DOCUMENT RESUME

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Review of GHI's Administration of Part B of Medicare in Queens County, New York. HRD-78-104; B-164031(4). April 11, 1978. 14 pp. + 2 enclosures (5 pp.).

Report to Rep. Benjamin S. Rosenthal; by Philip A. Bernstein (for Gregory J. Ahart, Director, Human Resources Div.).

Issue Area: Health Programs (1200).
Contact: Human Resources Div.
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Organization Concerned: Department of Health, Education, and Welfare; Health Care Financing Administration: Medicare Bureau; Group Health, Inc., NY.
Congressional Relevance: Rep. Benjamin S. Rosenthal.

Operations of Group Health Incorporated (GHI) in carrying out its responsibilities under Part B of the Medicare program in Queens County, New York, were reviewed. GHI has operated as the Medicare Part B carrier for Queens County since the beginning of the program. The initial contract commenced on February 11, 1966, and has been renewed annually. A detailed explanation of the events and circumstances leading to the initial contract award was not available. However, contracts are renewed yearly unless the carrier or the Government decides not to renew. From January 1, 1973, through June 30, 1976, there were only three instances where the Medicare Bureau reported a GHI operation as unsatisfactory. Claims processing and beneficiary services and provider relations received unsatisfactory ratings for the period ended June 30, 1976; these ratings were attributable to a strike at the carrier which lasted from January 1 to April 23, 1976, and which crippled both the Medicare and private business operation. The accessibility of GHI to beneficiaries in Queens does not appear to be any better or worse than that for other Medicare beneficiaries in the New York area. For the period July through September 1976, GHI had the second highest rate of processing errors per claim line item of all carriers in the region and one of the highest in the country. Because physicians in Queens County charge less, Medicare reimbursement rates there are generally lower than in other areas of New York City. (RRS)

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

HUMAN RESOURCES DIVISION

RELEASED 5/31/78

B-164031(4)

APR 11 1978

The Honorable Benjamin S. Rosenthal
House of Representatives

Dear Mr. Rosenthal:

In response to your request and subsequent discussions with your office, we reviewed certain operations of Group Health Incorporated (GHI) in carrying out its responsibilities under Part B of the Medicare program in Queens County, New York. Specifically, we examined

--the circumstances under which GHI was awarded the original contract for Queens County, and the basis for contract renewals;

--the length of time it takes GHI to process claims;

--GHI's responsiveness to the inquiries of beneficiaries and why a branch office is not located in Queens County;

--how accurately GHI processes claims; and,

--how GHI's prevailing rates compare with Blue Cross Blue Shield of Greater New York (Blue Cross/Blue Shield).

We also examined certain allegations of the Queens Society of Internal Medicine concerning the low Medicare reimbursement rates for specialists in internal medicine. Finally, we reviewed the processing of podiatry claims by GHI and Blue Cross/Blue Shield.

The Department of Health, Education, and Welfare (HEW) administers the Medicare program through the Medicare Bureau of the Health Care Financing Administration. 1/ The Bureau,

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1/In March 1977, the responsibility for the administration of Medicare was transferred from the then Bureau of Health Insurance of the Social Security Administration to the newly-created Health Care Financing Administration.

in turn, administers much of Part B of Medicare through contracts with private insurance companies (carriers).

Our work was performed primarily at the Bureau's headquarters located in Baltimore, Maryland; HEW's New York regional office; and GHI.

## CONTRACT AWARD AND RENEWAL

GHI has operated as the Medicare Part B carrier for Queens County since the beginning of the program. The initial contract commenced on February 11, 1966, and ran through June 30, 1967. The contract has since been renewed annually.

### Initial Award

A detailed explanation of the events and circumstances leading to GHI's initial contract award is not available. We determined, however, that (1) several meetings were held between the carrier and Social Security Administration (SSA) officials, and (2) SSA officials made a site visit to the carrier in May 1965, and reviewed its cost accounting system, group subscriber and professional relations, research and statistical operations, and claim operations.

In November 1965, HEW issued qualification criteria for prospective Medicare carriers. According to Bureau officials, GHI was awarded the Medicare contract because

--it met all of the HEW qualification criteria,

--it had 20 years of experience in medical insurance, and

--it had substantial numbers of subscribers and physicians participating under its own insurance plans.

