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

HUMAN RESOURCES
DIVISION

126974

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Carolyne K. Davis, Ph.D., Administrator
Health Care Financing Administration
Department of Health and Human Services

Dear Dr. Davis:

Subject: Payment for Inpatient Alcoholism Detoxification And Rehabilitation Services Under Medicare Needs Attention
(GAO/HRD-85-60)

On October 1, 1983, Medicare began its prospective payment system (PPS) under which hospitals are paid based on the illness of the patient. All hospitals receive the same amount (adjusted to reflect local wage levels, urban or rural location, and teaching facility status) for treating patients with the same diagnosis. Diagnoses are combined into 468 groups--called diagnosis related groups (DRGs)--that prior payment data and clinical judgment showed should require the same level of hospital resources to treat. Although alcohol-related treatments have been included in four of these groups, we do not believe the above DRG criteria are satisfied because patients may receive three different types of treatment which vary significantly in cost and level of resources used in their treatment. As a result, the payment rates for the alcohol-related DRGs overpay hospitals for one of the treatment types and underpay hospitals for the other two treatment types. This, in turn, gives hospitals an economic incentive to provide the overpaid treatment regardless of need and a disincentive to provide the underpaid treatments.

In addition, Medicare has paid for alcoholism treatments whose coverage was questionable under the program's guidance. The Health Care Financing Administration (HCFA) should ensure that reviewers of alcoholism treatments apply criteria that are consistent with and cover all aspects of Medicare's program guidance to prevent such payments.

HCFA has recognized that problems exist with the alcoholism treatment DRGs and has allowed alcohol abuse treatment hospitals, and parts of hospitals that specialize in alcohol abuse treatment, to request exclusion from PPS until October 1, 1985. HCFA has also taken action intended to obtain better data on which to base prospective rates for alcoholism treatment and

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to improve utilization review of such treatments; however, because of weaknesses in HCFA's data collection effort, the actions taken may not produce the desired results.

BACKGROUND

Medicare is a federal health insurance program for people 65 years of age and older and certain disabled people. Medicare will cover treatment for alcoholism in a hospital setting if such services are medically necessary. Patients entering a hospital for treatment for alcoholism may receive varying types of care, including

--detoxification, or care while the patient withdraws from the effects of alcohol;

--rehabilitation composed primarily of educational and therapeutic services designed to relieve the patient of alcohol dependence; and

--a combination of detoxification and rehabilitation.

Medicare guidelines for alcohol abuse treatment say that (1) detoxification can usually be accomplished in 2 to 3 days with an occasional need for up to 5 days, (2) rehabilitation can usually be accomplished in 16 to 19 days, and (3) combined detoxification and rehabilitation stays should generally not exceed 21 days. Some alcoholism treatment specialty hospitals use programs featuring chemical aversion therapy, which include shorter rehabilitation stays of about 10 days with later periodic reinforcement (or "recap") treatments of 1 or 2 days. In fiscal year 1984, Medicare paid about $128 million in hospital bills for about 51,000 inpatient treatments for alcoholism. Medicare payments for outpatient treatment for alcoholism are limited to $250 annually.

In the past, Professional Standards Review Organizations (PSROs) or private insurance companies, acting as Medicare intermediaries, had responsibility for enforcing Medicare's coverage guidelines. The Tax Equity & Fiscal Responsibility Act of 1982 (P.L. 97-248) established the utilization and quality control peer review (PRO) program, under which PROs have replaced the PSROs and intermediaries as reviewers of treatment provided to Medicare beneficiaries. As a condition of participation in Medicare, by November 15, 1984, all hospitals had to contract with a PRO for review of the necessity and appropriateness of the services provided to Medicare patients.

