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# MEDICARE

# Excessive Payments for Medical Supplies Continue Despite Improvements

Statement of Jonathan Ratner, Associate Director
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GAO/T-HEHS-96-5

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to contribute to the debate over the fundamentals of the Medicare program and its management. We recently issued a report, based on an extensive body of GAO work over the last few years, that recommends the need for modern management strategies to help curb waste, fraud, and abuse in the Medicare program.[1] In that report, we note that for many supplies and services, the Medicare payment far exceeds market rates. We also report that the scrutiny of incoming claims is often inadequate to reveal overpricing or oversupply.

Today, I would like to discuss a report we prepared at your request to examine Medicare's payments for medical supplies, including surgical dressings.[2] Our findings provide a striking illustration of Medicare's excessive payment rates and the inadequacy of its payment controls.

In brief, this report makes several points:

-- When compared with wholesale and many retail prices, Medicare's payment rates for surgical dressings are generally excessive.

-- Medicare contractors that process claims for hospitals, nursing homes, and other institutions are unable to identify the specific items Medicare is being billed for, which makes it difficult for the contractors to determine whether the total charges are reasonable.

-- Medicare contractors that process claims for physicians and other providers have paid for some types of surgical dressings without reviewing high-dollar claims before payment.

-- Medicare's two types of claims processing contractors cannot cross-reference payment records to determine whether duplicate payments are being made.

Despite recent improvements in the way Medicare monitors payments for medical supplies, problems with high payment rates and controls over payments for supplies persist. Several actions, as addressed in our report, are needed to fix these problems. First, the Congress could grant the Health Care

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[1]Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

[2]Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Financing Administration (HCFA) the legislative authority to set payments at rates more favorable to large volume purchasers. Second, HCFA could require institutional providers to itemize their claims for medical supplies. This would help contractors not only identify unreasonable charges but also cross-reference the payment of claims by another contractor. Third, HCFA could direct its contractors, when new benefits are introduced, to implement controls that would flag for review high-dollar and high-volume claims before they are paid.

## BACKGROUND

Medicare provides health insurance coverage for approximately 37 million elderly and disabled people under two parts: part A, primarily hospital insurance, and part B, supplementary insurance. HCFA, an agency within the Department of Health and Human Services (HHS), is responsible for Medicare administration and oversight. HCFA contracts with insurance companies, called fiscal intermediaries for part A and carriers for part B, to process, review, and pay claims for covered services.

Payments for medical supplies are made under either of Medicare's two parts. Medical supply claims submitted by hospitals or other institutions, such as nursing homes or home health agencies, are paid by 43 fiscal intermediaries located throughout the country. Before October 1993, medical supply claims submitted by noninstitutional providers, such as physicians or medical supply companies, were paid by 32 carriers. In October 1993, in response to legislation, HCFA started consolidating carrier claims processing responsibility for durable medical equipment (DME), prosthetics, orthotics, and medical supplies, including surgical dressings, at four regional carriers, which are commonly referred to as DMERCs, Durable Medical Equipment Regional Carriers.

In March 1994, HCFA greatly expanded its surgical dressing benefit, broadening the types of dressings covered and the conditions under which they would be covered. For example, the benefit was expanded to cover payment for various types and sizes of gauze pads that Medicare previously did not cover. Also, the duration of coverage was extended from 2 weeks to whatever is considered medically necessary.

## MEDICARE SURGICAL DRESSING PAYMENTS ARE GENERALLY EXCESSIVE

For surgical dressings, Medicare often pays too much--more than wholesale and many retail prices. When we compared the rates that Medicare pays for surgical dressings with other available prices, we found that Medicare's fee-schedule payments are generally excessive compared with wholesale prices, prices

paid by the Department of Veterans Affairs (VA), and even retail prices. Overall, we estimate that HCFA could save substantial amounts if its fee schedule were calculated on the basis of lower available prices. For example, as shown in table 1, if HCFA paid wholesale prices for 44 surgical dressings, total savings would be almost $20 million, or almost 35 percent of what it now pays. Potential savings for just nine dressings would be more than $9 million if HCFA paid the lowest rate that the VA paid for the dressings. Even if HCFA had paid the lowest retail rates found at four Los Angeles area drug stores for nine surgical dressings, potential savings would be more than $2 million.

