.

3. At another county hospital the medical care was largely supervised by the faculty of the affiliated medical school. A number of the physicians on the faculty were also full-time employees of a nearby Veterans Administration (VA) hospital.

VA has encouraged its hospitals and their medical staffs to become affiliated with medical schools. VA regulations permit full-time VA physicians to teach in educational institutions and to accept remuneration, provided that (1) the teaching activity does not impinge on the physicians' responsibilities for the care and treatment of VA patients and (2) the physicians do not assume responsibility for the continuing care of non-VA patients. Therefore full-time VA physicians could not function properly as attending physicians although the HEW regulations for billing Medicare require them to do so.

During fiscal year 1969 Medicare paid about $100,000 for the services of 17 full-time VA physicians who were on the faculty of the affiliated medical school supervising the medical care at the non-VA governmental hospital. Our sample of Medicare payments at this hospital included bills for about $4,800 for services provided to Medicare patients by 10 VA physicians. About 95 percent of the payments represented billings for services provided as an attending physician, contrasted to charges for a single limited service, such as a consultation.

The hospital's medical records showed that, in many cases, a full-time VA physician was not involved in <u>any</u> of the services billed in his name as a Medicare patient's attending physician although some of the patients were hospitalized for periods of more than a month.

Because these payments appeared to be in conflict with either the VA regulations or the HEW regulations, we brought the matter to the attention of these agencies. Subsequently VA, in February 1970, clarified its regulations to specifically prohibit its full-time physicians to act as attending physicians 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, and, in July 1970, SSA directed its carriers not to pay any Medicare bills applicable to the services of full-time VA physicians except for clinical consultation and for services provided by the relatively few VA physicians authorized to engage in special community service activities.

DIFFICULTIES IN ADMINISTERING DUAL REIMBURSEMENT SYSTEM

The costs of certain physicians' services in a hospital setting which are of benefit to patients in general are reimbursable to the hospital under the hospital insurance (part A) portion of Medicare, whereas physicians' services relating to the care of individual patients are reimbursable under part B.

We noted that, at five of the six hospitals, the carriers and intermediaries experienced problems in administering the dual part A and part B Medicare reimbursement system, which resulted in excessive reimbursements of about $434,000 to two of the hospitals included in our review.

As pointed out on page 8, HEW regulations issued in October 1966 provide for part B Medicare payments to hospitals for services to individual patients by physicians who are employed by, or receive compensation from or through, a hospital. To the extent that the hospitals pay these hospital-based physicians for services other than direct patient care--such as teaching, administration, and supervision of professional or technical personnel--such compensation is reimbursable to the hospital as a cost under part A.

The regulations further provide, however, that the sum of the payments to the hospital under parts A and B about equal the physicians' compensation allowable by the Medicare program except in certain circumstances where historically the hospital charges for physicians' professional services had been identified separately from the charges for other hospital services.

These regulations were not complied with at two governmental hospitals where the physicians were salaried employees and were paid by the hospitals for both part A and B services.

1. At the city-owned hospital, the staff physicians were employed by the city and were paid annual salaries. As a condition of their employment, the physicians were precluded from billing for the treatment of patients in the hospital.

Although the Medicare part B carrier paid about $354,000 to the hospital during the 3-year period ended June 30, 1969, for the services of the hospital physicians to individual Medicare patients, the hospital's costs of providing such services were only about $49,000. These costs had been eliminated from the hospital's claims for reimbursement under the part A portion of the Medicare program.

After subtracting the deductible and coinsurance amounts totaling about $14,000--which were payable by the Medicare patients--from the hospital's cost of $49,000, we estimated that part B payments received by the hospital exceeded its reimbursable Medicare costs by about $319,000.

2. At a county-owned hospital, the staff physicians were salaried employees who were precluded from billing for their services to patients in the hospital. We estimated that, for the 3-year period ended June 30, 1969, the amounts paid to the hospital under part B and the amounts claimed by the hospital under part A for physicians' services to Medicare patients exceeded the hospital's reimbursable Medicare costs by as much as $115,000.