Medicare beneficiaries treated as inpatients for alcohol-related conditions may be classified into one of four DRGs depending on the diagnosis of their condition. The four DRGs are:

DRG	Title
433	Substance use and substance induced organic mental disorders; patient left treatment against medical advice
436	Alcohol dependence
437	Alcohol use except dependence
438	Alcohol and substance induced organic mental syndrome

OBJECTIVES, SCOPE, AND METHODOLOGY

Because the different types of care included under each alcoholism DRG require different amounts of hospital resources and because testimony at congressional hearings[1] indicated that unnecessary and noncovered alcohol-related services had been reimbursed in the past and thus may have been included in the 1981 data base used to set the prospective payment rates, we reviewed inpatient alcoholism treatments under Medicare. We reviewed (1) the 1981 Medicare Provider Analysis and Review (MEDPAR) data used in setting the prospective payment rates for alcohol-related treatments, (2) the results of a validation review of coverage for alcoholism services by HCFA's San Francisco regional office, (3) HCFA's patient bill data concerning alcohol-related treatments for the quarter ended March 31, 1984, and (4) the records for a total of 167 cases of alcohol-related treatments provided by eight hospitals located in five states.

Our objectives were to evaluate compliance with Medicare guidelines for inpatient treatment of alcohol abuse and to examine the effects of PPS on the delivery of and payment for alcoholism treatment services.

We performed our work at HCFA headquarters in Baltimore; at HCFA's regional offices in Dallas and San Francisco; and at hospitals, PSROs, and/or intermediaries in New Mexico, Texas, Oklahoma, Iowa, and Nebraska.

At HCFA offices, we interviewed agency personnel responsible for formulating and enforcing Medicare guidelines and reviewed those guidelines, contracts for PROs, and reports and

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[1]Hearings before the Subcommittee on Health and Long-Term Care, House Select Committee on Aging on June 10, 1983 ("Alcohol and the Elderly," Committee Publication #98-406), and the Subcommittee on Health, Senate Committee on Finance on July 27, 1982 ("Medicare Coverage of Alcoholism Treatment").

studies on the treatment of alcoholism. At PSROs and intermediaries, we interviewed personnel responsible for reviewing and/or processing and paying treatment claims. At the hospitals, we interviewed personnel involved in alcoholism treatment and reviewed the medical records of Medicare beneficiaries and extracted data concerning the justification for the inpatient detoxification and rehabilitation stays. We used these data and consulted with our chief medical advisor regarding some cases to determine whether the need for inpatient care and length of stay was adequately documented. We selected the locations and claims judgmentally to provide a cross section of locality and treatment modes. The rationale for our selections is detailed in enclosure I to this letter.

We obtained and analyzed the 1981 data HCFA used in computing the DRG weights and analyzed HCFA's patient payment data for alcohol abuse treatments provided Medicare beneficiaries for the quarter ended March 31, 1984. For these analyses, we included cases concerned only with alcohol abuse and excluded cases of substance abuse. The 1981 HCFA data come from the MEDPAR file, which is a 20-percent sample of Medicare discharges. About 94 percent of the claims for treatment in 1981 and over 90 percent of the 1984 claims were classified into either DRG 436 or 438. We concentrated our review on those two DRGs because of the large proportion of alcoholism cases they represent and because DRGs 433 and 437 contain cases which are not likely candidates for rehabilitation stays. The cases in the former DRG are persons who choose to discontinue treatment, and the latter are cases diagnosed as alcohol abuse without alcohol dependence.

We also reviewed the contracts that HCFA had signed with 14 PROs. The contracts were selected judgmentally as follows: (1) contracts covering states included in our review, (2) a contract covering another state which a HCFA official had suggested might contain specific review objectives for alcoholism treatment, (3) a contract from a state in HCFA's San Francisco region, and (4) seven other contracts selected to cover other geographical areas of the country.

