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



HEK 088643

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RELEASED

DEC 22 1970

Dear Mr. Chairman:

Long - Senate

Pursuant to your request of May 7, 1970 (enclosure II), we are submitting a report (enclosure I) on our examination into Medicare payments made by Group Medical and Surgical Service in Texas (Blue Shield) for the services of supervisory and teaching physicians on the faculty of the University of Texas Southwestern Medical School at Parkland Memorial and Woodlawn Hospitals (Dallas County Hospital District) in Dallas, Texas. The Medicare payments, discussed in this fifth and last report submitted pursuant to your May 7 request, were made under the Supplementary Medical Insurance Benefits for the Aged (part B) portion of the Medicare program.

The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare, which has entered into contracts with various private insurance companies, such as Blue Shield organizations, to make benefit payments for physicians' services under part B.

Following is a summary of the information obtained during our review at the Dallas County Hospital District relating to the points of interest specified in your letter of May 7. These matters are discussed in more detail on the cited pages of enclosure I.

--For the 2-year period ended December 31, 1969, Blue Shield paid about \$570,000 under part B of the Medicare program for the services of medical school physicians at the hospitals. The billings were on a fee-for-service basis, were in the names of specific physicians, and were for specific services provided to specific Medicare patients. (See pp. 6 through 8.)

--Our comparison of the claims paid by Blue Shield on behalf of selected Medicare patients with the hospitals' medical records relating to these patients indicated that, after the June 1, 1969, implementation date of the SSA's April 1969 guidelines dealing with payments to supervisory and teaching physicians, there (1) was increased documentary evidence of the involvement of the attending physician for the specific services for which

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B-164031(4)

payment had been made and (2) were some changes in the medical school's billing practices, which had the effect of reducing the Medicare payments for the services of supervisory physicians.

The average Medicare part B charge allowed by Blue Shield for the nonsurgical cases included in our review was \$15.74 a day before, and \$10.27 a day on or after, June 1, 1969, a reduction of about 35 percent. We believe that this reduction in Medicare payments can be attributed, in part, to changes made by some medical school departments after June 1, 1969, with regard to billing for daily visits and for miscellaneous medical services which the hospital records showed had been provided, in many instances, by residents and interns. Residents and interns are not authorized to bill on a fee-for-service basis under part B of the Medicare program, but a portion of their salaries is reimbursable to the hospital under part A of the Medicare program. If reimbursement for these services were made under both parts A and B of the Medicare program, it would be paying twice for the same services.

-- We noted that, despite these improvements, some problems continued to persist for some of the services furnished after the effective date of SSA's April 1969 guidelines.

1. For about 60 percent of the billings for daily visits, the medical records did not indicate the involvement of the physicians in whose names the bills had been submitted. (See pp. 17 through 19.)
2. One department of the medical school continued to claim separate fees for other medical and minor surgical procedures which, according to the medical records, in most instances had been performed by residents and interns, whereas other medical school departments had stopped billing for such minor procedures unless the medical records showed that the billing physicians had been personally involved. (See pp. 22 through 24.)

B-164031(4)

- - For 1969, the hospital district will included in its claims for reimbursement under part A of the Medicare program about \$188,000 paid to the medical school. These payments represent a portion of the salaries of certain medical school physicians who also billed under part B for professional services rendered to individual Medicare patients. We noted evidence that an undetermined portion of the \$188,000 was applicable to the physicians' compensation for direct patient care. Such direct care should be excluded from allowable costs which are reimbursable under part A of the Medicare program. SSA informed us that it was going to follow up on this matter. (See pp. 33 through 35.)
- - The various medical school departments maintained separate billing systems. In most cases, the payments by Blue Shield were made to the physicians who had signed the claims. These physicians, however, did not retain these payments. Before September 1969, funds received by these physicians under part B of the Medicare program were deposited by the medical school in separate departmental trust funds. After September 1969, the Medicare funds received were deposited by the medical school in the Institutional Trust Fund. These funds were used to finance such activities as research, travel, and faculty salary augmentation. (See pp. 8 through 12.)
- - Under part B of the Medicare program, the patient is responsible for a portion of the charges for physicians' services (deductible and coinsurance). The department chairmen stated that they did not usually bill individual patients admitted to the Parkland and Woodlawn hospitals because most of these patients were either indigent or charity patients and the amounts collected would not cover the cost of billing.

The 50 Medicare patients included in our review had not been billed by the medical school departments for deductible and coinsurance amounts totaling about \$3,500. The Medicaid

B- 164031(4)

program in Texas, however, paid about \$1,900 of the \$3,500, or about 54 percent. (See p. 36.)

- Of the 100 Medicare claim forms applicable to the 50 patients, 49 were not signed by the patients, contrary to the requirements of the SSA's regulations. Blue Shield, however, notified the Medicare patients of the payments made on their behalf. (See pp. 37 and 38.)
- Charges for services rendered by the medical school physicians were based on separate fee schedules maintained by each of the medical school departments. Blue Shield, however, disallowed about 8 percent of the charges for services rendered to the patients included in our sample. The disallowance of about 71 percent of those charges resulted because they had exceeded customary and prevailing charges as determined by Blue Shield. (See pp. 6 and 14.)
- Services rendered by the medical school physicians at the Dallas County Hospital District that were paid for by other medical insurance programs, private patients, and the Texas Medicaid program were paid on a fee-for-service basis. Fees charged private insurers and private patients for surgical procedures and some medical services were comparable to fees charged the Medicare program during the same time period. Fees charged the Medicare program for initial visits and daily hospital care, however, were generally higher than fees charged insurers and private patients for the same services. (See pp. 39 and 40.)
- SSA issued guidelines, dated April 1969, which set forth more clearly the circumstances under which Medicare payments could be made to supervisory and teaching physicians. In accordance with instructions received from SSA in June 1969, Blue Shield suspended payments to the medical school physicians from August 14 through November 5, 1969 because it had not assured itself as to the medical school's compliance with

B- 164031(4)

the April 1969 guidelines. During this period, Blue Shield, SSA, and medical school officials took steps to interpret and implement the April 1969 guidelines.

On the basis of clarifying instruction issued to the medical school by Blue Shield in October 1969, four of the medical school departments issued written procedures designed to improve their basis for billing. The remaining departments did not issue written guidelines, but our review showed that they had taken steps to improve the quality of the medical records supporting their billings. (See pp. 41 through 43.)

We believe that the matters discussed in this report will be of interest to your Committee in connection with any further consideration it may give to the subject of reimbursement to teaching physicians under the Medicare program. Although medical school officials have tried to implement the existing Medicare requirements dealing with billing on a fee-for-service basis in the names of individual teaching physicians, our review indicated that some problems in complying with SSA reimbursement requirements continued to exist.

In commenting on a draft of our report, the dean of the medical school pointed out that, in an academic setting, payments for physicians' services on a fee-for-service basis are almost impossible to administer and audit. The dean stated 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

B-164031(4)

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 care 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. Rarely, if ever, has there been any question that the service was rendered for which a bill was submitted; the problem has been in terms of the record reflecting the exact role of the responsible physician in the provision of that care.

"In all fairness to the members of our faculty who are included in this study, I must state that from the outset, they have provided the documentation based on their understanding at that time as to what was required. In reading your report, I believe this is confirmed and if the study had been carried on beyond October of 1969, I am sure it would be further confirmed.

"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 inappropriate billing for services rendered. I do hope, however, that a program can be worked out that will better accommodate the situation in an academic medical center."

B- 164031(4)

* * * * *

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

The matters discussed in enclosure I were presented to SSA, Blue Shield, the medical school, and the hospital district for review. Their written comments were considered by us in the preparation of our report.

