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Report to the Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, United States Senate

August 1995

MEDICARE

Excessive Payments for Medical Supplies Continue Despite Improvements

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August 8, 1995

The Honorable Tom Harkin
Ranking Minority Member
Subcommittee on Labor, Health
and Human Services, Education,
and Related Agencies
Committee on Appropriations
United States Senate

Dear Senator Harkin:

In fiscal year 1994 alone, Medicare was billed over $6.8 billion for medical supplies. Congressional hearings and government studies have shown that Medicare has been extremely vulnerable to fraud and abuse in its payments for medical supplies, especially surgical dressings. For example, hearings before the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies last year identified a case in which Medicare paid over $15,000 worth of claims for a month's supply of surgical dressings for one patient, apparently without reviewing the reasonableness of the claims before payment.

Until recently, medical suppliers had considerable freedom in selecting the Medicare contractors that would process and pay their claims. Some exploited this freedom by "shopping" for contractors with the weakest controls and highest payment rates. To address this problem, Medicare revised its payment rules to preclude suppliers from contractor shopping and established four regional contractors to specialize in processing these and similar types of claims.

This report responds to your request that we determine the (1) circumstances allowing payment for unusually high surgical dressing claims and (2) adequacy of Medicare's internal controls to prevent paying such claims.[1] To make these determinations, we obtained information from Office of Inspector General (OIG) and Health Care Financing Administration (HCFA) officials at the Department of Health and Human Services (HHS) and visited three types of contractors that process and pay Medicare claims. See appendix I for a more detailed description of our scope and methodology.

[1]Surgical dressings may also come under the broader category of medical supplies. In this report, we use the term medical supplies when this is the case. When referring solely to surgical dressings, we use that term.

Results in Brief

Although HCFA has made improvements to prevent contractor shopping, unwarranted expenditures persist for several reasons. First, many Medicare contractors still lack internal controls that would reliably identify suspicious medical supply claims before payment. Following are examples of the lack of controls:

- Contractors that pay medical supply claims submitted by nursing homes, home health agencies, and other institutional providers do so without knowing specifically what they are being asked to pay for on behalf of beneficiaries. Submitted claims lack sufficient detail, for example, to inform contractors whether they are being asked to pay more than $21,000 for a pacemaker or $.75 for a gauze pad.
- None of the four regional contractors automatically reviewed high-dollar claims for newly covered surgical dressings. This explains why a contractor paid $23,000 for surgical dressings when the appropriate payment was $1,650.
- Medicare does not have a systematic way of detecting duplicate bills submitted to different types of Medicare contractors, and we found some evidence that duplicate payments occur.

Second, Medicare payment rates for surgical dressings are high compared with wholesale and many retail prices. For example, Medicare pays $2.32 for a gauze pad whose wholesale price is $.19 and that another government agency purchases for $.04.

HCFA and its contractors know about these problems and have tried to address some of them. Though the problems persist, these efforts have provided more and better information to define the problem. This information suggests that inadequate controls are causing Medicare to lose hundreds of millions of dollars. HCFA could curtail these losses by establishing procedures to (1) identify what Medicare is being asked to pay for, (2) prevent duplicate payments, and (3) identify high-dollar, high-volume claims that should be reviewed before payment. Further, HCFA needs the legislative authority to set payments at rates more favorable to large-volume purchasers.

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, which administers the Medicare program, 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 local fiscal intermediaries. Medical supply claims submitted by noninstitutional providers, such as physicians or medical supply companies, are paid by carriers. Thus, the same supply item can be billed to Medicare for an individual under two completely different payment systems, one for part A and another for part B. Under part A, the payment is generally made on the basis of reasonable costs. Under part B, the payment is made using a fee schedule established by HCFA.

Historically, part B fraud and abuse have plagued Medicare, and HCFA has recently reformed its operations. In October 1993, acting under specific statutory authority,[2] HCFA started transferring carrier claims processing responsibility for durable medical equipment (DME); prosthetics; orthotics; and medical supplies, including surgical dressings, from 32 local carriers to 4 regional carriers. These carriers are commonly referred to as durable medical equipment regional carriers (DMERC).