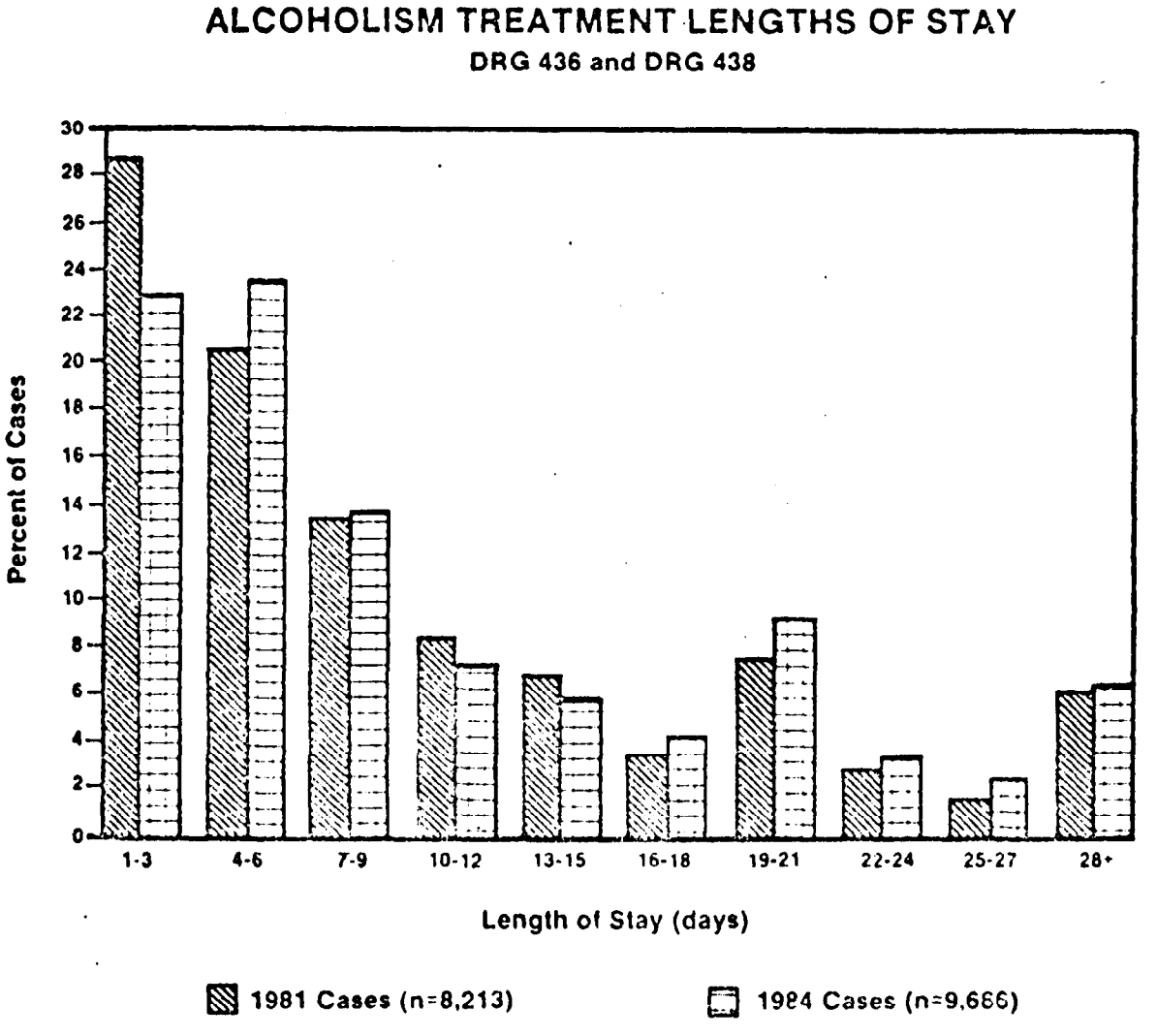
We also reviewed the methodology and supporting workpapers for the 1982 review of alcoholism treatment prepared by HCFA's San Francisco regional office. We examined follow-up records at that office and interviewed officials involved in the review and subsequent enforcement actions by the regional office.

Our fieldwork was conducted from October 1983 until November 1984. Our work was conducted in accordance with generally accepted government auditing standards.

PPS FOR ALCOHOLISM TREATMENT NEEDS ATTENTION

Medicare prospective payment rates do not accurately reflect the cost of alcoholism care for most individual cases because the DRG rates were computed by averaging hospital stays for various levels of care to produce standard rates which typify few of the actual treatments.