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

Sincerely yours,



Comptroller General
of the United States

Enclosures - 2

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

GENERAL ACCOUNTING OFFICE
EXAMINATION INTO
MEDICARE PAYMENTS FOR SERVICES OF
SUPERVISORY AND TEACHING PHYSICIANS AT
DALLAS COUNTY HOSPITAL DISTRICT
DALLAS, TEXAS

INTRODUCTION

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

Medicare provides two forms of health protection for eligible beneficiaries aged 65 and over. One form of protection, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services, as well as post-hospital care in an extended-care facility or in the patient's home. Payments for this protection are made from a trust fund financed through a social security payroll tax. Group Hospital Service, Inc. (Blue Cross), is the principal SSA contractor in Texas for making benefit payments under part A.

The second form of protection, designated as Supplementary Medical Insurance Benefits for the Aged (part B), covers physicians' services. Part B benefits are paid from a trust fund financed through premiums paid by beneficiaries electing to participate and by matching contributions from funds appropriated by the Congress. Effective July 1, 1970, the monthly premium was increased from \$4 to \$5.30. The beneficiary is responsible for paying the first \$50 for covered services in each year (deductible) and 20 percent of the reasonable charges in excess of the first \$50 (coinsurance). Group Medical and Surgical Service (Blue Shield) is the principal SSA contractor in Texas for making part B benefit payments.

Payments for services of
supervisory and teaching physicians

Payments on a fee-for-service basis for the services of supervisory and teaching physicians at teaching hospitals are allowed by SSA regulations under part B. SSA regulations issued on August 31, 1967,¹ stated that the physician, to qualify for payment, must be the Medicare patient's "attending physician" and either render services personally or provide "personal and identifiable direction to residents and interns" participating in the care of his patient. The salary costs of hospital residents and interns under approved training programs are reimbursed to the hospitals under part A.

In April 1969, SSA issued new and more comprehensive guidelines which were intended to clarify and supplement the criteria for making payments for services of supervisory and teaching physicians. These new guidelines were effective June 1, 1969. Some of the more important provisions are as follows:

"A. Conditions Which Must Be Met for a Teaching
Physician to be Eligible for Part B Reim-
bursement as an Attending Physician

"The physician¹ must be the patient's 'attending physician.' This means he must *** render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services to his other paying patients."

* * * * *

¹The term 'physician' does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff."

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

"3. Performance *** must be demonstrated, in part, by notes and orders in the patient's records that are either written or countersigned by the supervising physician."

MEDICAL CARE AT DALLAS COUNTY HOSPITAL DISTRICT
AND AFFILIATION WITH UNIVERSITY OF TEXAS

The Dallas County Hospital District (hospital district) comprises two hospital facilities, Parkland Memorial Hospital (Parkland) with 707 beds and Woodlawn Hospital (Woodlawn) with 143 beds. The overall administrative direction of the hospital district is provided by a hospital administrator who is responsible to a board of managers appointed by the Dallas County commissioners' court.

The hospital district provides hospital facilities and inpatient, outpatient, and emergency care for the medically indigent residents of Dallas County and, in an emergency, extends these facilities and medical care to persons who are not legal residents of Dallas County. In addition, the hospital district provides hospital facilities for a limited number of medically nonindigent residents. The cost of operating the hospital district is financed primarily through property taxes and fees paid by patients. During calendar year 1969, about 38 percent of the hospital district's operating cost was financed through fees paid by patients.

Parkland provides a full range of medical services, including the usual services in medicine, surgery, gynecology, obstetrics, and pediatrics. In addition, it has psychiatric, neurology, trauma, burn, physical medicine, and rehabilitation units which provide specialized care. Woodlawn has an extended-care facility; a chest division for patients with such diseases as emphysema, pneumonia, lung cancer, and tuberculosis; a psychiatric facility for adolescents; and an outpatient unit for chronic renal dialysis.

The hospital district's records showed that during 1969 about 21,100 inpatient days, or about 8 percent of total inpatient days, were applicable to Medicare patients.

The hospital district sponsors a full intern- and resident-training program in conjunction with the University of Texas Southwestern Medical School located adjacent to Parkland. The affiliation between the medical school and the hospital district has existed since 1943, but it was restated in a formal 10-year agreement signed on June 16, 1967.

In the agreement the hospital district agreed to provide, at no cost to the medical school, a fully accredited hospital system and a staff of interns and residents. The hospital district agreed also to reimburse the medical school for the portion of physicians' salaries not directly related to the educational and research activities of the medical school.

The medical school agreed to provide a sufficient number of qualified physicians to adequately direct and supervise professional medical services to all patients, at no cost to the hospital district except for portions of salaries of certain medical school physicians. These salary payments, which were subject to annual negotiation, are discussed on pages 33 through 35.

The agreement provided that (1) total patient care be furnished by the medical school faculty, (2) all patients admitted to Parkland and Woodlawn be available as "teaching" patients, and (3) these hospitals be the primary teaching hospitals used by the medical school.

Medical care at Parkland and Woodlawn has been largely dependent upon the house staff of about 300 residents and 50 interns who are taught and supervised by the attending medical staff. The attending medical staff consisted of physicians appointed by the hospital district's board of managers from those nominated by the dean of the medical school. The nominees were selected from the medical school's full- and part-time faculty; accordingly, the medical school faculty constituted the only attending medical staff of the hospital district.

As of April 1970, there were about 1,400 physicians on the medical staff. Of these 1,400 physicians, about 1,100, who were on the medical school faculty and were engaged in private practice in Dallas County, served voluntarily without pay. About 300 physicians were full- or part-time salaried employees of the medical school.

MEDICARE AND MEDICAID PAYMENTS
TO MEDICAL SCHOOL PHYSICIANS

Data obtained from Blue Shield showed that, between January 1, 1968, and December 31, 1969, Medicare part B payments of about \$570,900 were made to, or in the names of, salaried medical school physicians, as follows:

<u>Calendar</u> <u>year</u>	<u>Number of</u> <u>physicians</u> <u>paid</u>	<u>Medicare</u> <u>part B</u> <u>payments</u>
1968	83	\$370,000
1969	67	<u>200,900</u>
		<u>\$570,900</u>

In addition, Blue Shield acts as the fiscal agent in the State of Texas for the State Medicaid program. Data obtained from Blue Shield showed that during 1969 it made Medicaid payments of about \$370,800 to 68 medical school physicians.

There was no centralized organization at the medical school or hospital district to bill Medicare and others for services rendered by the medical school physicians. Each of the various medical school departments maintained a separate billing system.

As shown by the following table, the Medicare payments of \$200,900 made by Blue Shield in 1969 involved 67 medical school physicians affiliated with nine departments or divisions.

<u>Department</u>	<u>Number of physicians paid</u>	<u>Medicare part B payments</u>
Ophthalmology	2	\$ 24,500
Surgery	20	59,900
Internal medicine	23	44,100
Woodlawn chest division	1	26,600
Anesthesiology	7	20,700
Obstetrics and Gynecology	8	7,600
Radiology (cobalt therapy)	2	11,800
Neurology	2	4,400
Physical Medicine and Rehabilitation	<u>2</u>	<u>1,300</u>
Total	<u>67</u>	<u>\$200,900</u>

We were told by some of the department chairmen that portions of the above payments involved services rendered to Medicare patients at other hospitals in the Dallas area. Information supplied by these chairmen showed that, in five of the nine departments, at least 90 percent of the payments involved services rendered at the hospital district's facilities.

Each department employed at least one billing clerk who was responsible for preparing and processing bills for services rendered to patients by the members of that department's medical staff. These clerks, in certain instances, also processed bills to private insurance companies and private patients, as well as to the Medicare program.

All nine departmental billing systems were similar in that each bill was based on the patient's medical chart. Further, each bill and each supporting chart was examined and signed by the attending physician before the bill was submitted to Blue Shield for payment.