In March 1994, after lobbying by suppliers and manufacturers, among others, 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.

Payment Control Weaknesses Led to Widespread Abuses

DME claims have long been abused, in part, because of fundamental weaknesses in Medicare payment controls. In response to these weaknesses, HCFA has recently implemented significant changes in the processing of DME claims to reduce Medicare's vulnerability to this particular fraud and abuse.

Lack of Systemwide Controls Led to Large Losses

Before DME claims processing was transferred to the 4 regional carriers in 1993, each of the 32 carriers paid DME claims, which represented a small part of the total claims each carrier processed. Under this process, HCFA

[2]42 U.S.C. 1395m(a)(12).

did not require its contractors to implement basic controls before payment that would identify and set aside for review those claims with unusually high per-patient expenditures or improbably large quantities of supplies. Without such controls, some DME suppliers billed for equipment never delivered, higher cost equipment than delivered, or totally unnecessary equipment or supplies. Further, suppliers frequently engaged in contractor shopping. Although, they might deliver equipment or supplies to beneficiaries in one state, they would bill a contractor in another state because that contractor paid more for the items delivered or had relatively weak payment controls for the equipment or supply items.

These weaknesses explain why Medicare contractors processed, without questioning, claims that later proved to be fraudulent or abusive. For example, as reported by the OIG, Medicare paid

- an estimated $20 million in claims for unneeded nutritional supplements and feeding kits;
- approximately $5.2 million in claims for oxygen concentrators, nebulizers, medications, and tests either not needed or not delivered;
- approximately $500,000 in claims for unneeded transcutaneous electrical nerve stimulators; and
- $7 million in claims for orthotic body jackets that should not have been paid.

Claims Processing System Reformed to Limit Losses

Establishing four regional carriers to process and oversee DME claims, including surgical dressings, eliminated some of the weaknesses that allowed prior abuses to flourish. The regional carriers are better able to prevent Medicare payments for unusually high medical supply claims for two key reasons.

First, the ability of suppliers to shop for contractors with the highest payments and weakest controls has been eliminated. With only four regional carriers, HCFA has better standardized the amount that Medicare pays for medical supplies and the controls used to detect and prevent payment of problem claims. Claims must be submitted to the regional carrier responsible for payments in the state where the beneficiary resides rather than the carrier allowing the highest payment.

Second, medical supply and surgical dressing claims can receive more attention from regional carriers than local carriers because these claims are a larger portion of the regional carriers' workloads. As a result, the

regional carriers should be better able to detect and prevent inappropriate payments for abnormally expensive surgical dressing claims.

Significant Vulnerabilities Continue Despite Improvements

HCFA's recent efforts to prevent abuses in medical supply claims apply only to part B claims submitted to regional carriers, which represent half of Medicare's total medical supply payments. Claims processed by fiscal intermediaries are still subject to some of the same fraud and abuse problems that have historically plagued medical supply claims. Further, despite the improvements, medical supply claims submitted to the regional carriers are still subject to significant abuse.

Fiscal Intermediaries Do Not Know What Supplies They Pay For

Fiscal intermediaries pay medical supply claims without knowing specifically what they are being asked to pay for on behalf of beneficiaries. The claims submitted by providers have no detailed information that would allow fiscal intermediaries to assess the claims' 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 is code 270 (medical/surgical supplies and devices-general classification), which we found included many different items, such as a $21,437 pacemaker, a $.75 sterile sponge, and even daily rental charges of $59 for an aqua pad. Consequently, unless fiscal intermediaries identify these claims for review and request additional documentation before payment, they will pay for the claims without knowing what the specific purchase was or whether it was covered or medically necessary. For example, a fiscal intermediary processed a code 270 claim for more than $21,000 without any review. At our request, the fiscal intermediary asked the provider to submit medical records and a list of items billed under this claim. After the fiscal intermediary reviewed the documentation to support this claim, it denied more than $13,000 in charges because the medical records contained no doctor's orders for the billed items.