The standard reimbursement rates for DRGs 436 and 438 presume typical stays of 8.1 and 6.9 days, respectively, but most patients treated for alcoholism are hospitalized for periods substantially different from these stays. The lengths of stay for the 1981 and 1984 cases we analyzed are summarized below:



Only about 14 percent of the treatments in the 1981 and 1984 data bases involved hospital stays of 7 to 9 days, the range in which the standard lengths of stay represented by DRGs 436 and 438 fall. Shorter detoxification and "recap" type stays of 1 to 3 and 4 to 6 days for which the DRGs would probably overpay the hospitals accounted for over 45 percent of the cases in both years. On the other hand, hospitals would probably be underpaid for the about 35 percent of longer rehabilitation or combination-type stays, especially for the more than 20 percent of the cases exceeding 16 days.

HCFA is aware that the DRG payment rates for alcoholism treatments may be inequitable and has initiated a study of hospital discharges to see if the alcoholism DRGs can be modified to more equitably reimburse hospitals. For this study, HCFA instructed hospitals to submit data indicating whether patients treated for alcohol abuse received detoxification services, rehabilitation services, or both. Also, as mentioned above, HCFA has allowed hospitals or units of hospitals that specialize in alcoholism treatment to request exclusion from PPS until October 1, 1985, and to remain on cost reimbursement until then. This may be an expensive solution to the problem because the exempted providers will be paid the costs of their treatment programs while nonexempt providers will have an economic incentive to provide only detoxification treatments, which would usually be overpaid by the DRG payment mechanism.

HCFA's efforts to obtain better data to develop DRGs that more appropriately reflect the different lengths of stay for detoxification or rehabilitation treatments are a step in the right direction, but HCFA's study should be modified to assure sufficient data are developed. HCFA has made no provision to check the accuracy of hospitals' reports concerning whether treatments included detoxification services, rehabilitation services, or both.

In addition, HCFA should recognize that reports from hospitals using chemical aversion therapy will include relatively short initial stays and brief recap stays. These treatments will distort the data if included as regular rehabilitation stays.

ENFORCEMENT OF MEDICARE GUIDELINES HAS BEEN LAX

Medicare has provided guidelines limiting coverage for alcohol-related services. However, a HCFA San Francisco region study and our review indicate that certain PSROs and intermediaries have not adequately enforced Medicare's alcoholism treatment guidelines. As a result, Medicare has paid for alcoholism care whose coverage was questionable.

For treatment of alcoholism, Medicare's guidelines (Section 35-22 of the coverage issues appendix to Medicare's Part A Intermediary Manual) state that:

--Detoxification treatment on an inpatient basis is reasonable and necessary when a high probability or occurrence of medical complications (for example, delirium, confusion, trauma, or unconsciousness) requires the constant availability of physicians and/or complex medical equipment found only in the hospital setting.

--Rehabilitation treatment as a hospital inpatient is generally necessary if either (1) the physician documents that recent alcoholism rehabilitation services in a less intensive setting have proven unsuccessful or (2) the patient has concomitant medical condition(s) which warrant hospitalization. Treatment must also satisfy the "active treatment" criteria, which among other things requires that the care be reasonably expected to improve the patient's condition.

--Readmissions to a hospital, which include follow-up, reinforcement, or "recap" treatments, may be covered if there is documentation that such readmission can reasonably be expected to result in improvement in the patient's condition. For example, the documentation should indicate what changes in the patient's circumstances make improvement likely, or why the initial treatment was not sufficient. Prior admissions to the same or different hospitals may be an indication that the "active treatment" requirements are not met (that is, there is no reasonable expectation of improvement), and the stay should not be covered.

In 1982, HCFA's San Francisco regional office examined hospital records for 104 patients treated at six hospitals in Arizona, California, and Nevada. Regional HCFA staff and medical consultants concluded that 75 percent of the 1,751 treatment days should not have been covered under Medicare and attributed this problem to ineffective utilization review. Payments for these unnecessary services were about $325,000. The regional office was instrumental in encouraging PSROs and intermediaries within its region to impose stronger utilization controls over alcoholism treatment. As a result, region-wide hospital admissions for alcoholism treatment declined by 47 percent. This statistic is based on the regional office's comparison of hospital admissions in the region reported by 16 PSROs and 1 intermediary for various time periods before and after the introduction of stricter utilization controls in October 1982.