In two of the nine departments or divisions (the Woodlawn chest division and the cobalt therapy section of the radiology department), each Medicare bill was submitted in the name of the department or section chairman. In three departments, each bill was submitted in the name of the physician responsible for treating the patient. In three other departments, each bill was submitted in the name of the specific physician involved in the case or in the name of the department chairman who had secured multiple-billing agreements which permitted him to bill for services in the names of other full-time or voluntary staff members. In these departments, after the effective date (June 1, 1969) of SSA's April 1969 guidelines, the name of the physician who was actually involved in providing the service was also recorded on the bill.

In the remaining department, attending physicians were assigned to the hospital wards on a rotating basis and each bill was submitted in the name of the physician primarily responsible for the specific patient's care. This physician was usually the one in charge of a ward at the time the patient was admitted.

In all but one of the nine departments, each check received from Blue Shield was made payable to the specific physician who had signed the bill. Checks issued by Blue Shield for cobalt therapy claims were payable to the radiology trust fund.

Not all Medicare patients were billed
for professional services

A sample of admissions of Medicare patients to the hospitals indicated that not all the patients had been billed for the professional services of the medical school physicians.

From the 1,300 Medicare patient admissions to the hospitals between January and October 1969, we selected at random 70 patients and checked their names against the part B claims placed in process by Blue Shield through January 12, 1970. Two of the patients were not covered under part B at the time of their admissions to the hospitals. We noted that part B claims involving medical school physicians had not been processed for 37 of the 68 patients who had part B coverage. An analysis of those hospital admissions before the effective date (June 1, 1969) of SSA's April 1969 guidelines and after that date, as to whether claims under part B were processed, is shown in the following table.

	Medicare patients					
	Total		Admitted before		Admitted on or after	
			June 1, 1969		June 1, 1969	
	Number	Percent	Number	Percent	Number	Percent
Claims processed	31	46	15	56	16	39
No claims processed	<u>37</u>	<u>54</u>	<u>12</u>	<u>44</u>	<u>25</u>	<u>61</u>
Total sampled	<u>68</u>	<u>100</u>	<u>27</u>	<u>100</u>	<u>41</u>	<u>100</u>

Although we recognize that the differences between Medicare patient admissions and Medicare part B claims processed by Blue Shield after June 1, 1969, may be attributed to a suspension of claims payments in August 1969, we believe that the foregoing data indicates that a higher percentage of patients admitted to the hospital since June 1, 1969 are not being billed by the medical school for professional services.

INSTITUTIONAL TRUST FUND

Before September 1969, professional fees received by physicians employed by the medical school for treatment of their private patients were generally retained by the physicians. Those fees received which were generated by treatment to patients admitted by the hospital district (institutional or service patients) were deposited in separate departmental trust funds. These funds were administered independent of control by the University of Texas Board of Regents. The funds deposited in the departmental trust funds were used to finance such departmental activities as travel and salary augmentation.

In September 1967, the University of Texas Board of Regents approved the bylaws of the Medical Service, Research, and Development Plan (Plan) of the University of Texas Southwestern Medical School at Dallas. The bylaws stated that the plan complied with the intent of the university's board of regents to exercise control over the professional income earned by the full-time faculty. The plan was implemented at the medical school on September 1, 1969.

The Plan requires participation by all faculty members holding full-time appointments at the medical school. By September 1972, each full-time faculty member must belong to the Plan. As of November 26, 1969, 97 faculty members in the nine departments included in our review had joined the Plan.

The purpose of the Plan is set forth in its bylaws, as follows:

"It is the purpose to create a plan for management of the professional income of members of the full-time faculty of The University of Texas Southwestern Medical School at Dallas. The plan will create an Institutional Trust Fund and within this Institutional Trust Fund it will establish a Development Fund to be expended in support of the programs of the school as a whole. It will designate the portion of the Institutional Trust Fund to be available to each Clinical Department which may be used in support of clinical faculty compensation and other functions pertaining to departmental teaching,

research, and patient care activities. The Plan will provide its administrative expense. It will safeguard the interests of its membership in the proper continued growth in excellence of The University of Texas Southwestern Medical School at Dallas."

The Plan's bylaws require that all members assign their professional fees to the Institutional Trust Fund. Professional fees include all fees generated within the medical school, including fees from third-party payment plans; fees for all consultations and services rendered at any other State or Federal institution, except as shown below; and fees for court appearances. The members were not required to deposit in the fund professional honoraria, royalties, and non-professional retainers; payments for editing scientific publications; and consultation fees as a regional or national consultant to any branch of the U.S. Government. The fees received by attending physicians for services rendered to Medicare and Medicaid patients are considered to be professional fees and are subject to assignment to the fund.

The bylaws of the Plan provide that the expenses of operating the Plan not exceed 10 percent of the gross income of the fund. After operating expenses of the Plan are paid, the remaining funds are to be allocated on the basis of (1) 20 percent to the development fund which is to be expended, at the dean's discretion, to enhance and support programs of the medical school as a whole and (2) 80 percent to departmental restricted funds which are to be expended by the member departments, upon approval by the board of regents, for faculty compensation and in support of teaching, research, and patient-care activities.

The bylaws provide that the amounts allocated to the departmental restricted funds be apportioned to the member departments in proportion to each department's contribution to the Institutional Trust Fund's gross income.

Each faculty member received a base salary from the University of Texas. The salary range for each scholastic rank was approved by the board of regents. Each physician who was a member of the Plan could receive faculty compensation (salary augmentation), in addition to this base salary,

from departmental restricted funds. We were told by university officials that this augmentation could not exceed 50 percent of the maximum salary for the individual physician's scholastic rank.

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

Our review of medical records applicable to part B payments made on behalf of selected patients at Parkland and Woodlawn indicated that, after the implementation of the SSA's April 1969 guidelines dealing with payments to supervisory and teaching physicians, there (1) was increased documentary evidence of the involvement of attending physicians for the specific services for which payments had been made and (2) were some changes in the medical school's billing practices, which had the effect of reducing the Medicare payments for the services of supervisory physicians.

Of 50 Medicare patients included in our sample, 27 were treated at the hospitals before June 1, 1969 (the effective date of SSA's April 1969 guidelines), and 23 were treated on or after that date. Of the 27 patients treated before June 1, 1969, 16 were nonsurgical patients hospitalized for a total of 341 days. The average Medicare part B charge allowed by Blue Shield for these 16 patients was \$15.74 a day.

Of the 23 patients treated on or after June 1, 1969, 18 were nonsurgical patients hospitalized for a total of 258 days. The average Medicare part B charge allowed for these 18 patients was \$10.27 a day--a reduction of \$5.47 a day, or about 35 percent. As discussed in subsequent sections, we believe that this reduction in Medicare payments can be attributed, in part, to the changes made by some medical school departments after June 1, 1969, with regard to billing for daily visits and for miscellaneous medical services which the hospital records showed, had been provided, in many instances by residents and interns.

We noted that, despite these changes, some problems continued to persist for some of the services furnished after the effective date of SSA's April 1969 guidelines.

--For about 60 percent of the billings for daily visits, the medical records did not indicate the involvement of the physicians in whose names the bills had been submitted.

--One department of the medical school continued to claim separate fees for other medical and minor surgical procedures which, according to the medical records, in most instances had been performed only by interns and residents without evidence of the supervision and direction of the billing physicians.

The payments which we reviewed were made by Blue Shield between December 1968 and December 1969 and were for services provided to 50 Medicare patients from August 1968 through October 8, 1969. The nature and occasions of services and the amounts billed and allowed by Blue Shield are summarized in the following table.

