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

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The Honorable L. H. Fountain
Chairman, Subcommittee on Intergovernmental
Relations and Human Resources
Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

In response to your letter of March 24, 1977, concerning the listing of physicians and group practices receiving over $100,000 in Medicare payments, we have reviewed the events leading up to and following the release of the listing by the Department of Health, Education, and Welfare. This listing was released on March 14, 1977, and because of the considerable concern expressed about errors in the listing, you asked for our comments.

We contacted headquarters and regional office officials of the Health Care Financing Administration's Medicare Bureau (formerly Social Security Administration's Bureau of Health Insurance) to determine how the list was developed, what errors were made and why, what action has been taken to correct the errors, and what plans there are for future listings. We also contacted officials at several of the private insurance companies (called carriers) involved in producing and verifying much of the information.

Our review has shown that errors were caused primarily by the inaccurate and incomplete data the Bureau used in preparing the list. The list was prepared within an unnecessarily tight time limit, and the Bureau made many errors in verifying its accuracy.

PREPARATION OF THE LISTING

On March 1, 1977, Bureau officials were advised of the intent of the Secretary of Health, Education, and Welfare to make public the names of physicians whose billings had generated $100,000 or more in Medicare payments in calendar year 1975. The names and the amounts received were originally scheduled for release on March 12, 1977, but were ultimately released on March 14. According to Department officials, the

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disclosure of the information was the result of (1) a change in policy to conform with Public Law 94-409, Government in the Sunshine Act 1/ (effective March 12, 1977) and (2) a number of requests under the Freedom of Information Act (5 U.S.C. 552). 2/

To develop the data by March 12, the Bureau relied on an information base (computer printouts) referred to as the Payment Review Project. For calendar year 1975, these printouts listed over 26,000 physicians, groups/clinics, institutions, suppliers, and laboratories that generated over $25,000 in Medicare payments.

The source data for the printouts come from two separate and distinct, though related, computer files: the Payment Record File, and the Payment Record Reference File. The carriers provide the data used to produce both files. These files are maintained by the Social Security Administration in Baltimore, Maryland.

Each carrier is required to send a record to the Bureau to update the Payment Record File for each payment made under the Medicare program. The Payment Record File contains numerous data elements, including an identification number for the provider(s) of services, the amount of each payment made, and whether or not payment was made directly to a physician or supplier (assigned claim) or to the beneficiary (unassigned claim).

Each provider in the Medicare program is identified by an identification number given by the carrier servicing that provider. The purpose of the Payment Record Reference File is to identify the provider(s) associated with each identification number. For each number assigned, the carrier is required to notify the Bureau: (1) whether this number is assigned to a solo practitioner, a group practice, or a laboratory; (2) if assigned to a solo practitioner, the name

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1/Because the Government in the Sunshine Act applies generally to meetings, we do not see the applicability of the Act to the disclosure of information in this case.

2/The Freedom of Information Act did not require the Department to release the information when it did.

of the physician, his or her address, and specialty; and (3) if assigned to a group practice or laboratory, the names of all physicians in the group, the trade name used, the address, and the specialty. Carriers are required to report additions, deletions, and changes to the Payment Record Reference File on June 30 and December 31 of each year.

The Payment Review Project printouts were produced by extracting certain of the above data elements from the two files. For example, the Payment Record Reference File contained the trade name for a group practice, as well as the names of physicians practicing in that group, but the computer program used to prepare the printouts extracted only one name from the file. These printouts have historically been used to identify those providers whose pattern of practice and/or reimbursement might be considered to be aberrant and, therefore, candidates for more detailed investigations by the Bureau's regional offices and/or carriers. Payment information from these printouts has also been used for reports to the Senate Committee on Finance and to some individual Members of Congress.

According to Bureau officials, it was not necessary that the printouts accurately describe the composition and number of physicians in a group setting or tell whether a particular physician belonged to a group or was in solo practice because the printouts were only used as an indicator of possible aberrant practices. After providers were initially identified for investigation, primary reliance for completing the investigation was placed upon data in the carriers' records.