DIFFICULTIES IN CLEARLY ESTABLISHING ANY BENEFICIARY LIABILITY

Because the Medicare program primarily is an insurance program to privide protection against the cost of health care for most Americans aged 65 and over, the Medicare law provides that payments not be made for health services--including physicians' services--if the individual receiving such services has no legal obligation to pay for them.

The willingness of a Medicare patient to pay the part B deductible and coinsurance amounts and to sign a claim requesting Medicare payments to be made on his behalf provides some evidence that the patient acknowledges his obligation to pay for the services of the supervisory and teaching physicians.

There was, however, a general lack of beneficiary involvement in the billing arrangements for services of teaching and supervisory physicians. This condition caused difficulties in clearly establishing that the patients had acknowledged any obligation to pay for the services billed to Medicare on their behalf.

Patients generally not billed for deductible and coinsurance amounts

With few exceptions the Medicare patients generally were not billed for the deductible and coinsurance amounts applicable to the services provided by supervisory and teaching physicians. In some instances where a Medicare patient was also covered under the State Medicaid program or a private insurance policy supplementing Medicare, the State or the private insurers were billed and paid the deductible and coinsurance amounts.

According to the responsible billing officials, the Medicare deductible and coinsurance amounts generally were not billed to the individual patients because they were not financially able to pay.

Patients did not usually authorize billings

Under Medicare there were generally two forms used in billing for physicians' services. One form (form SSA-1554) was for use by hospitals only when they had a billing arrangement with physicians to collect their charges for the care of individual patients. One hospital used this form, and--according to SSA instructions--the patients were not required to sign each bill.[1] Instead, the hospital required the Medicare patients, at the time of admission, to sign a statement authorizing the hospital to bill Medicare for any benefits due the patients. Under this arrangement patients did not authorize any specific payments for services of any specific physician.

The other form (form SSA-1490) was for use by individual physicians or by the beneficiaries to bill Medicare for physicians' services. SSA instructions require, generally, that a patient sign the form requesting 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 the payment to be made directly to the physician or his billing organization, the patient's signature provides evidence that the patient has made the assignment and that he recognizes the right of the physician to request payment on the patient's behalf for services rendered.

At five hospitals,[1] forms SSA-1490 usually were used to bill for the services of supervisory and teaching physicians and the billings were handled as assignments (i.e. the beneficiary did not submit a claim for reimbursement to himself to pay the physician's bill).

At two governmental hospitals none of the claims for the payments included in our samples were signed by the

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[1]One of the departments of an affiliated medical school at another hospital had improperly used this hospital form to bill Medicare for the services of its faculty physicians.

Medicare beneficiaries. Also, at the three remaining hospitals, about 65 percent of the claims were not signed by the Medicare beneficiaries.

In commenting on the lack of patients' authorizations on the billings for the physicians' services, officials of the hospitals or other billing organizations generally advised us that (1) the patients were physically unable to sign or (2) the officials had misunderstood the SSA billing requirements.

DIFFICULTIES IN ESTABLISHING CUSTOMARY AND PREVAILING CHARGES

The Congress, in establishing the Medicare program, provided that payments for physicians' services be made on the basis of reasonable charges and that, in determining the reasonableness of charges, consideration be given to (1) the customary charges for similar services generally made by physicians and (2) the prevailing charges of physicians in the locality for similar services.

At two hospitals the Medicare carriers had a questionable basis for determining that the charges billed to Medicare for the services of supervisory and teaching physicians were customary and prevailing because these carriers did not pay for similar services at these hospitals for their own subscribers. Under these circumstances it could be argued that the customary or prevailing charge would be zero.

For example, at a privately owned hospital, the SSA carrier (Blue Shield) paid for surgical and inpatient medical and outpatient services provided to Medicare patients in the service section of the hospital. For its own subscribers, however, Blue Shield did not pay for inpatient medical or outpatient services to service patients although it did pay for surgically related services.