Type of service	Total			Services provided to 27 patients before June 1, 1969			Services provided to 23 patients after June 1, 1969		
	Occa- sions of ser- vice	Amount billed	Amount billed	Occa- sions of ser- vice	Amount billed	Amount allowed	Occa- sions of ser- vice	Amount billed	Amount allowed
MEDICAL SERVICES:									
Initial visits	28	\$ 1,070	\$ 844	12	\$ 440	\$ 324	16	\$ 630	\$ 520
Daily hospital visits	431	2,992	2,774	278	2,035	1,935	153	957	839
Outpatient clinic visits	39	430	367	33	370	312	6	60	55
Other medical services	190	1,990	1,904	129	1,401	1,345	61	589	559
Consultations	9	345	254	6	195	130	3	150	124
Radiation therapy	115	2,300	2,300	92	1,840	1,840	23	460	460
Total medical	812	9,127	8,443	550	6,281	5,886	262	2,846	2,557
SURGICAL SERVICES:									
Surgical procedures	20	5,375	5,031	14	3,450	3,181	6	1,925	1,850
Other surgical services	19	1,410	1,226	18	1,260	1,151	1	150	75
Total surgical	39	6,785	6,257	32	4,710	4,332	7	2,075	1,925
Total	851	\$15,912 ^a	\$14,700 ^a	582	\$10,991	\$10,218	269	\$4,921	4,482
Less deductibles and coinsurance			3,486			2,560			926
Total payments reviewed			\$11,214			\$ 7,658			\$3,556

^aThe \$1,212 difference between the amounts billed (\$15,912) and the amounts allowed (\$14,700) represents certain Blue Shield disallowances. Of the \$1,212, about 71 percent was disallowed because the billed charges exceeded the lower of customary or prevailing charges for the service computed by Blue Shield. The remaining 29 percent was disallowed because the amounts billed were for services provided to noneligible patients.

Inasmuch as the basic source for the billings prepared by the medical school departments had been the hospital medical records, we reviewed this source data applicable to the 50 Medicare patients. We attempted to ascertain the extent to which the medical records showed whether (1) the services had been provided and (2) the attending physicians in whose

names the bills had been submitted had been involved in providing such services.

Because of the technical nature of the data being reviewed, we requested the assistance of a Public Health Service (PHS) physician. The PHS physician independently examined the medical charts pertaining to all 50 patients in our sample. Except where noted, his findings were incorporated into the data shown in this report.

Initial visits

On admission to Parkland or Woodlawn, a patient was generally assigned an attending physician and provided with initial medical care which consisted of developing a patient's history and making a physical examination and a diagnosis. For billing purposes, this medical care was classified as an initial visit. Depending on the medical school department involved, the charges for this service ranged from \$25 to \$50, and Blue Shield allowed between \$15 and \$37.

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

	<u>Bills for services provided</u>		
	<u>Total</u>	<u>Before June 1, 1969</u>	<u>On or after June 1, 1969</u>
Occasions of service	<u>28</u>	<u>12</u>	<u>16</u>
Medical personnel identified in the records with the service:			
Attending physicians:			
Same as identified on bill	19	4	15
Other attending physicians	8	5	3
Residents	29	14	15
Interns	21	7	14
Medical students	9	6	3
Records not signed or signature not identifiable	<u>1</u>	<u>1</u>	<u>-</u>
Total	<u>87</u>	<u>37</u>	<u>50</u>

As shown on the preceding page, on or after June 1, 1969, the medical records showed a considerable increase in the frequency of documentation supporting that attending physicians had been involved in providing the services.

Daily hospital visits

The medical school departments generally billed Medicare in amounts from \$5 to \$8 for physicians' follow-up visits for each day of hospitalization after the first day, unless such visits were covered under the fees billed for surgery. Of 431 daily hospital visits provided to the 50 patients included in our review, 183 were provided by the Woodlawn chest division. On 78 of the 183 occasions, the visits were considered intensive and were billed at \$7.50 each. The remaining 105 visits were considered routine and were billed at \$5 each. The division's medical director told us that the \$7.50 charge was for more comprehensive care given in the intensive-care unit. The PHS physician who assisted us in our review examined the medical records for the 78 visits that were classified as intensive and took no exceptions to the classifications.

Our review of hospital medical records prepared by attending physicians, residents, or interns showed that, for 49 of the 431 daily visits, notations had not been made by any physicians, residents, or interns to indicate that they had seen the patients. In addition, we found no evidence in nurses' notes or in laboratory reports that the visits had been made. On the dates shown for two of these 49 visits, the patients were not in the hospital. Of the 49 visits, 27, including the two in which the patient was not in the hospital, were billed for by the Woodlawn chest division on or after June 1, 1969.

The following table summarizes our review of medical records supporting charges for daily visits. For many daily visits, the records showed that more than one resident, intern, and/or medical student had been involved. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	<u>Bills for services provided</u>		
	<u>Total</u>	<u>Before June 1, 1969</u>	<u>On or after June 1, 1969</u>
Occasions of service:			
Billed	431	278	153
Not supported by medi- cal records	<u>49</u>	<u>21</u>	<u>28</u>
Supported by medical records	<u>382</u>	<u>257</u>	<u>125</u>
Medical personnel identi- fied in the records with the service:			
Attending physicians:			
Same as identified on bill	73	7	66
Other attending physicians	21	18	3
Residents	190	180	10
Interns	269	137	132
Medical students	44	41	3
Records not signed or signature not iden- tifiable	<u>18</u>	<u>11</u>	<u>7</u>
Total	<u>615</u>	<u>394</u>	<u>221</u>

As indicated by the table, evidence in the hospital medical records of involvement by attending physicians in the specific services billed for on or after June 1, 1969, increased. After that date, however, the medical records for about 57 percent of the billings did not indicate the involvement of the physicians in whose name the bills had been submitted.

In addition, we noted some changes in the medical school's billing practices that had the effect of reducing Medicare payments for the services of supervisory or teaching physicians. For example, in one case the attending physician billed for only an initial visit even though the patient was hospitalized for 5 days. In another case, the attending physician billed for only four daily visits even though the patient was hospitalized for 16 days.

Regarding the 49 daily visits for which documentation was not found, we were advised by medical school and Blue Shield officials that a physician's entry on a patient's chart was not required for each consecutive day of hospitalization and that therefore the absence of a physician's notation did not necessarily mean that the patient had not been seen by a physician. Medical school officials advised us that Blue Shield, SSA, and the medical school had agreed that daily progress notes by the attending physician would not be required in order to bill for daily visits. If the patient's condition was stable, physician's notes on the patient's chart every 2 to 4 days would be adequate support for billing for daily visits.

Outpatient clinic visits

For the 50 patients included in our review, the internal medicine, surgery, and ophthalmology departments billed for 39 outpatient clinic visits at charges ranging from \$10 to \$20. Of these 39 visits, 33 were for services provided before June 1, 1969, and six were for services provided on or after that date. The reduction in the number of services provided and billed for on or after June 1, 1969, was the result of changes in the basis for billing for postoperative care by the surgery and ophthalmology departments.

Prior to SSA's April 1969 guidelines, lump-sum surgery fees were not considered to include, in many cases, charges for outpatient follow-up care. For this reason, outpatient clinic visits were billed separately. As a result of the April 1969 guidelines and of discussions with Blue Shield representatives, the surgery and ophthalmology departments revised their interpretation regarding surgery fees and in July 1969 began including both preoperative and postoperative care in the charges for the surgery. Surgery fees were maintained at the same level after this change, and separate billings for outpatient follow-up visits for surgery cases were virtually discontinued by both departments.

The following table summarizes our review of medical records supporting charges for outpatient clinic visits. For many of the visits, the records showed that more than one resident and/or intern had been involved. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	<u>Bills for services provided</u>		
	<u>Total</u>	<u>Before June 1, 1969</u>	<u>On or after June 1, 1969</u>
Occasions of service	<u>39</u>	<u>33</u>	<u>6</u>
Medical personnel identified in the records with the service:			
Attending physicians:			
Same as identified on bill	3	-	3
Other attending physicians	8	8	-
Residents	30	27	3
Interns	1	-	1
Records not signed or signature not identi- fiable	<u>15</u>	<u>14</u>	<u>1</u>
Total	<u>57</u>	<u>49</u>	<u>8</u>

Consultations

When one department (e.g., internal medicine) received medical advice from another department (e.g., physical medicine and rehabilitation) or from a subspecialty within the same department, the Medicare program was generally billed \$50 for a consultation. For the cases in our sample, the internal medicine and physical medicine and rehabilitation departments billed for nine consultations.