At the time of selection, GHI was a community-based plan incorporated and licensed in New York with about 1 million subscribers, 90 percent of whom were covered under group plans. Its Board of Directors consisted of 14 physicians and 15 laymen. Payments were made to about 10,000 participating physicians on a paid-in-full basis in accordance with GHI-developed fee schedules. These fees were considered as payment in full by the participating physicians regardless of the subscriber's income.

We were unable to determine why Queens County was the territory assigned to GHI; however, we noted that GHI had asked to be selected as the carrier for the entire State of New York.

## Contract renewals

Contracts are renewed yearly unless the carrier or the Government decides not to renew. A Bureau regional official stated that a carrier could perform inadequately for years and still not lose its contract. He said that it is very expensive to replace a carrier and that there is no assurance that a new carrier will do any better.

Carrier performance is evaluated under the Bureau's Contractor Inspection Evaluation Program, and results are summarized yearly in an Annual Contractor Evaluation Report. The report is divided into several operational areas which highlight the carrier's performance in carrying out its program responsibilities.

According to the three most recent reports covering the periods January 1, 1973, through June 30, 1976, there were only three instances where the Bureau reported a GHI operation as being unsatisfactory. Two of these operations--claims processing, and beneficiary services and provider relations--received unsatisfactory ratings for the period ended June 30, 1976. The poor ratings, however, were attributable to a strike at the carrier which lasted from January 1, 1976, to April 23, 1976. 1/ The third area, fiscal management, also received an unsatisfactory rating for the same time period because of problems with Medicare budget management and delays in filing fiscal reports. Bureau officials told us that although these operations were rated unsatisfactory in fiscal year 1976, GHI's overall performance over the years has been good.

## CLAIMS PROCESSING

The strike at GHI crippled the carrier's Medicare and private business operations. With only management personnel available during the strike, emphasis was placed on processing claims; however, a growing backlog of unprocessed claims could

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1/The issues involved in the strike included the employee union's desire for higher wages and longer vacations.

not be contained. After the stike, GHI attempted to clear up the huge backlog of work by adding extra management and clerical personnel. Even so, it took several months before operations were normal.

The Bureau has developed a number of statistical indices which provide an indication of a carrier's ability to process claims in a timely fashion. Essentially, the indicators show that GHI's performance has improved significantly since the strike. Four of these indicators, together with GHI's performance, follow.

Weeks' work on hand
The weeks' work on hand was 5.6 weeks at the end of the strike in April 1976. It decreased to 1 week in August 1977, which was below the national average of 1.5 weeks.

Percentage of claims on hand pending over 30 days
For August 1977, the percentage of claims pending over 30 days was 15 percent (about 3,000 claims), compared to 17 percent nationally. This represents an improvement from 20 percent in April 1976 (16,000 claims) and 44 percent in September 1976 (22,000 claims).

Workload processing and pending index
This index is a composite processing score a carrier receives relative to a national index of 100. A score in excess of 100 indicates better than average performance while a score less than 100 indicates below average performance. The index is based on such factors as the time it takes to process claims and the length of time claims are pending. Before the strike GHI's index was 82; during and immediately after the strike it stood at around 11. At the end of March 1977, the index was 95.

Claim processing timeliness
Average processing time went from 22 days immediately before the strike to a high of 62 days in March 1976. Since March 1977, it has fluctuated between 12 and 19 days. The national average for all carriers in 1977 was about 13 days.

We verified the carrier's reported claim processing time by following 200 randomly selected claims through the system. The claims were received by GHI on April 26, 1977, and took an average of about 10 days to process, which is somewhat less than the processing times GHI reported for that period.

## BENEFICIARY CONTACTS AND SERVICES

GHI's ability to answer written and telephone inquiries was severely limited during the strike because only a few people were working. However, the carrier did provide some services, including:

--using a recorded message to inform telephone callers to send mail to a special address where the claims or correspondence would be processed,

--processing claims involving severe hardship cases that were specifically brought to its attention, and

--responding to inquiries from persons visiting GHI.

The Bureau monitored GHI very closely during the strike. Bureau officials considered having claims processed by the carrier's Florida office but this was not feasible because the data processing systems were different. Also, to lessen the administrative burden at the carrier, the Bureau asked physicians to hold claims until the strike was over.