Table 1: Potential Medicare Savings on Surgical Dressings

| | | Estimated 1995 expenditures | | Potential savings | |
|---|---|---|---|---|---|
| Type of price compared | Number of dressings compared | Fee schedule | Compared price | Dollars | Percent of fee schedule |
| Wholesale | 44 | $57,113,852 | $37,388,654 | $19,725,197 | 34.54 |
| Lowest retail | 44 | 48,089,936 | 25,762,198 | 22,327,741 | 46.42 |
| Actual retail | 9 | 17,984,235 | 15,967,898 | 2,016,337 | 11.21 |
| VA | 9 | 17,055,044 | 7,871,643 | 9,183,401 | 53.85 |

The method HCFA used to calculate the fee schedule for surgical dressings caused these high payments. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) required HCFA to establish a fee schedule for surgical dressings by computing the average historical charges for the dressings. Because it had decided to expand the coverage for the types of surgical dressings it would pay for, however, HCFA did not have data on historical charges. Instead, HCFA used retail surgical dressing supply catalogs to create a price list for each type of covered surgical dressing. The amount of the median-priced dressing for each type became the fee-schedule amount.

If HCFA makes a mistake in calculating the fee schedule, it can correct the mistake (for example, if it used wholesale prices instead of retail prices). However, HCFA cannot change the methodology for determining the fee schedule nor can it adjust the fee schedule downward, even if the prices of dressings drop.

For certain DME items--but not for surgical dressings and other medical supplies--the Secretary of HHS can adjust prices that are not inherently reasonable.[3] In these cases, the authority is very limited and involves a complex set of procedures that can take a lengthy amount of time--as long as 3 years--to complete.

We believe that the fee-schedule approach to setting prices provides a good starting point for setting appropriate Medicare prices. As we have reported several times, however, HCFA needs greater authority and flexibility to quickly adjust fee schedule prices when market conditions warrant such changes. To allow Medicare to take advantage of competitive prices, the Congress should consider authorizing HCFA or its carriers to promptly modify prices for DME and other medical supplies.

## FISCAL INTERMEDIARIES DO NOT KNOW WHAT SUPPLIES THEY PAY FOR

Fiscal intermediaries do not know what they are paying for when processing claims for medical supplies. For part A claims, surgical dressings are not separately identifiable or billable. Rather, they are included in a broad medical supply category. The claims submitted by providers have no detailed information that would allow fiscal intermediaries to assess their reasonableness. This lack of detail exists because HCFA guidance allows providers to bill all medical supplies under 10 broad codes; billed items are not listed by type or amount. A code frequently used to record medical supplies, code 270, includes many different items. As a result, a $21,000 claim could be for a pacemaker or a truckload of 79-cent surgical sponges. This makes it difficult for the contractor to question whether charges are reasonable.

To gauge the potential impact of requiring itemization instead of billing under such broad codes, we requested that a fiscal intermediary obtain the medical records and an itemized list of supplies supporting 85 high-dollar medical supply claims submitted during a 1-month period. All of these claims had been processed without any review. The fiscal intermediary's subsequent review found that 89 percent of the claims for which documentation was received should have been totally or partially denied; and almost 61 percent of the dollars billed for these claims should have been denied for various reasons, including items not medically necessary, not covered by Medicare or covered as part of routine or administrative costs, no documentation of supplies used, no doctors' orders, and no itemized list of supplies. All claims for which documentation was not received were subsequently denied.

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[3] 42 U.S.C. 1395m(a)(10)(B).

## Legislation Partially Addresses Problem

OBRA 1993 partially addressed the broad billing code problem.[4] The legislation provided essentially for certain supplies, including surgical dressings, to be paid based on the fee schedule DME carriers use in the part B program. As a result, providers must submit such claims to fiscal intermediaries with an itemization of the specific supplies and quantities being billed. Because the provision does not apply to all medical supplies, however, many other types of medical supplies will still be billed using broad codes that do not adequately describe the types and amounts of such supplies being billed. Also, the OBRA 1993 provision does not apply to surgical dressing claims submitted by home health agencies, which billed Medicare for almost half a billion dollars of medical supplies in 1994.

As we recommend in our report, the Secretary of HHS should direct the HCFA Administrator to require that all part A bills itemize medical supplies. Related legislation for surgical dressings should be expanded to include all medical supplies and should apply to all providers billing the program, including home health agencies. Such itemization is required of all part B providers.

## DME CARRIERS HAVE PAID HIGH-DOLLAR CLAIMS WITHOUT QUESTION

Carriers have paid without question many high-dollar, high-volume part B surgical dressing claims. As of the end of fiscal year 1995, the DME carriers had not established important fraud and abuse controls that would trigger a review of claims. Specifically, the 29 surgical dressings covered as a result of the expanded surgical dressing benefit did not have formal criteria--called medical policies--specifying the conditions under which payment will be made. Without these policies, DME carriers have had no basis for identifying questionable claims.

We found that the utilization level--the number of dressings billed per beneficiary--was, on average, nearly three times higher for the newly covered dressings, that is, those without formal medical policies. Moreover, on average, the dressings not covered by medical policies exceeded the expected utilization level, as determined by recommended industry and draft DME carrier standards. In some cases, the average number of dressings billed per beneficiary was four times greater than expected.