The number and type of medical personnel identified as being involved in providing the specific services relating to consultations are summarized in the following table. In some cases, more than one individual was identified as having been involved with the services provided. Therefore, the number of medical personnel identified with the services exceeds the total occasions of service billed.

	<u>Bills for services provided</u>		
	<u>Total</u>	<u>Before June 1, 1969</u>	<u>On or after June 1, 1969</u>
Occasions of service	<u>9</u>	<u>6</u>	<u>3</u>
Medical personnel identified in the records with the service:			
Attending physicians:			
Same as identified on bill	5	2	3
Other attending physicians	3	3	-
Residents	4	4	-
Interns	<u>2</u>	<u>-</u>	<u>2</u>
Total	<u>14</u>	<u>9</u>	<u>5</u>

Other medical and minor surgical procedures

In addition to billing for initial visits and daily medical care, four medical school departments billed for 190 other medical and minor surgical services, such as electrocardiograms, blood gases tests, lumbar punctures, skin tests, sputum cultures, thoracenteses, and catheterizations. For about 80 percent of these services, the hospital medical records did not show any involvement of attending physicians. The fees billed ranged from \$3 for a skin test to \$25 for thoracentesis and endotracheal intubation. The Woodlawn chest division billed for 121 of the 190 services, the internal medicine department billed for 65 services, and the neurology and physical medicine departments billed for the remaining four services.

Our review of hospital medical records showed that, for seven of the 190 services billed, notations had not been made by any attending physicians, residents, or interns to indicate that the services had been provided. In addition, we found no evidence in nurses' notes or of laboratory reports to support such charges.

The PHS physician who assisted us in our review examined the medical records pertaining to the 190 services billed and agreed that the records did not contain any evidence that the seven services, for which Blue Shield had allowed \$70, had been provided.

The PHS physician also raised certain questions pertaining to the other medical services billed by the Woodlawn chest division. The PHS physician informed us that certain miscellaneous services were normally billed by the hospitals under part A of the program and that he had noted numerous instances where such services, in his opinion, should not have been billed under part B.

We discussed these billing practices with the medical director at Woodlawn. He stated that he had billed only for those procedures performed by physicians for diagnostic purposes during the initial examinations or performed at night when technicians were not available. The director stated further, that, on the basis of billing instructions received

from the department of internal medicine in January 1970, he had discontinued billing for some of these minor procedures.

In November 1969, when we originally examined two patients' medical records supporting charges made by the Woodlawn chest division, we noted that they did not contain evidence of involvement by attending physicians in six electrocardiograms and a tracheotomy. We presented a statement of facts, along with the patients' charts, to the medical director in February 1970 for review. When the PHS physician reviewed the patients' charts in March 1970, he found that the physician's signature was on the records supporting the seven services questioned by us in November.

The medical director informed us that, when a patient expired or was transferred to a nursing home, the patient's chart was immediately sent to Parkland for completion. The director said that, when this occurred, he had to wait as long as 2 months before he could complete the chart. He said that this had occurred in the two cases involved and that he had added signatures to the charts after our review in November 1969 but before we had asked him to review the charts in February 1970.

The number and type of medical personnel identified as having been involved in providing the specific services relating to other medical and minor surgical services billed by the Woodlawn chest division and the department of internal medicine are summarized in the following table. In many cases, more than one individual was identified as having been involved in providing the same service. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	Bills for services provided					
	Total		Before June 1, 1969		On or after June 1, 1969	
	Woodlawn chest div.	Internal medicine	Woodlawn chest div.	Internal medicine	Woodlawn chest div.	Internal medicine
Occasions of service:						
Billed	121	65	73	52	48	13
Not supported by medical records	<u>6</u>	<u>1</u>	<u>4</u>	<u>1</u>	<u>2</u>	<u>-</u>
Supported by medical records	<u>115</u>	<u>64</u>	<u>69</u>	<u>51</u>	<u>46</u>	<u>13</u>
Medical personnel identified in the records with the service:						
Attending physicians:						
Same as identified on bill	14	13	3	2	11	11
Other attending physicians	-	5	-	3	-	2
Residents	20	10	17	10	3	-
Interns	52	21	23	18	29	3
Medical students	-	22	-	22	-	-
Records not signed or signature not identifiable	<u>59</u>	<u>20</u>	<u>41</u>	<u>20</u>	<u>18</u>	<u>-</u>
Total	<u>145</u>	<u>91</u>	<u>84</u>	<u>75</u>	<u>61</u>	<u>16</u>

The internal medicine department greatly reduced the number of bills submitted for other medical and minor surgical services provided after the effective date of SSA's April 1969 guidelines. The involvement of an attending physician could be documented for each of these services that was billed.

In contrast, the Woodlawn chest division continued to bill for medical and minor surgical services provided on or after June 1, 1969, in addition to billing for initial visits and daily hospital care for every day the patients were in the hospital.

As previously noted, hospital medical records relating to charges for other medical and minor surgical services were reviewed by the PHS physician. His findings agreed with ours, with the exception of the instances in which signatures had been placed on the records by the medical director of the Woodlawn chest division in the interim between our initial review of the records in November 1969 and the PHS physician's review in March 1970. We did not consider these signatures to be appropriate documentation for the purposes of our review.

Cobalt therapy

Our review included five claims submitted in the name of the chief of the radiation therapy section of the radiology department involving a total of 115 cobalt therapy treatments rendered to four Medicare patients. All the treatments were billed at \$20 each, and all checks received from Blue Shield were made payable to the radiology department's trust fund.

Our examination of the records of roentgen therapy supporting the 115 occasions of service did not reveal any evidence of personal involvement in the treatments by the attending physician named on the bills; however, in most instances, we found evidence that other attending physicians had been involved in providing the treatments billed for.

The section chief in whose name the bills had been submitted stated that he was the only physician in the section who was qualified to determine the type of treatment to be given or to approve a change in the type of treatment given. He added that only in unusual circumstances would another physician make such a decision. He stated, however, that he might not be present when each treatment was given.

Operating-room surgery

For 17 of the 50 Medicare patients included in our review, the surgery, ophthalmology, and obstetrics and gynecology departments billed for 20 surgical procedures which required the use of Parkland's operating rooms. The charges allowed by Blue Shield for these 20 procedures ranged from \$75 for a dilation and curettage billed by the obstetrics and gynecology department to \$500 for an iridectomy billed by the ophthalmology department.

Our review of the hospital's medical records showed that 17 of the 20 procedures had been performed by residents who had been assisted by other residents and interns in 14 cases, and by attending physicians in three cases. For three of the 20 procedures, the attending physicians were shown as the principal surgeons, and for one procedure, the physician was the same as named on the bill.

With regard to reimbursement for services of attending physicians who supervise interns and residents, the SSA regulations in effect before and after June 1, 1969, provide 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."

We found that, for four of 14 surgical procedures performed before June 1, 1969, the medical records contained evidence of the presence in the operating room of the attending physicians in whose names the bills had been submitted. For an additional seven of the 14 procedures, attending physicians other than those named on the bills were shown as having been present during the surgery. There was no evidence in the medical records that attending physicians had been present in the remaining three cases.

The medical records contained evidence that the attending physicians named on the bills had been present at all six of the operations performed on or after June 1, 1969.