Since the strike the Bureau has continued to closely monitor the carrier's service to beneficiaries. Using the following Bureau indicators, it appears that the carrier has improved its responsiveness.

Responsiveness to telephone inquiries
The speed of telephone pick-ups has improved. Ninety-nine percent of the calls made by the Bureau in reviewing GHI's responsiveness were answered within five rings. All questions were answered correctly.

Written inquiries pending over 30 days
The number of inquiries pending over 30 days has decreased from about 3,500 in September and October 1976, to 20 and 33 in July and August 1977, respectively.

Requests pending over 60 days
Providers and beneficiaries can request a reconsideration of their claims if they are dissatisfied with the amount of reimbursement or believe a request for payment is not being acted upon promptly. Forty-five percent of all such requests were pending 60 days or more in the fourth quarter of 1976. In the second quarter of 1977, only 9.4 percent of the requests were pending 60 or more days. This rate is less than the regional and national averages of 9.5 and 14.9 percent, respectively.

We reviewed all written inquiries received on July 20, and July 21, 1977, and all were answered within 5 working days. This response time conforms with the Bureau's performance standard of answering written inquiries within 10 working days.

As requested, we reviewed the possibility of GHI opening a branch office in Queens so that senior citizens would not have to travel to Manhattan for personal services. We believe that the desirability of opening an office in Queens is questionable because:

--about 67 percent of all inquiries are made by telephone and currently the service is good;

--six Social Security District offices are located throughout Queens and personnel are trained to answer Medicare questions; and,

--a GHI branch office would be able to provide only limited service, and access to claims would still only be available in Manhattan.

The accessibility of the carrier to beneficiaries in Queens does not appear to be any better or worse than that for other Medicare beneficiaries in the New York area. Blue Cross/Blue Shield, which is located in Manhattan, does not have a branch office although it serves the Bronx, Brooklyn, Staten Island, and 12 other counties.

## ACCURACY OF CLAIMS PROCESSING

Medicare Part B carriers are required to perform a weekly review of a sample of claims processed. The purpose of this review is to identify all errors made in the weekly sample which remain uncorrected at the completion of initial processing. The Bureau also reviews the accuracy of claims processing by examining a subsample of the carrier's sample.

For the period July through September 1976, GHI had the second highest rate of processing errors per claim line item (occurrence error rate) of all carriers in the region and one of the highest in the country. However, since then GHI's occurrence error rate has been improving but is still higher than the regional average.

Occurrence Error Rate
(percent)

| Period | GHI | Regional Average |
|---|---|---|
| July-Sept. 1976 | 11.7 | 11.3 |
| Oct.-Dec. 1976 | 9.6 | 9.0 |
| Jan.-March 1977 | 8.9 | 7.8 |
| April-June 1977 | 7.6 | 6.4 |

GHI officials told us that high error rates in the second half of 1976 were attributable to the strike. They said that error rates remained high after the strike because, in reducing the backlog of claims, quality was sacrificed for quantity.

We tested the accuracy of the carrier's review by examining 147 of the 343 claims reviewed by both the carrier and the Bureau. The claims were processed during April and May 1977. Although we found nine errors that had not been previously identified, their impact on the reported error rate was not significant.

The reports pertaining to the carrier's review for the period May 1976 through May 1977 showed that coding errors were one of the most prevalent types of errors made. The resulting dollar impact, however, was a relatively small overpayment of about $27,000 for the 1,126,000 claims processed by the carrier in the 13-month period.

## LOWER REIMBURSEMENT RATES IN QUEENS

According to a Bureau study, because physicians in Queens County charge less, Medicare reimbursement rates there are generally lower than they are in other areas of New York City. Additionally, another factor that may be contributing to lower reimbursements in Queens is the difference in the methods used by GHI and Blue Cross/Blue Shield in making "reasonable charge" determinations.

### Computation of Reimbursement Rates

The carriers that process and pay claims for Medicare Part B services are responsible for insuring that payments are based on the "reasonable charges" for physicians' and suppliers' services. The reasonable charge for a physician's or supplier's service is the lowest of three kinds of charges--the actual charge, the physician's or supplier's customary charge, and the prevailing charge in the area.

The actual charge is the charge that the physician or supplier billed for his or her service. The customary charge is the charge the physician or supplier usually bills most patients for the same service. The prevailing charge is the lowest charge high enough to include at least three-fourths of the customary charges for the same service billed by all the physicians or suppliers in the same area. Whichever one of these three charges is the lowest is called the reasonable charge.