Blue Shield informed us that one of the conditions of its medical insurance policies was that professional fees be paid only for services rendered to private patients. The term "private patient" was defined as a patient with whom a physician or dentist has an expressed or implied

contract to render services for a fee. Because service patients at this hospital were not expected to pay for supervisory physicians' services if they had no insurance, Blue Shield considered that no contract, expressed or implied, existed between its subscribers who were service patients and the supervisory and teaching physicians.

Also we noted that insurance companies other than Blue Shield did not pay for inpatient medical services or outpatient services rendered by teaching physicians to service patients at this hospital.

At a county hospital, the SSA carrier (Blue Shield) would not pay for any supervisory or teaching physicians' services rendered to its own policy holders although--in 1 year--it paid part B funds of $1.6 million for such services to Medicare patients. Some insurance companies, however, other than Blue Shield did pay fees for physicians' services at this hospital.

CHAPTER 4

MAGNITUDE OF OVERALL PROBLEM AND ACTIONS TAKEN BY SSA AND THE CARRIERS

In April 1969 SSA recognized the seriousness of the problems that existed in Medicare because of the payment on a fee-for-service basis for the services of supervisory and teaching physicians in a hospital setting. During the 2-year period between April 1969 and April 1971, SSA issued various instructions to its carriers to clarify the regulations, to determine where possible overpayments existed, and to obtain data on the subject; however, as of April 1971 SSA was still unable to definitely establish the magnitude of the overall problem.

In addition to the problems associated with the Medicare program, the Federal Government also has participated in payments to supervisory and teaching physicians under various State Medicaid programs providing medical care to the indigent.

ESTIMATED MAGNITUDE OF PROBLEM UNDER MEDICARE

Although SSA has never clearly established the overall magnitude of the problem in terms of the total Medicare payments that have been made for the services of supervisory and teaching physicians, the Senate Finance Committee has estimated that total payments could be more than $100 million annually.

On the basis of our reviews at the six hospitals where Medicare payments averaged about $500,000 a year and responses that we received to a questionnaire from other teaching hospitals selected randomly, it appears that the problem is widespread and significant.

Information requested of 20 hospitals

In an attempt to develop information on the overall magnitude of the Medicare payments for the services of

supervisory and teaching physicians, we randomly selected 20 teaching hospitals from the 200 non-Federal medical school-affiliated hospitals that were members of the Council of Teaching Hospitals of the Association of American Medical Colleges and SSA queried them as to the extent of their Medicare reimbursements for the services of supervisory and teaching physicians. Eighteen responses were received, which indicated that for 1968 and 1969

--11 hospitals received a total of $3.2 million,

--five hospitals made no billings,

--one hospital could not determine the amount received, and

--one hospital reported that Medicare payments had been suspended during much of the period.

For those hospitals from which a positive response was received (including those that reported no billings), the Medicare payments averaged about $100,000 annually.

SSA DIRECTION TO CARRIERS

Since April 1969 SSA has issued various instructions and guidelines concerning the conditions under which Medicare payments could be made for the services of supervisory and teaching physicians and also as a means for determining where possible overpayments existed. A summary of SSA's instructions is shown in appendix I. Some of the more significant steps taken are discussed below.

Suspension of payments

In June 1969 SSA instructed its carriers to suspend Medicare payments for supervisory and teaching physicians' services at university-affiliated teaching hospitals in those cases where the carriers were not satisfied that the hospitals were complying with the April 1969 guidelines. In August 1969 SSA issued instructions to the effect that payments at teaching hospitals that were not affiliated with universities were also to be suspended, if appropriate.

In December 1970 SSA reported that at one time or another Medicare part B payments had been suspended at about 250 hospitals, and in September 1971 SSA reported that payments remained suspended at 22 of the hospitals.

Number and scope of carrier audits

SSA's April 1969 guidelines require carriers to make appropriate checks of hospitals' medical records of patients to verify that services for which charges are billed meet SSA's coverage criteria.