The SSA's April 1969 guidelines emphasized the conditions which should be met before Blue Shield should allow the full reasonable charges for services provided by supervisory or teaching physicians in surgery cases. The SSA guidelines stated, for example, that, if the supervisory surgeon was present at surgery and the surgery was performed by a resident acting under his close supervision and instruction, the supervisory physician would not be the attending surgeon unless it was customary in the community for such services to be provided in a similar fashion to a private patient who paid for services rendered by a private physician.

The SSA guidelines, however, stated further that, if the supervisory physician was scrubbed for surgery and acted as an assistant, payment could be made to him as a surgical assistant if such an assistant was necessary and if a resident or another physician did not fill the role. According to a widely used relative-value study, the fee for an

assistant at surgery was 20 percent of the fee for the surgical procedure.

With respect to determining the amount payable in a surgery case, the SSA's April 1969 guidelines provided that, if surgery was performed and the supervisory physician rendered identifiable personal service to the patient in the operating room, it would be necessary for Blue Shield to determine whether the physician performed services more nearly analagous to a consultant, an assistant at surgery, or as an attending surgeon, in order to identify the appropriate reasonable charge.

For the six surgery cases in which surgery was performed after June 1, 1969, we noted that, in one case, the physician in whose name the bill had been submitted had been named as the principal surgeon performing the operation; in another case, the physician¹ had been identified as the assistant; and, in the remaining four cases the physicians had been shown as being present in the operating room while the operations were performed by residents. Although the character of the services rendered by the physicians differed in these cases, Blue Shield did not take the differences into consideration in determining the appropriate reasonable charges.

During our review we were informed by Blue Shield that it had not determined whether it was customary in the community for private physicians to charge private patients for surgery performed by surgical residents in the presence of the physicians. In commenting on a draft of this report, however, Blue Shield informed us that "Private physicians do customarily charge private patients for surgery performed by surgical residents since these physicians do not receive from other sources compensation for teaching activities and must, therefore, receive their primary income from patients and third party payers."

¹As the result of a multiple-billing agreement, the bill was made in the name of the department chairman, rather than in the name of the physician identified as the assistant.

In its comments Blue Shield did not indicate whether such charges to patients were equal to physicians' customary charges for given surgical procedures or if such charges usually were reduced because the physicians had not performed the surgery personally.

In commenting on a draft of this report, SSA agreed with us that, to determine the reasonableness of charges to private patients as opposed to service patients, there was a need for Blue Shield to know how services provided to private patients differed from those provided to service patients. SSA stated that Blue Shield had been asked to obtain information regarding whether it was customary in the community for private physicians to charge private patients for surgery performed by residents in the physicians' presence.

Anesthesiology and other surgical services

In addition to billing for surgical procedures which required the use of the hospital's operating rooms, the surgery and anesthesiology departments billed for 16 anesthesiology services and three other surgical services provided to the patients included in our sample. One of the 16 anesthesiology bills was a duplicate bill, which resulted from a clerical error on the part of the billing clerk.

Our sample did not include any bill for anesthesiology services provided on or after June 1, 1969. The chairman of the anesthesiology department stated that, in accordance with verbal directions from Blue Shield, bills were not submitted to it between May 14 and November 4, 1969. He stated that, as of February 19, 1970, bills for services provided through September 1969 had been submitted to Blue Shield.

The hospital's medical records relating to the 15 anesthesiology services that were provided before June 1, 1969, showed that:

- In five cases, the attending physicians in whose name the services had been billed had been involved.
- In three cases attending physicians other than the physicians named on the bills had been involved.
- In seven cases, the anesthesia had been administered by residents, and there was no evidence that attending physicians had been involved.

The surgery department billed \$25 for each of two audiograms and \$150 for a myelogram. We found no evidence in the medical records that an attending physician had been involved in any of the three services.

The medical records relating to the 19 occasions of service for which bills had been submitted were reviewed by the PHS physician. The results of his review were incorporated in the information summarized above. In addition, he pointed out three cases in which the medical records indicated that anesthesia services had been rendered by attending physicians but for which no bill had been submitted.

Medical school Blue Shield and SSA comments
on our review of medical records

In commenting on a draft of this report, the dean of the medical school stated:

"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 care 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. Rarely, if ever, has there been any question that the service was rendered for which a bill was submitted; the problem has been in terms of the record reflecting the exact role of the responsible physician in the provision of that care.

"In all fairness to the members of our faculty who are included in this study, I must state that from the outset, they have provided the documentation based on their understanding at that time as to what was required. In reading your report, I believe this is confirmed and if the study had been carried on beyond October of 1969, I am sure it would be further confirmed.

"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 inappropriate billing for services rendered. I do hope, however, that a program can be worked out that will better accommodate the situation in an academic medical center."

* * * * *

"In summary, there are several conclusions that seem valid after reviewing the report:

- "(1) The present legislation and guidelines makes it almost impossible to administer and audit the Medicare program in an academic medical center setting.
- "(2) Even if Item I could be achieved, it would be in-ordinately expensive and wasteful.
- "(3) The medical school faculty has not done anything that could be construed as dishonest or deceitful. The steady progress in terms of documentation as the guidelines were changed is proof of their desire to comply in every respect.
- "(4) It is apparent that a new format must be evolved to adequately cover such a health care program conducted in an academic medical center setting if we are going to achieve quality at the most reasonable cost."

Blue Shield in its comments on a draft of this report stated:

"We feel you and your staff have pointed out that the teaching physicians requirements for Part B reimbursement are cumbersome on the physicians and are extremely difficult to administer and we support this position. It is gratifying to note the report frequently indicates the physician documentation for services billed increased after our first attempt to clarify the requirements furnished to all carriers in *** SSA's April 1969 guidelines ."

* * * * *

"The medical school officials and department chairmen have, however, displayed to us a sincere desire to understand and abide by the requirements. This was again evident when a recent review of the medical records revealed still more physician documentation as a result of the operational guidelines developed by our organization and the medical school last October."

In commenting on a draft of this report, SAA stated that, although there had been improvements in the documentation and billing practices after the implementation of its April 1969 guidelines, there was the possibility of overpayment prior to that time and that it would exercise all efforts to identify the overpayment if it existed and would take appropriate recovery action.

POSSIBLE OVERLAPPING OF COMPENSATION
FOR PHYSICIANS' SERVICES UNDER
PARTS A AND B OF THE PROGRAM

During 1969 the hospital district paid about \$188,000 to the medical school for a portion of the salaries of certain medical school physicians who had provided services to individual patients under part B of the Medicare program. The Medicare program was billed for these services on a fee-for-service basis.

Although the hospital district's cost report supporting its claim for reimbursable costs for 1969 under part A of the program had not been submitted to Blue Cross at the time of our fieldwork, we were informed by officials of the hospital district that the district intended to include the entire \$188,000 in its allowable hospital costs for 1969. A portion of such costs would then be allocated to Medicare patients for reimbursement under part A. Because it appeared likely that the hospital district's payments to the medical school for the services of these physicians had included compensation for direct patient care to the medically indigent, we believe that allowable hospital costs should be reduced by the undetermined portion of the \$188,000 which was applicable to the salary payments for providing direct patient care.

The \$188,000 paid by the hospital district to the medical school was for salaries of the physicians of the following departments.

Anesthesiology	\$131,732
Internal medicine	44,936
Radiology (cobalt therapy)	<u>11,000</u>
Total	<u>\$187,668</u>

The SSA instructions pertaining to the reimbursement of hospital costs under part A of the Medicare program provide that the portion of any compensation to physicians for medical or surgical services provided to individual patients (direct patient care) be excluded from allowable costs under part A.