Each July 1, Medicare carriers are to update the customary and prevailing charges to be used as the basis for paying Medicare claims. The updated charges are based on charge data for services performed during the preceding calendar year. For example, the charges used from July 1, 1977, to June 30, 1978, (fee screen year 1978) are based on charges made in calendar year 1976.

In 1972 the Congress decided to limit increases in Medicare prevailing charges through the application of a limit called an "economic index." The economic index is based on increases in physician fees and limits how much Medicare prevailing charges may increase above fiscal year 1973 levels (the base year).

Bureau study of reimbursement rates

Prevailing rates in Queens County are generally lower than in other areas of New York City. The greatest disparity is between Queens and Manhattan. A large disparity also exists when comparing Queens to Blue Cross/Blue Shield's Locality B (comprised of Brooklyn, the Bronx, Staten Island, and Westchester County).

In 1976, the Bureau performed a study in response to complaints that GHI's rates of reimbursement were much lower than Blue Cross/Blue Shield's. The study concluded that there were significant differences in reimbursement levels between the two carriers and that these differences were due to variances in the charging patterns between physicians in Queens and those in other areas of New York City. Although the methodologies used by the carriers in computing reasonable charges differed somewhat, the Bureau reported that both carriers were correctly applying the Bureau's reasonable charge guidelines.

The Bureau reviewed a total of 44 procedures for specialists and non-specialists, both with and without economic index adjustments. Only the prevailing rates with the economic index

adjustments are used in determining reimbursements, but the unadjusted prevailing rates more accurately reflect the level of physicians' charges.

The study showed that, where comparisons were possible, 41 percent of GHI's adjusted prevailing rates for non-specialists were lower and 33 percent were higher than Blue Cross/Blue Shield's Locality B. The remaining 26 percent were the same. Fifty percent of all GHI's unadjusted prevailing rates were lower and 29 percent were higher than Locality B's. The Bureau estimated that if the prevailing rates from Locality B had been used in Queens, reimbursements for services performed by non-specialists would have increased 18 percent.

The study also showed that 75 percent of GHI's adjusted rates for specialists were lower than Blue Cross/Blue Shield's Locality B. Without the economic index adjustment, 66 percent of GHI's procedures were lower than Locality B. The Bureau determined that reimbursements in Queens for services performed by specialists would have increased by 12 percent if Locality B rates were used.

The following is a list of selected procedures and prevailing rates for fee screen year 1978 (July 1, 1977, to June 30, 1978) for GHI and Blue Cross/Blue Shield's Locality B.

Non-Specialist
Prevailing Rates

| Procedure | Locality B | GHI |
|---|---|---|
| Initial office visit, new patient | $20.40 | $13.60 |
| Initial comprehensive office visit, new patient | $25.00 | $20.00 |
| Routine follow-up, brief office visit | $13.60 | $10.90 |
| Initial comprehensive hospital visit | $25.00 | $33.90 |
| Chest X-ray | $20.40 | $24.40 |
| X-ray of [illegible]ine | $35.00 | $61.10 |
| Pap test | $10.00 | $10.00 |
| EKG | $27.10 | $23.10 |

Specialist
Prevailing Rates

| Procedure | Locality B | GHI |
|---|---|---|
| Initial office visit, new patient | $33.90 a/ | $25.00 |
| Initial comprehensive office visit, new patient | $33.90 a/ | $35.00 |
| Routine follow-up, brief office visit | $20.00 | $15.00 |
| Initial comprehensive hospital visit | $38.00 | $47.50 |
| Insertion of pacemaker | $407.10 | $814.20 |
| Radical Mastectomy | $1,153.50 | $1,017.80 |
| Repair of Hernia | $542.80 | $542.80 |
| Chest X-ray | $25.00 | $30.00 |
| X-ray of spine | $36.60 | $47.50 |

a/A Bureau regional official could not explain why the prevailing rates for these procedures are the same.