The San Francisco office's initiative did not stimulate action in other parts of the country. HCFA revised the Medicare guidelines, effective in September 1982, to clarify the

circumstances which would generally indicate the need for inpatient alcoholism treatment, but to our knowledge only the San Francisco regional office took action to improve compliance with Medicare guidelines. In July 1984, HCFA's Chief, Institutional Services Branch, Division of Provider Services Coverage Policy, told us that to his knowledge neither HCFA headquarters nor the other nine regional offices took action as a result of the San Francisco office's effort, which was summarized in a report to HCFA headquarters in August 1983 and made available to the other regional offices. The Special Assistant to HCFA's Associate Administrator for Operations also observed that heightened enforcement actions were confined to the San Francisco region, based on his knowledge as of April 1985. He also said that utilization problems with alcoholism treatment were probably present nationwide but may have been a low priority of PSROs and intermediaries.

We reviewed the efforts of three PSROs and five intermediaries[2] to enforce Medicare's alcoholism treatment guidelines in five states in HCFA's Dallas and Kansas City regions. We found that (1) the PSROs had delegated nearly all claims review responsibility to providers, (2) none of the intermediaries were routinely reviewing necessity of hospital admissions for alcohol-related treatments, and (3) only two intermediaries were routinely screening length of stay for alcohol-related treatments.

We reviewed the hospital records for 167 inpatient alcoholism treatments at a total of eight hospitals in New Mexico, Texas, Oklahoma, Iowa, and Nebraska. We looked for documentation in the records regarding the necessity of inpatient treatment. In our opinion, the need for inpatient treatment was not adequately documented for 3,528 days (or 82 percent) of the 4,300 days of care we reviewed. Our results are similar to those of HCFA's San Francisco region and suggest that the overutilization identified by that region was not a local problem.

The treatments we questioned included

--166 days of inpatient detoxification for which the records did not indicate that the beneficiary was experiencing or was likely to experience medical complications,

--1,715 days of inpatient rehabilitation for which the records did not indicate that a prior attempt in a less intensive setting was unsuccessful or that the patient had a concomitant condition requiring hospitalization,

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[2]Our field work was concluded before PROs assumed responsibility for reviewing the necessity and reasonableness of treatments.

--563 days of care for readmissions to inpatient treatment without documentation explaining how the additional stays could reasonably be expected to improve the patients' condition, and

--1,084 days of treatment provided in excess of Medicare's length-of-stay guidelines without documentation substantiating the necessity of the additional treatment.

We discussed our findings with representatives of the hospitals, intermediaries, and/or PSROs. In general, they agreed that the documentary evidence supporting the treatments should have been better. Hospital representatives believed that at least some of the treatments could be justified by additional documentation. Our estimate of the Medicare reimbursement for the questionable services is $1.1 million.

Concerning combined detoxification and rehabilitation programs, Medicare guidelines state that

> "Fiscal intermediaries should apply the guidelines* * * to both phases of a combined inpatient hospital alcohol detoxification/rehabilitation program. Not all patients who require the inpatient hospital setting for detoxification also need the inpatient hospital setting for rehabilitation."

In reviewing the records of those beneficiaries who received both detoxification and rehabilitation services, we looked for documentation for decisions on the appropriate setting for each phase of treatment.

Our sample of 167 claims included 124 claims which had both a detoxification and rehabilitation stay, and in only 11 cases were both phases justified in the documentation. For 49 cases, neither phase had justification documentation. For the other 64 cases, either the detoxification or rehabilitation phase lacked justification. The questionable treatment days for these combined treatments are included in the figures cited above.

Case examples illustrating the types of questionable services we found are summarized in enclosure II. Case examples 3 and 4 included payments for treatment beyond Medicare's general 21-day limit (see p. 3) without documentation justifying the need for such care. As a more current indicator, we used payment data for all Medicare providers for the quarter ended March 31, 1984, to determine the volume of payments for care in excess of 21 days under DRGs 436 and 438. For that period, 1,212 (about 12 percent) of the 9,666 inpatient alcoholism stays exceeded 21 days.