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[4]P.L. 103-66, section 13544, 107 Stat. 312, 589.

A striking example of payments made in the absence of medical policies concerns claims Medicare paid for adhesive tape. During a 15-month period, suppliers billed for an average of 60 rolls of tape per beneficiary. Medicare paid one supplier, however, for an average of 268 rolls of tape per beneficiary during that period.

HCFA expanded surgical dressing coverage and instructed DME carriers to pay for newly covered surgical dressings before the carriers had a chance to develop new medical policies. As a result, most claims for surgical dressings that did not have payment policies were paid without a routine review to determine whether the amount of dressings billed was reasonable or medically necessary.

As of yesterday, the DME carriers put into place the medical policies covering new surgical dressing benefits, according to HHS. But the losses Medicare incurred until these policies were in place serve as a lesson for all newly covered benefits. As our report recommends, HCFA should, as a matter of course, develop and get approval for medical policies before the coverage of new benefits goes into effect.

MEDICARE SYSTEM IS VULNERABLE
TO DUPLICATE PAYMENTS

Medicare does not have effective tests to determine whether both DME carriers and fiscal intermediaries are paying for the same surgical dressings, medical supplies, and other items. As a result, nothing prevents Medicare from paying for the same item twice.

Surgical dressings and many medical supplies can be billed to either fiscal intermediaries or DME carriers, but Medicare does not have an effective control to prevent both types of contractors from paying for the same medical supplies or surgical dressings. Our review found evidence that Medicare has made such duplicate payments. In one instance, a fiscal intermediary paid a nursing home for 2 bedside drainage bags used by a patient during a 1-month stay, while, for the same patient, a DME carrier also paid a supplier for 30 drainage bags.

As we recommend in our report, HCFA needs to establish procedures to prevent duplicate payments by fiscal intermediaries and carriers. HCFA should be able to establish such procedures without too much difficulty if providers billing part A intermediaries were required to itemize medical supplies as we have recommended. Fiscal intermediaries and DME carriers both would receive claims that are itemized and, therefore, are in a similar format, making it easier for contractors to identify duplicate payments.

## IMPROVEMENTS MADE IN MONITORING MEDICAL SUPPLY PAYMENTS

Recent monitoring improvements should help reduce Medicare's vulnerability to fraud and abuse in this area. The consolidation of DME and medical supply claims processing at four regional carriers has several advantages. Medical supply and surgical dressing claims can receive more attention now than previously from local carriers. DME carriers specialize in processing these types of claims and are in a better position to detect and prevent payment of abnormally high claims for medical supplies. The consolidation also makes it easier to compile comprehensive national data--that were not available previously--on medical supply utilization and payments.

In 1993, HCFA also developed a programwide emphasis on data analysis. Calling its approach focused medical review, HCFA required contractors to begin identifying general spending patterns and trends that would allow them to identify potential problems. Fiscal intermediaries have started implementing this approach and some have identified the different types and number of claims that Medicare may be paying inappropriately. For example, as a result of one focused review, an intermediary denied 85 percent of the claims reviewed during a 1-month period, saving $5.8 million.

Moreover, some intermediaries have estimated how much Medicare can potentially save by tightening prepayment review controls. One intermediary identified eight problem areas, in addition to those it was already reviewing, that should be reviewed because of such things as precipitous increases in utilization rates. The intermediary estimated that focused reviews of these areas could save $57 million, but it did not have the resources to conduct these reviews.

Armed with this new information from DME carriers and focused medical review reports, HCFA is now much better positioned than in past years to provide HHS, the Office of Management and Budget, and the Congress with concrete information on contractor activities that save program dollars.

## CONCLUSIONS

Despite HCFA's claims monitoring improvements, some problems in paying for medical supplies remain for several reasons. The inflexibility of Medicare's fee schedule results in payment rates that are higher than wholesale and many retail prices. In addition, in the case of many part A claims, claims processing contractors do not know what they are paying for, and in the case of part B claims, have not had a basis for questioning unreasonably high charges. Neither type of contractor has been able to test claims for possible duplicate payments. For this

combination of reasons, Medicare has lost hundreds of millions of dollars in unnecessary payments.

We make several recommendations in our report to help correct these problems. By obtaining the legislative authority to modify payment rates in accordance with market conditions, requiring providers to itemize claims, and introducing the relevant medical policies before paying for new benefits, HCFA could reduce its dollar losses related to medical supply payments. Contractors could avoid paying unreasonable charges and making duplicate payments.

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Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or other Members of the Subcommittee may have.

For more information on this testimony, please call Jonathan Ratner, Associate Director, at (202) 512-7119. Other major contributors included Hannah Fein, Sam Mattes, and Don Walthall.

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