Effect of GHI private business data on Medicare reimbursements

In its calculations of Medicare reasonable charges, prior to fiscal year 1976, GHI included charge data from doctors in Queens who participated in two GHI private insurance plans and those who did not participate but whose patients had GHI medical insurance. The participating physicians agreed to accept a GHI-established fee as payment in full. On the other hand, non-participating physicians were not bound to any agreement and could charge accordingly. GHI stopped using participating physician charge data in fiscal year 1976, but continued to use non-participating physician charge data. 1/ According

1/According to a Bureau official, GHI has been instructed to include participating physician data in its calculations for fee screen year 1979.

to a Bureau regional official, the participating physician charge data was excluded because it was lowering the charge profiles of some physicians.

Approximately 26 percent of the data used by GHI in developing customary charges under Medicare comes from its private insurance plans. Presently, Blue Cross/Blue Shield only uses Medicare charge data.

To determine what effect the inclusion of certain private plan data may have had on Medicare charge levels, GHI recomputed its fiscal year 1976 prevailing rates using only Medicare charges. 1/ The analysis indicated that the inclusion of the non-participating physician charge data may have increased prevailing rate levels.

We questioned these results because the study did not consider what effect, if any, the inclusion of participating physician charges had on prevailing rates in the fiscal year 1973 base year computation. We believe that the study should have analyzed the fiscal year 1973 period because current prevailing rates are affected by the charges used in the 1973 base year (see pages 7 and 8). GHI and Bureau regional officials agreed.

At our request, GHI is recomputing its fiscal year 1973 prevailing rates excluding all private business charges. These rates will then be compared to the existing base year figures to determine the effect these charges have on current prevailing rates. The Bureau has agreed to provide us with the results by mid-April 1978, at which time we will discuss the findings with you.

## REIMBURSEMENT RATES FOR INTERNISTS

In connection with our work regarding the reimbursement rates at GHI, we reviewed certain issues brought to our attention by the Queens Society of Internal Medicine. The Society maintained that for years the elderly in Queens have been denied adequate reimbursement for care provided by specialists in internal medicine. The Society contended that prevailing rates

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1/According to Bureau officials a similar study is being made at Blue Cross/Blue Shield to determine what effect inclusion of private plan data would have on Medicare charge levels.

for specialists in Queens were diluted by GHI's practice of including lower rate charges by certain general practitioners with charges made by internists certified by the American Board of Internal Medicine, and Board eligible internists.

The Society told us that its members, because they are specialists in internal medicine, generally charge more for their services than do non-specialists. It attributes the low reimbursements to the lower charges submitted by non-specialist physicians who received an internist rating from the New York State Workmen's Compensation Board. GHI's practice is to consider all physicians who receive internists ratings from the Workmen's Compensation Board as specialists in internal medicine, regardless of their standing with the American Board of Internal Medicine.

The Director of Medical Services of the New York State Medical Society told us that until about 5 years ago, family physicians, general practitioners, as well as internists were receiving the internist rating from the Workmen's Compensation Board. However, in these instances, according to the Director, only those physicians who were experts in the field of internal medicine were receiving the rating. Since then, the rating has been received only by internists certified by the American Board of Internal Medicine. According to an official of the New York State Workmen's Compensation Board, the internist rating has always specified that the physician is limiting his practice to internal medicine.

The Society believes that GHI should recognize physicians as specialists only if they are certified or eligible for certification by specialty boards. However, Medicare guidelines are broader and state that physicians who classify themselves as specialists, regardless of whether they are certified or eligible for certification, may be considered specialists by carriers.

Thus, GHI's practice of combining charges made by certain general practitioners who practice internal medicine with those of internists who are Board certified or Board eligible is consistent with Medicare guidelines. Blue Cross/Blue Shield follows a similar practice. In addition to recognizing Board certified or eligible physicians as specialists, Blue Cross/Blue Shield allows a physician to designate himself a specialist and computes reimbursement rates accordingly.

To determine what effect GHI's practice may have on reimbursements for services rendered by specialists in internal medicine, we asked GHI to make a study of differences in charges

between the Boar certified and non-Board certified internists in Queens. GHI sampled a total of 110 internists from the 209 Board certified and 571 non-Board certified internists identified for the study. They reviewed six services selected by the Society. The results are shown below.