We noted evidence that the \$188,000 the hospital district intended to include in its reimbursable hospital costs

included compensation for direct patient care. For example, the chairman of the anesthesiology department advised us that:

"Salaries for the 16 full-time staff in anesthesiology are paid by the University of Texas Southwestern Medical School, totaling \$436,700 for 1969. During that year, *** [the hospital district] remitted to the Medical School approximately \$131,700 for support to those parts of the Anesthesiology budget related to teaching responsibilities to the Dallas County Hospital District house staff; administrative responsibility for the operating room schedule, for the recovery rooms, for obstetrical anesthesia, and for the pain clinic; and for the care of indigent and non-insured patients." (Underscoring supplied.)

Two assistant administrators at Parkland told us that:

1. In the anesthesiology department, the payments made for physicians' salaries cover to some degree patient care. In addition, the hospital pays for administrative duties performed by the chairman of the department.
2. In the radiation (cobalt) therapy section of the radiology department, the hospital is paying strictly for patient care in the form of supervision of technicians, residents, and interns.

In addition, the dean of the medical school furnished us with information pertaining to the duties of medical school physicians in the anesthesiology department and in the radiation (cobalt) therapy section. This information identified the portions of the physicians' time spent at the hospitals that were attributable to administrative, teaching, and patient-care responsibilities.

Our analysis of the information indicated that during 1969 physicians of the anesthesiology department spent an aggregate of about 40 percent of their time in the care of patients at the hospitals and that the physician in charge of the radiation therapy section spent a total of 67 percent of his time in the care of patients at the hospitals. This time

was spent in the care of all patients, including Medicare, Medicaid, private, and charity patients. Accordingly it appears that, in determining the hospital's reimbursable costs under part A of the Medicare program, some portion of the \$188,000 paid by the hospital district to the medical school in 1969 should be excluded from the costs allocated to the care of Medicare patients when costs are finally determined, because it represents part B patient-care services to the medically indigent.

The dean of the medical school, in commenting on a draft of this report, stated that the medical school physicians did not ask for or receive any reimbursement from the hospital district for the time they devoted to private or third-party-pay patients. He added, however, that some small percentage of the \$188,000 represented reimbursement for the care of indigent patients. We believe, however, that, in accordance with SSA instructions, salary costs related to the care of any individual patients--irrespective of whether they are private or third-party-pay patients--should be eliminated from the costs claimed under part A of the program.

The hospital district administrator stated:

"*** With respect to the allowability of costs of hospital based physicians *** we reimburse the school only for that percentage of time spent for professional services allocated to hospital patients over and above the requirements for teaching medical students and house staff."

SSA stated that it was following up with Blue Cross on this matter and that SSA would also inquire into prior years' determinations of reimbursable hospital costs under part A, to determine whether similar overlapping of hospital and medical school reimbursements for physicians' services had occurred.

We believe that the statements by medical school and hospital officials regarding the nature and purpose of the hospital district's payments to the medical school illustrate the problems involved in paying for physicians' services in an institutional or teaching setting for certain of their services on a cost basis under part A of the program and for other services on a fee-for-service basis under part B.

PATIENT INVOLVEMENT IN PAYMENTS
MADE ON THEIR BEHALF

The Medicare patients included in our sample had not been billed directly by the medical school departments for deductible and coinsurance amounts totaling about \$3,500. Data furnished by Blue Shield showed, however, that the Texas Medicaid program had paid about \$1,900 of the \$3,500, or about 54 percent. In addition, 49 of the 100 Medicare claim forms we reviewed had not been signed by the patients on whose behalf the claims had been filed. Blue Shield, however, had notified the patients of the payments made on their behalf.

Extent to which patients paid for
deductibles and coinsurance under part B

Under part B of the Medicare program, the patient is responsible for paying the first \$50 for covered services in each year (deductible) and 20 percent of the reasonable charges in excess of the first \$50 (coinsurance).

As shown in the schedule on page 14, the charges allowed by Blue Shield under part B on behalf of the 50 patients included in our sample totaled \$14,700. Of this amount, \$3,486 represented the deductible and coinsurance amounts that were the responsibility of the patients.

Of these 50 patients, 31 qualified for benefits under the State Medicaid program to supplement their Medicare benefits. Blue Shield--which, in addition to being the Medicare carrier, is the Medicaid fiscal agent for Texas--informed us that it had made Medicaid payments totaling \$1,902 for deductible and coinsurance amounts applicable to the 31 patients.

At the time of our fieldwork, the medical school had not billed Medicare patients for the remaining deductible and coinsurance amounts owed. The department chairmen stated that they generally did not bill individual patients admitted by Parkland or Woodlawn because the amounts collected would not cover the cost of preparing the bills. They stated further that the majority of the institutional patients admitted to the two hospitals were charity or indigent patients and therefore would not be able to pay even if billed.

Patients did not sign claims

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

The payments made by Blue Shield to medical school physicians were through assignments. We found that Blue Shield had paid claims even though claim forms had not been signed by the patients. Of the 100 SSA-1490's we reviewed, only 51 had been signed by the patients. Of the remaining 49 claims, 32 contained the statement "Signature on File," nine were signed by a third party, and eight did not contain either signatures or notations.

Of the 32 claims containing the "Signature on File" notation, 22 originated in the medical school's internal medicine department. The billing clerk in this department told us that, in each case in which she did not have a Form SSA-1490 signed by the patient, she had typed in "Signature on File" and had forwarded the claim to Blue Shield. She stated that she did not query other departments or the hospital to determine whether the patient had, in fact, signed any form authorizing such a payment.

Of the nine claims signed by third parties, six were signed by the billing clerk employed by the medical school's surgery department. Eight claims paid by Blue Shield did not contain signatures or notations of any kind.

Notification to patients of part B payments

To determine whether Medicare patients had received explanations of part B benefits paid by Blue Shield on their behalf, we selected a subsample of 10 of the claims included in our sample and examined Blue Shield's notification records for these claims. In all 10 cases, we found that Blue Shield

had furnished the patients with an "Explanation of Benefits" form identifying the individuals receiving payments, the place and date of service, and the charges allowed.

OTHER MEDICAL INSURANCE PROGRAMS AND
INDIVIDUALS PAYING FOR PHYSICIANS' SERVICES

We examined bills submitted to private insurance companies and private patients by five of the nine medical school departments included in our review. These five departments received 88 percent of total Medicare part B payments received by the medical school in 1969.

We found evidence, in the form of deposit slips and copies of billing documents, that these five departments consistently had billed, and had received payments from, private insurance companies both before and after the beginning of Medicare on July 1, 1966. Also, as discussed previously, the State Medicaid program made payments for the professional services of the medical school faculty. In addition, our examination revealed that charges made to Medicare by the internal medicine department and the Woodlawn chest division for initial visits and daily hospital visits were higher than their charges to private sources for similar services.

We found evidence that four of the five departments had billed and had received payments directly from private patients. A representative of the fifth department (Woodlawn chest division) informed us that only the insurance companies had been billed and that the amounts received had been accepted as final payments for the professional services rendered.

Representatives of the four departments informed us that private patients were billed when it was determined that they had the ability to pay. Representatives of one of the four departments advised us that these bills were rare because Parkland primarily was a charity hospital.

Representatives of the departments contacted gave us listings of the private insurance companies that honored claims for the services of supervisory or teaching physicians. These representatives informed us that, although these listings might not be complete, they fairly represented the extent of departmental billing activity. The number of insurance companies that honored claims from the five departments that provided most of the Medicare services billed during 1969 is as follows:

Ophthalmology)	65	companies
Surgery)		
Internal medicine	100	"
Woodlawn chest division	24	"
Anesthesiology	69	"

We were informed that the surgery department had experienced some difficulty in securing payments from three of the companies included in its listing and that the anesthesiology department had experienced some trouble with two other companies. We learned that one of these companies did not honor an assigned claim but did pay if the patient was billed directly. The representatives of these two departments told us that the remaining four companies occasionally had refused to pay claims but that the companies were not consistent in this regard.