In September 1969 SSA directed that, before resuming payment at those hospitals where payments were suspended, the carriers should examine about 100 paid or unpaid billings to determine if the physicians named on the billings had rendered the personal and identifiable services expected of an attending physician in his private practice.

In December 1970 SSA reported to its carriers that it was unable to issue a definitive national policy for recovery of overpayments and queried the carriers throughout the country to identify those that had made audits of hospitals' medical records to determine the propriety of payments for services rendered before June 1969--the effective date of SSA's April 1969 guidelines.

As of February 1971 SSA had received responses from 43 of the 48 carriers; only 11 carriers reported that they had made audits. Excluding four hospitals where SSA had initiated action to recover overpayments, the carriers' audits were made at 58 hospitals throughout the country, of which one carrier accounted for 36 hospitals or more than one half of the audits reported.

This carrier informed us that, on receiving SSA's audit instructions in September 1969, it proceeded to review current Medicare claims for reimbursement but that it had retained no working papers showing the claims reviewed. In April 1971 this carrier informed us also that it was making a second audit at the 36 hospitals and that it would document the nature and scope of the work which would include services rendered prior to June 1969.

In April 1971 SSA issued instructions to its carriers regarding the determination and recovery of overpayments for teaching physicians' services provided before June 1969. According to SSA officials these instructions should involve about 300 teaching hospitals. The carriers were instructed to make their audits in the following two stages.

--An audit was to be made of a sample of about 75 claims to determine whether the potential overpayments justified the cost of an in-depth audit.

--If a substantial overpayment was indicated, an in-depth audit of Medicare claims should be made to determine the amount of the overpayment.

The April 1971 instructions further provided that, whenever the carrier decided not to make an in-depth audit, the rationale supporting the decision should be fully documented.

Actions initiated to recover overpayments at 12 hospitals

In addition to the six hospitals included in our reviews, SSA had identified six other teaching hospitals where potential Medicare overpayments for the services of supervisory and teaching physicians might have occurred.

As of June 1, 1971, SSA had determined that overpayments totaling about $2.5 million were made at four of the 12 hospitals and it had initiated collection actions. The carriers' SSA-directed audits were in process and negotiations for refunds had been initiated at six hospitals. At one hospital the intermediary and carrier were making a joint audit; at the remaining hospital no specific recovery actions had been taken by SSA at that time.

OTHER FEDERALLY SPONSORED PROGRAMS PAYING FOR THE SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS

Congressional concern regarding payments for the services of supervisory and teaching physicians has been primarily directed toward payments made under the Medicare program because of HEW's August 1967 regulations specifically authorizing such payments (see p. 8) and because of the substantial amounts involved. Similar payments have been made under the Medicaid program--authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--which is also an HEW program. The Medicaid program is a grant-in-aid program under which the Federal Government participates in costs incurred by the States in providing medical assistance to individuals who are unable to pay for such services.

As of December 1970, 48 States and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had adopted Medicaid programs. The Federal Government pays from 50 to 83 percent (depending on the per capita income of the States) of the costs incurred by States in providing medical services under their Medicaid programs. For fiscal year 1970 the States and jurisdictions then having Medicaid programs reported expenditures of about $4.7 billion of which about $2.4 billion represented the Federal share. About $572 million of the total Medicaid expenditures was for physicians' services.

Although this report concerns the problems involving payments made under Medicare, we believe that similar problems exist with regard to payments made under Medicaid.

Medicaid payments at the six hospitals reviewed by GAO

At the time of our review at the six hospitals, five of the hospitals were located in States that had Medicare programs. Payments were made under the Medicaid program for supervisory and teaching physicians' services rendered at four of the five hospitals. At one of the five hospitals, the State had refused to pay for such services under the Medicaid program. The Medicaid payments for the services at the four hospitals varied from $500 to $371,000. On an

annual basis, the payments averaged about $112,000 and included payments which represented the Medicare deductible and coinsurance amounts. (See p. 40.)