Comparisons of Fiscal Year 1976
Prevailing Charges for Internists in Queens

| | Board certified | Not Board certified |
|---|---|---|
| Office visits | | |
| Initial comprehensive | $50.00 | $48.00 |
| Routine follow-up | $20.00 | $25.00 |
| Hospital visits | | |
| Initial comprehensive | $50.00 | $50.00 |
| Routine follow-up | $25.00 | $21.00 |
| Consultations | | |
| In-hospital | $75.00 | $60.00 |
| Office | $55.00 | $50.00 |

Although the above results show some differences in charges between the two groups, Bureau officials do not believe the differences are significant enough to warrant any changes by the carrier in physician specialty classification or prevailing rates.

PODIATRY CLAIMS

Your office provided us with six podiatry claims for routine foot care which were denied by GHI, but allegedly would have been paid by Blue Cross/Blue Shield. We discussed these claims with GHI officials and were satisfied that the carrier's original determinations were correct.

We then took the six claims to Blue Cross/Blue Shield and were told that it would have paid the claims. We found that Blue Cross/Blue Shield was paying many claims for routine

foot care even though required information was missing or not verified. As a result, many claims should not have been paid.

We brought this matter to the attention of the Administrator of the Health Care Financing Administration by letter dated January 4, 1978. The Medicare Bureau Director replied, (by letter dated February 27, 1978), that steps would be initiated to assure that carriers are verifying the physician's diagnosis and that program payments are not made for noncovered services. Copies of these letters are enclosed for your use.

At your request, we did not obtain written agency comments. The matters covered in this report, however, were discussed with agency officials and their comments were incorporated where appropriate.

Unless you publicly announce the report's contents earlier, no further distribution will be made until 30 days from the date of the report. At that time, we will send copies to interested parties and make copies available to others upon request.

We trust this response meets your needs.

Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 2

ENCLOSURE I

ENCLOSURE I

UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

HUMAN RESOURCES DIVISION

IN REPLY REFER TO

JAN 4 1978

Mr. Robert A. Derzon, Administrator
Health Care Financing Administration
Department of Health, Education, and
Welfare

Dear Mr. Derzon:

The purpose of this letter is to confirm the understandings our staff had reached with officials of the Medicare Bureau concerning the need for a national study of Medicare claims for podiatric care.

The desirability of such a review is evidenced by the findings of Blue Cross Blue Shield of Greater New York (Blue Cross/Blue Shield) to the effect that many claims paid for podiatric care did not meet Medicare criteria for allowable payments. Specifically, many claims for routine foot care were paid even though required information was missing or not verified.

The Bureau's New York Regional Office also found problems with podiatry claims at three other carriers in the region. Given these findings and their potential significance, we believe there is a need for the Bureau to make a national study of podiatry claims.

CLAIMS PAID WITHOUT VERIFICATION OF DIAGNOSIS

Routine foot care can be a covered Medicare service, if the patient has a sufficiently severe systemic disease where treatment by a nonprofessional may pose harm. Where the routine foot care is done by a podiatrist, the claim must contain

--the name of the medical doctor (M.D.) or doctor of osteopathy (D.O.) diagnosing the condition, and
--certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement.

The Bureau's New York Regional Office further instructed its carriers to assure that the diagnosing M.D. or D.O. actually did diagnose or treat the condition.

Blue Cross/Blue Shield made a study to determine whether there was a problem with claims for routine foot care that would warrant contacting diagnosing physicians to assure eligibility of all claims. Blue Cross/Blue Shield sampled 481 of the approximately 30,000 routine foot care claims it paid from May 15, through June 15, 1977. Questionnaires were sent to the diagnosing physicians.

The study disclosed that 197 of the sampled claims, or 41 percent should not have been paid because

--79 claims contained a proper diagnosis, but the M.D. or D.O. could not substantiate the severity of the condition,
--59 claims listed physicians who denied making the diagnosis,
--5 claims contained diagnosis not acceptable for payment,
--4 claims did not list an M.D. or D.O., and
--on 11 claims, the physicians denied any knowledge of the patient.

Blue Cross/Blue Shield found that only 128 claims, or 27 percent, met Medicare regulations. Additionally, 156 claims, or 32 percent, were excluded from the sample results because the diagnosing physician either could not be contacted or did not respond.

Bureau officials in the Regional Office believed there were major weaknesses in the Blue Cross/Blue Shield study which precluded its projection to the entire universe of claims for routine foot care. Nevertheless, the fact that at least 41 percent of the studied claims should not have been paid indicates potential fraud or abuse. The results of the study were sent to the Health Care Financing Administration's Office of Program Integrity. The Regional Office also directed Blue Cross/Blue Shield to make an in-depth study of all podiatry claims. The study is still in progress.