PROs OFFER THE PROMISE OF IMPROVED UTILIZATION REVIEW

PROs have replaced PSROs and intermediaries as reviewers of the necessity and reasonableness of treatments furnished to Medicare beneficiaries. The PRO arrangement offers the promise that more attention will be given to alcohol-related claims, but we believe that additional actions are necessary for effective utilization control.

While PSROs were allowed to delegate admissions review to hospitals, HCFA is requiring that PROs conduct such reviews. This change could facilitate stricter enforcement of Medicare's coverage guidelines because the reviewing entity will be independent of the hospital.

HCFA is also requiring PROs to (1) review a minimum 5 percent random sample of all Medicare admissions, (2) develop a plan to review Medicare admissions to and days of care in alcoholism detoxification and rehabilitation units, and (3) review all transfers to alcoholism treatment units which are distinct parts of acute hospitals and have been exempted from PPS. These requirements may also facilitate better oversight of alcoholism treatment.

The 14 PRO contracts we reviewed generally contained some provisions for review of alcoholism claims, but while 3 addressed all aspects of Medicare's guidelines for alcoholism treatment coverage, 11 contracts did not. For example:

--Seven contracts included criteria which did not mention the requirement for physician documentation of recent unsuccessful rehabilitation attempts in an outpatient or less intensive setting before admitting a patient for rehabilitation.

--Seven contracts did not mention the requirement for documentation of how readmissions can reasonably be expected to improve the patients' condition.

--One contract would permit inpatient rehabilitation treatment for up to 24 days rather than Medicare's 19-day guideline.

We believe that HCFA should assure that PROs use review criteria which address all aspects of Medicare's alcoholism coverage guidelines.

CONCLUSIONS

The DRGs do not account for different levels of alcohol abuse treatment and thus probably pay providers too much for detoxification treatments and not enough for rehabilitation

treatments. HCFA is studying the DRGs, but we believe HCFA needs to refine the study to verify the accuracy of the data collected and recognize that rehabilitation treatments may be of different types and varying lengths, especially the "recap" or reinforcement treatments associated with chemical aversion therapy.

Medicare guidelines for the treatment of alcohol abuse were not adequately enforced in the past. As a result, Medicare has paid for inpatient care whose coverage was questionable. The experience of HCFA's San Francisco regional office shows that utilization review can reduce hospital admissions. The PROs may improve on the PSROs' and intermediaries' alcoholism claims review efforts, but many PRO contracts do not contain assurances that all aspects of Medicare's coverage guidelines will be applied in their reviews.

RECOMMENDATIONS

We recommend that you:

--Refine the study of the alcoholism treatment DRGs by (1) verifying, on a sample basis, the data submitted by hospitals and (2) identifying and accounting for all types of treatments (detoxification, rehabilitation, combination and "recap" or reinforcement treatments).

--Ensure that PROs use alcoholism treatment review criteria that are consistent with and cover all aspects of Medicare guidelines for alcoholism treatments.

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We would appreciate hearing from you within 30 days on whatever action you take or plan concerning our recommendations.

Sincerely yours,

Thomas Dowdal

Thomas Dowdal
Group Director

Enclosures - 2

CRITERIA FOR SELECTION FOR HOSPITALS AND TREATMENT CLAIMS

	Hospitals		Claims		
tate	Basis for selection	Number	Basis for selection	Number reviewed	Treatment days
ew Mexico	Providers with the highest frequency of alcoholism treatments exceeding 21 days.	2	Random sample of alcoholism claims for each selected hospital paid in 1982	43	722
exas	Convenience - claims were readily available at the intermediary (Mutual of Omaha)	1	All recently paid claims for which medical records were readily available	7	153
klahoma	Three of the 10 providers with the highest frequency of alcoholism treatments	3	All 1982 and 1983 claims with alcoholism care exceeding 21 days	89	2,674
owa	Convenient because location was in the same city as the PSRO	1	Random sample of 20 of the 38 Medicare alcoholism treatments for 1983	20	532
ebraska	Convenient because location was in Omaha near the intermediary	1	Recently paid claims readily identifiable from the intermediary's payment records	8	219
		8		167	4,300