Information requested of 20 hospitals

The responses received from the 18 hospitals referred to on pages 44 and 45 indicated that 10 hospitals billed the Medicaid program for supervisory and teaching physicians' services, six made no billings, and two hospitals did not respond to the question concerning the amounts received from Medicaid. The average annual amount received during the years 1968 and 1969 for each of the 16 hospitals that responded to our questionnaires was about $125,000.

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Although the overall magnitude of the problem involved in payments for supervisory and teaching physicians' services under the Medicare and Medicaid programs has not been definitely established, the available evidence indicates that it is widespread and significant. In our opinion, SSA's experience over a 2-year period in attempting to clarify the pertinent regulations and to obtain overall data on the subject is indicative of the difficulties inherent in administering a fee-for-service reimbursement system that is neither easily understood nor readily susceptible to effective controls.

CHAPTER 5

LEGISLATIVE CHANGES BEING CONSIDERED BY THE CONGRESS

CONGRESSIONAL DELIBERATIONS

In April 1969 the Committee on Finance, U.S. Senate, requested us to review the Medicare payments made to an association of supervisory and teaching physicians at a large midwestern hospital. On July 1 and 2, 1969, the Committee held public hearings at which our representatives and officials of HEW testified.

Report of staff of Senate Finance Committee

On February 9, 1970, the staff of the Senate Finance Committee issued a report[1] to the Chairman which recommended that payments on a fee-for-service basis for supervisory or teaching physicians' services rendered to nonprivate or service patients be terminated until such time as the Congress clearly and specifically expresses an intention to pay for these services and specifies the criteria under which they will be paid.

The staff report questioned whether the Medicare beneficiary who is an institutional or service patient in a hospital is under any legal obligation to pay for such physicians' services and noted that, although medical schools and teaching hospitals are in need of additional sources of funds, millions of older people should not be required to subsidize medical education through their Medicare part B premium payments. The staff reported that the Congress had recognized that the proper approach to additional financing of medical education was through the appropriation process, where needs could be established, justified, and met on the basis of specific requirements of specific institutions.

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[1] Medicare and Medicaid--Problems, Issues, and Alternatives.

Social Security Amendments of 1970

In May 1970 the House of Representatives passed House bill 17550, entitled "Social Security Amendments of 1970," which included a provision to change the basis of reimbursement under part B for the services of teaching physicians from a fee-for-service basis to a cost-reimbursement basis when the services are furnished under 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 physicians' charges.

The House bill provided for the reimbursement of 100 percent of the reasonable cost of such services to a hospital or other medical service organization, including medical schools, and thus would have made it unnecessary for these institutions to obtain the deductible and coinsurance amounts from the individual Medicare patients.

The U.S. Senate passed an amended version of House bill 17550, on December 29, 1970, but the bill was not enacted into law because the ninety-first Congress adjourned before the differences in the bills could be resolved by a House and Senate Conference Committee.

The Senate version of the bill provided that, except in certain circumstances, payment for the services of teaching physicians to Medicare patients be made under part A[1] on the basis of actual or "equivalent" cost. Under the bill payment under part B would continue to be authorized where (1) the Medicare patients were bona fide "private" patients of the billing physician or (2) during the 2-year period

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[1]When a patient only had part B coverage, payment would be made on the basis of reasonable costs under part B.

ended December 31, 1967, and each year thereafter, all the institution's patients were regularly billed on a fee-for-service basis for professional services and most patients paid such charges.

The bill provided that payments on a cost basis under part A could include the salaries paid by an affiliated medical school to faculty physicians for patient care furnished to Medicare patients in the hospital. It provided also for payments to a hospital's organized medical staff for the services provided by the unpaid voluntary medical staff of a hospital on the basis of the average salary for all full-time physicians (i.e., on an equivalent cost basis).

Thus, under the Senate version, payment under Medicare would be made for a proportionate share of these costs in much the same manner as payments are presently made for the services of residents and interns.

As for the Medicaid program, the Senate version of House bill 17550 provided that, where States elect to pay for the services of supervisory or teaching physicians, Federal matching would be limited to reimbursements not in excess of that allowable under Medicare.