In total, we requested the fiscal intermediary to obtain the medical records and an itemized list of supplies supporting 85 high-dollar medical supply claims submitted by 38 providers during a 1-month period. All of these claims had been processed without any review. The results of the fiscal intermediary's subsequent review are as follows:

- Eighty-nine percent of the claims for which documentation was received and reviewed (42 of 47) should have been totally or partially denied.
- Almost 61 percent of the dollars billed for medical supplies ($193,147 of $316,824) should have been denied for various reasons, including, among others, items not medically necessary, items not covered by Medicare or covered as part of routine or administrative costs, no documentation of supplies used, no doctor's orders, and no itemized list of supplies. (See app. II for detailed information.)[3]
- Forty-five percent of the claims for which documentation was not returned (38 of 85), totaling $487,412, was subsequently denied.
- One claim was determined to be potentially fraudulent because the beneficiary's condition required none of the $2,404 in medical supplies billed. A further review, by the fiscal intermediary's fraud and abuse unit, of the same provider's claims for this beneficiary for the previous 5 months resulted in the identification of an additional $20,393 in potentially fraudulent medical supply charges.

Fiscal intermediaries obtain similar or better results when they conduct their own prepayment reviews of medical supply claims. For example, a fiscal intermediary used a computerized payment control to identify all medical supply claims (code 270) in excess of $500 submitted between October and December 1993. After reviewing documentation supporting the claims, the fiscal intermediary denied 69 percent of the dollars billed ($59,542 of $86,046).

Legislation Partially Addresses Problem

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) partially addressed the problem of providers not submitting documentation that would allow fiscal intermediaries to adequately assess medical supply claims.[4] OBRA 1993 provided essentially for certain supplies, including surgical dressings, to be paid on the basis of the fee schedule that regional carriers use for the part B program. As a result, providers must submit to fiscal intermediaries claims that itemize the specific supplies and quantities being billed. Because the provision does not apply to all medical supplies, many other types of medical supplies are still billed using broad codes that do not adequately describe the type and amount of such supplies.

[3]In addition to the medical supplies that should have been denied on these claims, the fiscal intermediary reviewers also identified another $174,489 for items other than medical supplies that should have been denied. Consequently, total denials for these claims should have been $367,636 or an average of $7,822 for each claim reviewed. (See app. III for detailed information on the denial of nonmedical supplies.)

[4]Public Law 103-66, sec. 13544, 107 Stat. 312, 589.

The provision does not at all apply to surgical dressings supplied by a home health agency. As a result, home health agencies, which billed Medicare for almost half a billion dollars of medical supplies in fiscal year 1994, can continue to submit claims for surgical dressings without the detailed itemization required of other types of providers billing for these items.

Regional Carriers Still Lack Significant Controls

For Medicare part B claims, the regional carriers have not adopted important fraud and abuse controls for many surgical dressing items. Specifically, the 29 surgical dressings covered by the expanded Medicare surgical dressing benefit have no formal medical policies specifying the conditions under which payment is to be made.[5] Without these policies, regional carriers cannot implement systematic controls to identify questionable claims for review. As a result, they pay many high-dollar, high-volume claims without review.

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 for which no formal medical policies apply. Moreover, on average, the dressings that have no medical policies exceeded the expected utilization level, as determined by recommended industry and draft regional carrier standards. In some cases, the average number of dressings billed per beneficiary was four times greater than expected.

Formal medical policies for the newly covered dressings cannot be adopted until the surgical dressing industry and others have been allowed to comment on them. HCFA expanded surgical dressing coverage and instructed regional 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 for which no medical policies apply are being paid and will continue to be paid without a routine review to determine whether the amount of dressings billed is reasonable or medically necessary. HHS estimates that this process will be completed and medical policies will be effective October 1, 1995.

We asked officials at one regional carrier to identify high-dollar claims it paid. While the claims the carrier identified for us were subject to some review before payment, the review only applied to those dressings that

[5]See appendix IV for a description of all Medicare-covered surgical dressings, including the 29 newly covered dressings for which no medical policies apply.

had a formal medical policy. As a result, thousands of dollars were paid for surgical dressings that were not needed and the claims for which were not subject to review because they did not have formal medical policies.