CASE EXAMPLES OF QUESTIONABLE ALCOHOLISM TREATMENTS

EXAMPLE 1

In New Mexico, a 65-year-old patient was admitted to a hospital's 21-day detoxification and rehabilitation program with a diagnosis of alcoholism and probable minor hypertension (high blood pressure). The patient had completed the full 21-day program at this same hospital 2 months earlier, but there was no documentation in the record to indicate what changes in the patient's medical condition, social or emotional status, or treatment plan made improvement likely for this latest admission. The admitting history and physical for this patient mentioned that no alcohol withdrawal problems had been experienced in the past, and there was no evidence that the patient's high blood pressure constituted a condition requiring hospital-level care. File notes during treatment stated that the patient had poor participation in group sessions and, 2 days before discharge, that the prognosis for sobriety was poor. The 21-day detoxification and rehabilitation treatment cost Medicare $3,844.

EXAMPLE 2

Also in New Mexico, a 44-year-old disabled patient was admitted intoxicated and spent 7 days detoxifying before being transferred to the rehabilitation unit for 14 days of care. The only evidence of prior treatment was a note of 1977 detoxification in a Veterans Administration hospital. The medical file contained no documentation that accompanying medical conditions required hospitalization, and during the rehabilitation phase the patient spent much of his time watching television and visiting fellow patients and nurses. Clinical progress notes on the night before discharge state that "progress has been poor and his stay here in treatment was because he had no other place to go". Three days earlier the notes read "no real clinical progress* * * little insight to mechanisms underlying his drinking." The detoxification period was justified by evidence of potential medical complications. There was no evidence of (1) recent unsuccessful alcohol rehabilitation services in a less intensive setting or (2) concomitant medical conditions warranting hospitalization to justify the 14 rehabilitation days. We estimated the Medicare cost of this beneficiary's rehabilitation treatment was about $4,300.

EXAMPLE 3

In Oklahoma, a 76-year-old patient was admitted to the hospital for 5 days of detoxification and 23 days of rehabilitation. The record shows this patient's drinking began at age 15 and that he had been arrested five times for driving while intoxicated and had spent a total of 4 months in jail for those offenses. On an earlier rehabilitation attempt at this same

hospital, the patient was accompanied by his probation officer with the choice of treatment or jail. In all, he had been hospitalized on five prior occasions for treatment of his alcoholism. For this readmission, the file contained evidence of medical need for inpatient detoxification, but there was no documentation showing how another inpatient rehabilitation stay could reasonably be expected to improve the patient's condition. We estimated that the Medicare reimbursement for the rehabilitation portion of the stay was about $7,900. Between February and September 1983, this patient was admitted for three additional alcoholism treatments totaling 45 days.

EXAMPLE 4

In Oklahoma a 35-year-old disabled patient was admitted for 5 days of detoxification and 22 days of rehabilitation despite a history of at least 10 prior treatments in hospital psychiatric wards and approximately 30 stays in a state hospital's alcohol unit. This readmission was not supported with a physician's statement of how the additional inpatient treatment could reasonably be expected to improve the patient's condition, and the patient's medical records did not contain evidence of complications or concomitant conditions to justify the inpatient detoxification or rehabilitation stay. Upon discharge the patient's prognosis was poor. Medicare reimbursement for these 27 days of questionable inpatient care was $8,305. Between May 1982 and January 1983 the patient was readmitted to the same hospital for three additional short alcoholism stays.

EXAMPLE 5

In Texas a 69-year-old patient was admitted for at least his fourth inpatient alcoholism treatment. The records contained evidence of potential medical complications to justify 4 days of detoxification, but under Medicare's guidelines the prior unsuccessful stays preclude rehabilitation coverage in the absence of documentation of how readmission can reasonably be expected to improve the patient's condition. This documentation was absent, and physician progress notes throughout the 17 days of rehabilitation indicated that the patient continued to deny his alcohol dependence and showed little or no progress. For example, the physician's note on day 15 read "patient still is in denial and is putting nothing into the program and is getting nothing out of it." Approximate Medicare reimbursement for the questioned rehabilitation portion of this stay was $5,200.