We found that the fees charged insurance companies by the five departments generally were comparable to charges for similar services rendered to Medicare patients. We observed, however, that charges to Medicare by the internal medicine department and Woodlawn chest division for initial visits and daily hospital visits were higher than those to private sources for similar services, as shown below.

	Charges	
	<u>To Medicare</u>	<u>To private sources</u>
Internal medicine:		
Initial visits	\$35.00	\$25.00
Daily visits	8.00	7.50
Woodlawn chest division,		
initial visits	50.00	25.00

ACTIONS TAKEN BY BLUE SHIELD AND
MEDICAL SCHOOL TO IMPLEMENT SSA'S
APRIL 1969 GUIDELINES REGARDING PAYMENTS
TO SUPERVISORY AND TEACHING PHYSICIANS

SSA's April 1969 guidelines clarified the conditions that must be met for supervisory and teaching physicians to be eligible for payments under Medicare as attending physicians. On June 20, 1969, SSA requested Blue Shield to meet with university-affiliated institutions, if it had not already done so, to determine whether medical personnel understood the guidelines. SSA also directed that, if the guidelines were not being followed completely in a given institution, payments be suspended until such time as appropriate agreements could be reached. On July 16, 1969, SSA inquired of Blue Shield as to what action, if any, had been taken.

Blue Shield responded, by letter dated August 7, 1969, that it had encountered some objections by medical personnel at teaching hospitals to some of the provisions of the April 1969 guidelines and requested that SSA answer certain questions that had been raised. Blue Shield added that it was continuing its efforts to explain and clarify SSA's new guidelines.

On August 14, 1969, Blue Shield suspended the processing of all bills for services furnished by the medical school supervisory physicians in the teaching setting at Parkland and Woodlawn. Blue Shield resumed payments to medical school physicians on November 5, 1969. A Blue Shield official informed us that the resumption had been based on Blue Shield's audit of 162 medical records. This official was able to furnish us with documented evidence of the review of medical records involving only 16 claims paid on behalf of 15 patients. He stated that he had not made notes of the review of the remainder of the records, because he felt it necessary to document only the sampling of records reviewed.

In commenting on a draft of this report, Blue Shield stated that:

"Payments were not suspended until August 14, 1969, because the certifications indicating an understanding of the Medicare coverage requirements had been obtained from the medical school and our records of the medical school's billing practices indicated it was proper to reimburse them on the basis of usual, customary and prevailing criteria. We could not have been aware of or have made a determination of inadequate or acceptable documentation since adequate documentation by the physician had not been defined nor at that time had we and the medical school agreed upon the guidelines."

We were informed by Blue Shield and medical school officials that the SSA's April 1969 guidelines were not fully implemented until October 1969, or 5 months after the June 1, 1969, implementation date established by SSA.

Blue Shield and medical school officials informed us that Blue Shield began to clarify the documentation requirements in May 1969 but that full understanding was not achieved by the medical school physicians until October 1969. The director of the Woodlawn chest division stated, however, that he did not receive clarifying instructions from his superiors until January 1970.

On October 13, 1969, Blue Shield issued supplementary billing instructions to the medical school's attending physicians that helped clarify SSA's April 1969 guidelines. On the basis of these instructions, the departments of surgery, ophthalmology, and internal medicine issued written procedures to their staffs in October 1969 and the Woodlawn chest division issued written procedures in March 1970. The remaining departments did not issue written procedures, but the chairmen of these departments informed us that they had altered their documentation policy to conform to the SSA's April 1969 guidelines and the Blue Shield's October 1969 supplementary instructions.

Our review did not include any claims involving services provided after October 13, 1969; however, the chairmen of

various medical school departments advised us that, after the implementation of Blue Shield's October 1969 instructions, virtually all the medical charts of Medicare patients on whose behalf claims were filed did show that the attending physicians had been personally involved.

We were informed by the chairman of the department of surgery that, after the medical school implemented SSA's April 1969 guidelines, his department began submitting Medicare bills without charges to Blue Shield. The chairman indicated that such no-charge bills had been submitted to show that charges had not been made for surgical services rendered to Medicare patients in some cases, because the involvement of the supervisory or teaching physicians did not warrant fees for professional services.

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TOM VAIL, CHIEF COUNSEL

United States Senate

COMMITTEE ON FINANCE
 WASHINGTON, D.C. 20510

May 7, 1970

The Honorable
 Elmer B. Staats
 Comptroller General
 of the United States
 Washington, D. C.

Dear Mr. Staats:

I understand that your office has been making reviews of Medicare payments for the services of supervisory and teaching physicians at five hospitals which are similar to the review made at the request of this Committee of Medicare payments to supervisory and teaching physicians at Cook County Hospital in Chicago, Illinois. I also understand that your Office contemplates issuing an overall report to the Congress presenting the findings, conclusions, and recommendations developed in connection with the reviews at the five hospitals.

On May 4, 1970, the Committee on Ways and Means of the House of Representatives announced that, in connection with its consideration of amendments to title XVIII of the Social Security Act, it had proposed certain restrictions with respect to payments under the supplementary medical insurance (part B) portion of the Medicare program to supervisory and teaching physicians.

This Committee will soon consider legislative changes concerning Medicare payments to supervisory and teaching physicians. In connection with this work, would you please furnish to this Committee individual reports of these reviews.

Although it will not be necessary for you to develop overall conclusions and recommendations relating to this information, the material furnished to this Committee should at least cover the following points with respect to the payments made on behalf of selected Medicare beneficiaries:

The Honorable
Elmer B. Staats

- 2 -

May 7, 1970

1. The extent that the services paid for were furnished by the supervisory or teaching physician in whose name the services were billed, by other attending physicians, or by residents and interns, as shown by the hospitals' medical records. Also, information as to any changes in billing or record-keeping practices since the implementation of Social Security's April 1969 guidelines relating to such payments.
2. The extent to which payments made from Medicare (part B) funds represented payments for services of physicians whose compensation may have also been reimbursed in part to the hospitals under the hospital insurance (part A) portion of Medicare. For those physicians who were not compensated by the hospitals, information as to their medical school affiliations and the bases for their compensation by these institutions would be helpful.
3. Information as to whether the individual physicians bill for claimed services or whether the billing is done by the hospital or some other organization, and information as to the disposition of such funds obtained from part B of the Medicare program. For example, are the payments retained by the physician or are they turned over to the hospital, medical school, or some other organization.
4. Whether: (a) the Medicare patients were billed for and subsequently paid the deductible and coinsurance portions of the Medicare charges, (b) the patients signed the appropriate claims forms requesting that Medicare payments be made on their behalf, and (c) the patients received "explanations of benefits" or other notification of the payments made on their behalf.
5. Information as to the basis for arriving at the amounts of "reasonable charges" for the services paid for.

The Honorable
Elmer B. Staats

- 3 -

May 7, 1970

6. Information as to whether any other medical insurance programs or other patients regularly made payments for services provided by the supervisory and teaching physicians at the hospitals in amounts comparable to those paid from Medicare funds under comparable circumstances.

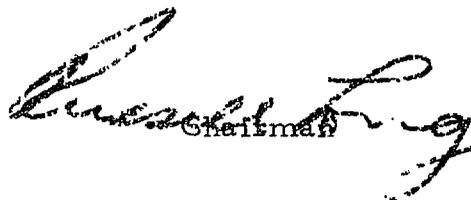
7. Information as to the steps taken by the hospitals and the carriers to obtain compliance with SSA's April 1969 guidelines concerning payments to supervisory and teaching physicians, including actions taken to suspend or recover payments.

8. Any other pertinent information which you believe would be helpful to this Committee in its consideration of the subject.

Although there is no need to obtain formal advance comments from the Department of Health, Education and Welfare, the Committee has no objection to your Office discussing the matters covered in the reports with appropriate officials of the Department.

With e very good wish, I am

Sincerely,



Chairman