For example, in the case of one beneficiary, the carrier—over 3 months and on the basis of a formal medical policy—had denied over $8,500 worth of claims for dressings and sterile saline before paying $23,000. However, in performing the review we requested, the carrier determined that only $1,650 of the $23,000 for dressings should have been paid because the beneficiary's condition did not appear to justify the use of large quantities of dressings. The $23,000 had been paid without review for medical necessity because no formal medical policies applied to most of the surgical dressings. Therefore, no internal policies were in place to trigger a review of these dressings.

Without such policies, suppliers have exploited Medicare with little risk of ever having to repay the program. Following are examples of this exploitation:

- One supplier regularly billed Medicare for 60 or more transparent films per beneficiary per month. For some beneficiaries the supplier billed for 120 or more films a month. Recommended industry standards suggest the need for no more than 24 films per beneficiary per month.[6]
- Another supplier billed Medicare an average of 268 units of tape per beneficiary during a 15-month period.[7] The average for all suppliers was 60 units during the 15-month period. Some beneficiaries received between 180 to 720 units of tape in 1 month. Using a 10-yard roll of tape, a common industry length, these beneficiaries would have been wrapped in 60 to 240 yards of tape per day.

Supplier abuse is not limited to surgical dressings; other medical supply items for which no formal policies or systematic controls apply have also been exploited:

- At least four suppliers regularly billed Medicare for 30 or more drainage bottles a month for each beneficiary. This is 90 times more than the

[6]According to the Wound Ostomy and Continence Nurses Society's and the Health Industry Distributors Association's draft recommendations on utilization levels for surgical dressings, up to two transparent films can be used per dressing change. In addition, these types of dressings should be changed no more than two to three times per week.

[7]According to the Health Industry Distributors Association, normal usage of tape is no more than two rolls per dressing change.

proposed standard of one bottle every 3 months.[8] The number of drainage bottles billed by these suppliers was 79 percent of all bottles billed to the regional carrier.

- One supplier billed Medicare an average of nine urinary leg bags per beneficiary a month. For some beneficiaries, the supplier billed for one leg bag a day or 15 times more than the proposed standard of two leg bags a month.[9] In total, this supplier billed Medicare for 50,834 leg bags or 21 percent of all leg bags billed to the regional carrier over 15 months.

Medicare System Vulnerable to Duplicate Payments

Medicare can pay for the same item twice because it does not have effective tests to determine whether both regional carriers and fiscal intermediaries are paying for the same surgical dressings, medical supplies, and other items. Surgical dressings and many medical supplies can be billed to either fiscal intermediaries or regional carriers. If suppliers submit claims for the same items to both types of contractors, only one should pay the claim. For example, if a fiscal intermediary pays a nursing home for surgical dressings, a regional carrier should not pay the supplier for the same dressings. Conversely, if a regional carrier pays a supplier for surgical dressings, the fiscal intermediary should not pay the nursing home that used the dressings.

Medicare does not have an effective control to prevent both types of contractors from paying for the same medical supplies or surgical dressings. As part of Medicare's claims processing system, all claims received by contractors are compared with historical beneficiary data to verify eligibility for payment and benefits. HCFA uses this system to conduct many types of computerized controls to determine if payment for the claims should be approved or rejected. The system does not check, however, to see if items paid by regional carriers have already been paid by fiscal intermediaries or whether items paid by fiscal intermediaries have already been paid by regional carriers. We identified a case in which a computerized control for duplicate items would have prevented Medicare from paying twice for the same item.[10] In this case, the fiscal

[8]According to the regional carriers' draft payment and coverage policy, drainage bottles are usually changed once every 3 months.

[9]According to the regional carriers' draft payment and coverage policy, leg bags are usually replaced twice a month.