Social Security Amendments of 1971

On January 22, 1971, House bill 1 entitled "Social Security Amendments of 1971" was introduced in the House of Representatives. On May 26, 1971, the House Ways and Means Committee reported out its version of House bill 1 which contained the same provisions for the reimbursement of supervisory and teaching physicians' services under Medicare as the Senate's version of House bill 17550. These provisions were included in the bill passed by the House on June 22, 1971.

CHAPTER 6

CONCLUSIONS

In our opinion, the legislative changes proposed by the cognizant legislative committees are designed to provide reasonable solutions to certain of the problems we identified in administering the fee-for-service method for making Medicare payments for supervisory and teaching physicians' services in a teaching setting.

We believe that the proposed legislation--which provides that, except in certain circumstances, payments under Medicare would be made for teaching physicians' services under part A (hospital costs) on the basis of a proportionate share of the reasonable costs of such services to all patients--if effectively implemented, would

- --minimize the problem of unsupported bills because Medicare payments would be related to that part of a supervisory physician's time applied to the care of patients at the hospital and would no longer require the extensive documentation now required to support charges for specific services on a patient-by-patient basis,

- --eliminate the need to demonstrate that a supervisory or teaching physician is the patient's attending physician in order to qualify for reimbursement, and

- --minimize the difficulties in administering the dual Medicare reimbursement system for the physicians' services such as have occurred when a part of a physician's services may be reimbursed on the basis of reasonable costs under part A and a part of the same physician's services involving individual patients may be reimbursed on the basis of reasonable charges under part B.

The proposed legislation also gives consideration to our findings on the difficulties in (1) clearly establishing any beneficiary liability because of the lack of beneficiary involvement in the billing arrangements and (2) establishing customary and prevailing charges. For example:

--Medicare payments on a fee-for-service basis would continue to be authorized under part B for those Medicare patients who are bona fide private patients of the billing physician. According to the Committees' reports on the proposed legislation, one of the criteria for establishing that a bona fide private patient-physician relationship exists would be that (1) the Medicare patient is legally obligated to pay the charges billed, including the deductible and coinsurance amounts, and (2) the physician routinely and regularly seeks to collect such charges.

When the services of teaching physicians are to be reimbursed on the basis of reasonable costs under part A, however, the part B deductible and coinsurance provisions would not be applicable. This would make it unnecessary for the hospitals or other billing organizations to obtain such amounts from the individual Medicare patients. Further, under the Committees' proposed cost-based reimbursement system, it would not be necessary to clearly establish a specific patient's liability to pay a specific physician for specific services.

--Medicare payments on a fee-for-service basis also would be authorized under part B of Medicare when, during the 2-year period ended December 31, 1967, and during each year thereafter for which charges for physicians' services are being claimed: (1) all the institutions' patients were billed regularly for professional services, (2) reasonable efforts were made to collect these billed charges, and (3) at least 50 percent of the patients paid such charges.

Because, under this proposal, physicians' fees were required to have been charged and regularly collected during a 6-month period (January 1 through June 30, 1966) before the effective date of Medicare, the proposed legislation would require consideration of the customary billing practices at the time Medicare came into effect, as well as the customary practices on a more current basis.

REMAINING POTENTIAL PROBLEM AREA

We believe that, under the proposed legislation, it would still be possible to pay for teaching physicians' services to their bona fide private patients at institutions on the fee-for-service basis under part B, and also to pay for the same physicians' services to their nonprivate patients at institutions on the basis of costs under part A. Under these circumstances the difficulties in administering the dual part A and part B Medicare reimbursement system could be a continuing problem.

Therefore, if the proposed legislative changes are enacted, HEW should develop detailed guidelines (including provisions for audit) to help establish and maintain effective procedures for determining the proper amounts to be paid for supervisory and teaching physicians' services which are reimbursed on both the cost basis and the fee-for-service basis at the same institution.