On March 2, 1977, Bureau personnel extracted from the printouts a listing of approximately 2,500 physicians, groups, and laboratories, generating over $100,000 in payments in calendar year 1975. Officials were aware that the files used to produce the printouts were not completely accurate and that the program used to prepare the printouts did not extract all the information from the files. Therefore, on March 3 the Bureau requested its regional offices to contact the appropriate carriers in their service areas to verify the information. Emphasis was placed on insuring that the solo practitioners were correctly identified. Some regional offices were requested to verify the payment data for group practices and, if possible in the short time available, obtain proper identification for the group. The regional offices responded with the requested information on March 7, 8, 9, and 10.

After receiving some additional information on the morning of March 11, the listing was printed. Copies were delivered to the Department's Office of Public Affairs that evening.

Since the listing was prepared from data used for other purposes, the Bureau estimated that the additional costs incurred in preparing it were $13,900, including $4,100 in carrier costs.

ERRORS/COMPLAINTS AND THEIR CAUSES

As previously mentioned, Bureau officials knew that the files used to produce the Program Review Project printouts and to develop the listed information contained inaccuracies and incomplete information. Accordingly, a cover sheet was prepared and released with the list in an effort to caution users that, despite verification efforts, the list might contain errors. Over 470 physicians complained directly to the Department or through the American Medical Association about errors in the listing.

Approximately 300 of the complaints concerned the use of an individual physician's name to identify a group practice. Because the computer program used in preparing the printouts extracted only one name from the Payment Record Reference File for each provider, in many cases an individual's name was used to identify a group practice. Although some attempts were made to better identify the groups, the Bureau felt there was not sufficient time available in most cases. Each page of the listing had a heading identifying whether the names listed were solo practitioners or part of a group practice. According to the Bureau, the news media apparently mishandled this information. Many news accounts did not show the distinction between solo and group practices. In many cases, where one physician's name was used to identify a group, the news media stated or implied that the physician had received all the payments.

Although the information may have been mishandled, the use of an individual physician's name to identify a group practice could easily be misunderstood. It was not clear in those cases whether the dollar amounts shown were received by the group in total or were received by the individual as part of the group.

In many cases, the name shown for a group practice was so incomplete that proper identification was impossible. For example, some providers were identified only by a single letter, such as Doctor "A." This was particularly true for the section of the listing for the Dallas region. Again, Bureau officials felt there was insufficient time available to obtain proper identification.

There were approximately 100 complaints that physicians in group practices were listed as solo practitioners. In verifying the list of solo practitioners, some of the carriers considered those individuals who received payments on assigned claims as solo practitioners. In many cases, if the payment on behalf of a group was made to a single individual, the carrier considered that individual as a solo practitioner.

As a result of the verification efforts, the regional offices advised the Bureau that many of the individuals identified as solo practitioners should be changed to the group classification. According to the Bureau, most of these changes were made. We found, however, some cases where changes recommended by a regional office were not reflected in the listing released by the Department. For example, the Chicago Regional Office was given a list of over 60 providers in Michigan and was asked to determine whether the providers were in solo or group practice. Only three of the physicians on this list were confirmed to be in solo practice. This information, according to region officials, was reported to the Bureau Headquarters. However, the listing released by the Department showed a total of 19 providers in Michigan as solo practitioners.

We reviewed data in the Payment Record Reference File which was readily available on microfilm. We found several cases where the microfilm contained more accurate and complete information for certain providers than what was released by the Department. For example, there were several cases where an individual was shown on the listing as a solo practitioner, but the microfilm showed several other individuals sharing that same practice. In addition, we found cases where a more complete name and address for the group practice was in the file. According to a Bureau official, no attempt was made to review the information in the Payment Record Reference File. Also, the computer program used for compiling the Payment Review Project listing was not modified to extract more complete identification information from the file.

Many complaints were received about the dollar amounts listed. Approximately 60 complaints resulted from the carriers reporting payments under the same identification number for a number of physicians who were not associated in the same group. Other complaints concerning the dollar amounts were apparently caused by the fact that the list included assigned and unassigned payments. The press release prepared by the Department included a statement that assigned and unassigned payments were included in the amounts shown for each provider and that, on unassigned cases, Medicare is not notified whether the beneficiary actually paid the physician.