[10]We randomly selected 25 of the 85 high-volume, high-dollar claims that the fiscal intermediary reviewed at our request to determine the appropriateness of the payments made. On the basis of dates of service, we determined that 6 of these 25 claims were potential duplicate payments. Of these six claims, we found one duplication and another that appeared to be a duplicate payment. In the latter case, we could not be sure of the duplicate payment because the supplier did not provide the fiscal intermediary with requested documentation supporting the claim.

intermediary paid a nursing home for two bedside drainage bags used by a patient during a 1-month stay. A regional carrier also paid a supplier for 30 drainage bags allegedly provided to the same patient while in the nursing home. If a duplicate payment control had existed, the regional carrier would not have made the duplicate payment.

Medicare Surgical Dressing Payments Generally Excessive

Medicare's fee schedule payments for surgical dressings are generally excessive when 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 was 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 at the lowest rate, that which VA paid for dressings. We even identified potential savings of more than $2 million for nine surgical dressings if HCFA paid at the lowest retail rates found at four Los Angeles-area drug stores.

Table 1: Potential Medicare Savings on Surgical Dressings

Type of price compared	Number of dressings compared	Estimated 1995 expenditures		Potential savings	
		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

Note: See appendix V for detailed tables for each type of price compared.

HCFA's method of calculating the fee schedule for surgical dressings caused these high payments. OBRA 1993 required HCFA to establish a fee schedule for surgical dressings by computing the average historical charges for the dressings. Because of the expansion of the surgical dressing benefit, however, HCFA did not have data on historical charges. Instead, HCFA used a gap-filling process to establish the fee schedule: HCFA used retail surgical dressing supply catalogs to create a price list for each type of covered surgical dressing. The price of the median-priced dressing for each type became the fee schedule price. For example, HCFA identified 13 different

alginate dressings 16 square inches or less (HCFA Common Procedure Code K0196). The retail prices of the dressings ranged from $3.14 to $19.07. The fee schedule price was set at $6.62, the median-priced or sixth dressing on HCFA's list. The lowest wholesale price for this type of dressing is $1.88.

If HCFA makes a mistake in calculating the fee schedule, it can correct the mistake (for example, by using wholesale prices instead of retail prices). However, HCFA may not change the methodology for determining the fee schedule nor may it adjust the fee schedule if dressing prices decrease. Therefore, if, as one HCFA official told us, the prices of surgical dressings fall as more manufacturers produce the many types of surgical dressings that HCFA now pays for, HCFA cannot lower the fee schedule to reflect the change in market condition. Instead, Medicare will pay a price that is even higher, relative to the market prices, than it pays today.

For certain DME items—but not for surgical dressings and other medical supplies—the Secretary of HHS may adjust prices that are inherently unreasonable.[11] In these cases, the authority is very limited and involves a complex set of procedures that can take a long time to complete. For example, it took HCFA nearly 3 years to reduce the price it was paying for home blood glucose monitors from a nationwide range of $144 to $211 to $58.71, even though they were widely available for about $50 and, in some cases, provided free as a means of obtaining customers for the disposable items associated with this test equipment. Because of the time and resources involved, HCFA only uses this process for one item at a time.

Before 1987, individual Medicare carriers had the authority to increase or decrease prices to reflect local market conditions.[12] The process for doing so, which included notifying area suppliers and publishing the new prices, could be completed in less than 90 days. If HCFA or the carriers had the authority to adjust excessive prices in a timely manner, they could save millions in program dollars. A HCFA official told us, however, that it devotes no resources to routine monitoring of medical equipment and supply prices. As a result, discrepancies in price between what Medicare pays and what other large-volume buyers pay go undetected.

[11] 42 U.S.C. 1395m(a)(10)(B).

[12] The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203, sec. 4062(b), 101 Stat. 1330, 1330-100) effectively eliminated the carriers' inherent reasonableness authority regarding DME, prosthetics, and orthotics paid for through the fee schedule and prohibited HCFA from using such authority until 1991. The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360, sec. 411(g)(1)(B)(xiii), 102 Stat. 683, 782) provided that HCFA's authority could be exercised only through a burdensome regulatory process that previously had been applied only to physician services and includes publication in the Federal Register.