AGENCY COMMENTS

In commenting on the foregoing observations (see app. II), HEW advised us that it was aware of the possible problems of administering the dual part A and part B reimbursement system for physicians' services and that it was sensitive to their implications. HEW stated that, in developing guidelines and instructions to implement the new amendments, when they are enacted, HEW would deal with the problem of reimbursement under both part A and part B for teaching physicians' services.

CHAPTER 7

SCOPE OF REVIEW

We examined into Medicare payments for the services of supervisory and teaching physicians at six teaching hospitals. Our examination included comparisons of the billings for 315 Medicare patients with the hospitals' medical records applicable to the patients to ascertain the extent to which the medical records showed (1) whether the services were provided and (2) who was involved in providing them. Because of the technical nature of the data being reviewed, we received professional assistance at each of the six hospitals either from Public Health Service physicians or from consulting physicians employed by the SSA carriers, who independently checked our findings with the medical records. The physicians' findings were incorporated into our individual reports to the cognizant legislative committees of the Congress and into this overall summary report.

Our examination also included reviews of (1) the hospitals' claims for reimbursement for physicians' services under the hospital insurance (part A) portion of Medicare, (2) the extent of the billings for the Medicare deductible and coinsurance amounts which were the responsibility of the patients, and (3) the billing practices for physicians' services as they pertained to the State Medicaid programs and to health insurers other than Medicare.

For each of the six hospitals, we obtained written comments on drafts of our individual reports from SSA; from the applicable Blue Shield carriers; and from the hospitals, affiliated medical school, or other billing organization directly involved. We considered these comments in the preparation of our individual reports and in the preparation of this report.

Our selection of the hospitals was principally based on (1) direction from congressional committees (two hospitals), (2) our reviews in process dealing with overall Medicare reimbursement matters (three hospitals), and (3) information obtained from nongovernmental sources indicated the existence of problems (one hospital). Because of the nonrandom basis for our selection, our findings at the six hospitals

may not be representative of conditions at all teaching hospitals.

At our request SSA sent questionnaires to 20 teaching hospitals, selected by us at random, to develop additional information as to the extent of the payments for the services of supervisory and teaching physicians under the Medicare and Medicaid programs.

Our reviews were made at SSA headquarters in Baltimore, Maryland, and at the offices of the applicable SSA carriers and intermediaries and the six hospitals located in the States of Florida, Illinois, Massachusetts, Michigan, and Texas.

As part of our reviews, we examined into the basic legislation authorizing the Medicare program and the pertinent HEW regulations and SSA instructions and guidelines implementing the program. We examined also pertinent documents at the offices of the SSA carriers and intermediaries and at the hospitals and/or affiliated medical schools.

APPENDIXES

LISTING OF INSTRUCTIONS CONCERNING

PAYMENTS TO SUPERVISORY AND TEACHING PHYSICIANS

ISSUED BY SSA AFTER THE APRIL 1969 GUIDELINES

June 1969--directing carriers to suspend payments to university-affiliated teaching hospitals if they were not complying with the April 1969 guidelines.

July 1969--requesting information as to what steps have been taken by the carriers concerning their responsibilities for claim review and verification as outlined in the April 1969 guidelines.

August 1969--cautioning carriers to resume payments that have been suspended only after discussion with SSA because of the many questions concerning the propriety of payments.

August 1969--directing carriers to suspend payments to non-university-affiliated teaching hospitals if they were not in compliance with the April 1969 guidelines.

August 1969--directing carriers to give review priority to university-affiliated teaching hospitals over the non-university affiliated types, starting with those having extensive intern and residency programs.

September 1969--specifically directing carriers to examine patient records (about 100) at teaching hospitals where payments were suspended and to discuss recovery of overpayments where identified.

September 1969--identification of major issues emanating from SSA questionnaires completed by university-affiliated teaching hospitals.

November 1969--directing local SSA offices to review carrier activities regarding the April 1969 guidelines.

December 1969--recognition that the problem of overpayment needs further study and advising carriers that the existence of a possible overpayment should not

preclude resumption of payment if the institution meets the April 1969 guidelines.