In its own inquiries, the region found that 4 of 7 carriers in the region, including Blue Cross/Blue Shield, were not verifying that the physicians listed on routine foot care claims were in fact the physicians who diagnosed or treated the systemic condition. These carriers have now been directed to do so.

## BLUE CROSS/BLUE SHIELD POLICY CONTRIBUTED TO ERRONEOUS PAYMENTS

Since February 11, 1975, Blue Cross/Blue Shield's policy had been to pay routine foot care claims where the systemic disease was arteriosclerosis obliterans even though required information was missing (i.e., name of the diagnosing M.D. or D.O., and/or the severity of the condition). A regional official told us that 30 of the 43 claims identified by Blue Cross/Blue Shield in its study, where the name of the diagnosing physician was missing, were for arteriosclerosis obliterans and were erroneously paid.

Regional officials told us they had requested Blue Cross/Blue Shield on numerous occasions to conform to Medicare regulations and assumed that they had done so. On September 19, 1977, however, Blue Cross/Blue Shield officials told us that they still had not complied with the Bureau's request. We notified the Regional Office of this situation and were told that on September 29, 1977, Blue Cross/Blue Shield changed its policy to comply with the regulations. Specifically, Blue Cross/Blue Shield will try to obtain missing required information from providers and beneficiaries before making payment. In cases where information cannot be obtained, the claim will be denied.

At our request, the Regional Office asked Blue Cross/Blue Shield to address in its study of podiatry claims those problems noted with regard to arteriosclerosis obliterans.

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On October 5, 1977, we discussed with Medicare Bureau officials in Baltimore the problems with routine foot care claims. Also, because of the potential significance, we suggested that they study the extent of the problems nationally. Bureau officials agreed to have all carriers perform a study to determine if routine foot care claims are being paid in accordance with Medicare regulations.

On the basis of this understanding, we have decided not to initiate a review of podiatric claims in selected regions ourselves even though we feel that this area offers a high potential for identifying fraud or abuse. Nevertheless, we would appreciate being informed on the progress of the Bureau's proposed study.

Sincerely yours,

Robert E. Iffert, Jr.
Assistant Director

ENCLOSURE II

ENCLOSURE II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

BALTIMORE, MARYLAND 21235

REFER TO:

IHI-631

FEB 2 7 1978

Mr. Robert E. Iffert, Jr.
Assistant Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Iffert:

This is in further response to your letter concerning the need for a national study of Medicare claims for podiatric care. I regret the delay in my reply.

On October 5, 1977, members of the Medicare Bureau met with GAO representatives from the New York Region to discuss some questions a recent carrier audit raised concerning the extent to which Medicare carriers are verifying physician (MD or DO) diagnosis listed on podiatry claims involving routine foot care. We stated at that meeting that we would take necessary action to assure that carriers are verifying these diagnosis so that program payments are not made for noncovered services.

A further examination of this situation indicated that the best way to prevent erroneous payments for these routine foot care services was to clarify existing instructions in the carrier operating manual which outline the requirements for coverage of these services. Accordingly, we revised the appropriate manual section (Part 3, §4120, Medicare Carriers Manual) to state that all carriers must verify on an ongoing basis that the MDs and DOs listed on routine foot care claims submitted by podiatrists have in fact made the required diagnoses, agree with the podiatrists' statements as to the severity of the diseases, and where required, are actively treating the patient for the disease.

This manual revision, which will be issued in March, also instucts carriers to place claims from podiatrists, who have been identified in the samples as having nonconcurrence of appropriate MD or DO sources, under comprehensive review prior to payment. As an additional safeguard, carriers are instructed to make periodic contacts with podiatrists, MDs, and DOs to inform them of the verification system they have in place, as well as to

reemphasize the Medicare requirements for coverage of routine foot care services.

In addition to this revision of the carrier manual, we are preparing instructions for Medicare Bureau regional offices to alert them to the fact that the requirements for coverage of routine foot care services rendered by podiatrists have been clarified. This issuance will also instruct regional offices to confirm that all carriers are performing the required verification of podiatry claims as part of their ongoing reviews of carrier performance.

Sincerely yours,

Thomas M. Tierney
Director
Medicare Bureau