A cover sheet accompanying the listing also explained that the listing showed both assigned and unassigned payments.

Despite these explanations, in some instances, the news media stated or implied that the listed physicians received or were paid the listed amount from Medicare. Most of these complaints were resolved, according to the Bureau, by explaining to the physicians that unassigned amounts were included.

Twenty-five complaints were also received that names were used of physicians who had died, retired, or were no longer associated with a group practice in 1975. According to the Bureau, these errors were generally caused by the failure of carriers to report such changes to the Bureau. Such changes are not always reported to the carriers, however, by the group or the physician who had left the practice.

There were other obvious errors noted in the listing in addition to those discussed above. These errors, although relatively minor, appear to indicate that there was little or no proofreading of the listing before it was forwarded for printing.

CORRECTIONS AND FUTURE PLANS

The Department released a list of corrections to the original listing on September 18, 1977, to clarify all of the situations in which physicians complained that there were mistakes or misunderstandings. According to the Department, all complaints were discussed with the physicians involved or their representatives and with the carriers. Corrections were made in all cases where the Department's review determined that the complaints received were justified.

The Bureau stated that there were some complaints for which information could not be verified without an extended investigation, and data from the carriers indicated that the original entries were accurate. For these complaints, the corrected list stated the nature of the complaint but indicated the original entry accurately reflected the information currently available to the Department.

Bureau officials estimated that the costs incurred in correcting the listing totaled $122,000, including $11,000 in computer costs. Of this amount, about $76,000 was incurred directly by the Bureau and $46,000 by the carriers.

Concerning future releases of the Medicare payment information, the Secretary of Health, Education, and Welfare has stated that as much information will be made available as possible, and all necessary steps will be taken to assure the accuracy of the information released. The Secretary has directed the Health Care Financing Administration to consider different methods of publication. Bureau officials advised us that the files used to prepare the Payment Review Project printouts would not be used for this purpose again.

The Bureau has issued instructions which will require all carriers to make available for public inspection a listing of all physicians and suppliers and the amount of assigned and unassigned payments made for services and supplies furnished by each. This listing would be made available for public inspection by April 30 of each year for payments made in the preceding calendar year.

On the basis of estimates from a sample of carriers, the Bureau believes that the carriers would incur startup costs of approximately $950,000 to initiate this program, including $650,000 in computer programing and development costs. Further, the Bureau estimates the annual recurring costs to be approximately $530,000. We did not verify the accuracy of these estimates.

CONCLUSIONS

The Department's preparation and release of the listing was poorly managed. Officials were aware of the potential inaccuracies and incompleteness of the files used to prepare the listing and that an adequate verification of the data was not possible in the established time.

The Department should have taken more time to prepare the listing and insure the accuracy of the information released. Although attempts were made to verify some of the information, the quality of these efforts varied. Also, there was apparently little or no proofreading of the listing prior to its printing.

Although Bureau officials told us that the files were not completely accurate, we did not attempt to verify the accuracy or completeness of these files. However, information from these files is used to make required reports to the Congress; to maintain records of program payments to individuals or organizations which furnish services and/or supplies, and to prepare necessary administrative, statistical, and program

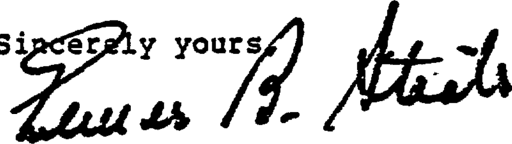
studies. If the information in these files is going to continue to be used for such purposes, then the Bureau should determine and maintain the files' accuracy.

At your request, we have not obtained written comments on this report from the Department of Health, Education, and Welfare. We did, however, discuss our findings with representatives of the Department, and their comments have been considered.

We also received requests from Congressmen Andy Ireland and James M. Hanley concerning this matter. As arranged with your office, we are sending them copies of this report. Unless you publicly announce its contents earlier, no further distribution of this report will be made until 7 days from the date of the report.

We trust the above information will be of assistance to you.

Sincerely yours,



Comptroller General
of the United States