January 1970--31 questions and answers relating to implementation of the April 1969 guidelines.

March 1970--directing carriers to suspend payments for services rendered full-time VA physicians in teaching hospitals.

June 1970--exclusion of teaching hospitals from detailed implementation of the April 1969 guidelines if (1) the Medicare patients had a physician-patient relationship with the supervisory and teaching physician before hospitalization, (2) all patients pay on a fee-for-service basis for the services, including amounts not paid by insurance or other third parties, and (3) the fees paid by the patients are retained by the physicians.

August 1970--clarification of April 1969 guidelines relating to payments where the physician's service to a patient is interrupted by rotation.

December 1970--SSA recognition that it was still unable to issue a definitive national policy on the approach to be taken regarding the recovery of overpayments.

April 1971--instructing carriers to determine and recover overpayments on claims for teaching physicians' services for the period before June 1969.

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

.E OF THE SECRETARY

SEP 22 1971

Mr. Philip Charam
Associate Director, Civil Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Charam:

The Secretary has asked that I reply to your letter of July 29, 1971, which transmitted copies of your draft report, "Problems in Administering Medicare Payments for the Services of Supervisory and Teaching Physicians in a Hospital Setting" (B-164031-4, July 29, 1971).

This report was primarily prepared for the guidance of members of the Congress in considering legislative proposals designed to resolve problems that have arisen in connection with Medicare reimbursement for the services of supervisory and teaching physicians in a hospital setting. The draft report summarizes the more significant problems GAO found in reviews of six teaching hospitals and describes some of the actions taken by SSA to deal with these problems. In Chapter 4 and Appendix I of the draft report, GAO gives specific recognition to SSA efforts to (a) clarify the conditions under which payment can be made on a fee-for-service basis for the services of supervisory and teaching physicians, (b) identify particular teaching hospitals where overpayments may have occurred, and (c) recover overpayments.

GAO concludes that the proposed legislation currently under consideration would, if enacted, help to resolve the major problems identified during the reviews. It notes, however, that even under the proposed legislation, the difficulties in administering the dual Part A-Part B Medicare reimbursement system could be a continuing problem where a teaching physician has both private and nonprivate patients in the same institution. GAO suggests that detailed guidelines be developed to help establish and maintain effective procedures for determining the proper reimbursement for services based on both costs and fee-for-service at the same institution. We are aware of this possible problem and are sensitive to its implications. In developing guidelines and instructions implementing the new amendments when they are enacted, we will provide for the problem of reimbursement under both Part A and Part B.

In the draft report, GAO considers whether the guidelines issued by SSA in April 1969 to clarify and supplement the criteria for making payment for the services of supervisory and teaching physicians provided satisfactory solutions to the problems of unsupported or questionable billings for services furnished by these physicians. Based on a review of Medicare

payments at three teaching hospitals for periods before and after the effective date of the instructions, GAO concludes that, in their opinion, these problems were not effectively resolved. We believe, however, that GAO's sample of claims for periods subsequent to April 1969 may not have been representative since it was for the period immediately following the effective date of the instructions, and full implementation of these guidelines was not immediately achieved. Consequently, we think GAO may have drawn certain conclusions which are not properly reflective of the ultimate effect of the instructions. Overall, we think the evidence shows there has been considerable improvement since April 1969 in the medical record documentation supporting billing by supervisory and teaching physicians. Chiefly because of this improvement, payments have been resumed to all but 22 of the 250 hospitals where payments for these services had been initally suspended.

We appreciate the continuing interest of GAO in improving the operation of the Medicare program.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

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

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH INSURANCE (note a):		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

[a]The Bureau of Health Insurance was a part of the Bureau of Disability and Health Insurance until September 1965. At that time separate bureaus were established to handle the functions of the disability program and the health insurance program.

Copies of this report are available from the U. S. General Accounting Office, Room 6417, 441 G Street, N W., Washington, D.C., 20548.

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