HCFA Initiatives Show Promise

HCFA recently created a framework that eventually will allow it to identify and begin addressing fraud and abuse associated with medical supply claims. For the first time, HCFA will have data to begin assessing the size and scope of fraud and abuse and its contractors' performance in addressing them. In addition, these data will allow HCFA to assess options for addressing program weaknesses.

HCFA's consolidation of DME and medical supply claims processing at four regional carriers provides comprehensive national data—that were not available previously—on utilization and payments. These data will allow HCFA to identify, on a nationwide basis, DME and medical supplies that may be subject to overutilization and inappropriate billing. 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 have recently begun compiling and analyzing claims payment and utilization data. So far, some intermediaries have identified the different types and number of claims that Medicare may be inappropriately paying. For example, one type of review conducted by an intermediary we visited resulted in 85 percent of the claims reviewed during a 1-month period being denied—a total of $5.8 million in program savings. Moreover, some intermediaries have estimated the dollars that Medicare can potentially save by tightening prepayment review controls. The intermediary we visited identified eight other problem areas, in addition to those that it was already reviewing, that should be reviewed because of such things as precipitous increases in utilization rates. This intermediary estimated potential savings of $57 million by implementing the additional reviews, but it did not have the resources to do so.

Armed with its new information from DMERCs and focused medical review program 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. This information could include, for example, explicit documentation on the savings achievable from efforts to stop paying unwarranted or overpriced claims.

Conclusions

HCFA has taken some initial steps to address Medicare medical supply and surgical dressing payment abuses. Transferring the processing to regional carriers—and the accompanying greater standardization of payment policies and better information to detect problem claims—are important steps in combatting fraud and abuse.

Medicare's vulnerability to overpaying for surgical dressing claims will persist, however, for several reasons:

- Many claims for surgical dressings lack sufficient detail for Medicare fiscal intermediaries to assess what they are being asked to pay for.
- Medicare contractors have not yet developed the administrative capabilities to detect questionable claims for many surgical dressings.
- Though the same patient may receive surgical dressings paid by either a part A intermediary or part B carrier, HCFA has no controls to detect duplicate bills.
- Medicare's payment rates for dressings are high compared with wholesale and many retail prices.

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to

- require that bills submitted to fiscal intermediaries itemize supplies;
- develop and implement prepayment review policies as part of the process of implementing any new or expanded Medicare coverage; and
- establish procedures to prevent duplicate payments by fiscal intermediaries and carriers.

Matter for Congressional Consideration

The fee schedule approach to setting prices provides a good starting point for setting appropriate Medicare prices. HCFA, however, 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. For this to work effectively, however, HCFA or the carriers must devote adequate resources to routine price monitoring.

HHS Comments and Our Evaluation

HHS commented on a draft of our report in a letter dated July 18, 1995 (see app. VI). In an overall comment, HHS stated that several ongoing Medicare initiatives involving the four regional carriers are already addressing the

problems highlighted in this report. Specifically mentioned were the use of information from processed claims to identify for prepayment review suspicious suppliers and high-dollar, high-volume claims; prepayment screens to detect egregious utilization of a supply item; and comprehensive medical reviews of suppliers whose billing patterns indicate possible overutilization.

As we have stated in this report, a number of HCFA initiatives show promise. We specifically mentioned that transferring the claims processing for DME and supplies to four regional carriers gives HCFA the ability to identify overutilization and inappropriate billing. We also mentioned that the programwide emphasis on data analysis through focused medical review identifies potential problem areas. While such initiatives are promising, we do not believe that they or the other promising activities of the four regional carriers address all the problems identified in this report.

For example, HHS disagreed with our first recommendation that bills submitted to fiscal intermediaries itemize supplies. HHS stated that it had assessed the benefit of requiring providers to itemize home health supply bills and found that the additional contractor and provider cost and burden outweighed the value of the itemization. As an alternative, HHS stated that it is assessing the benefit of requiring fiscal intermediaries to suspend for prepayment review those bills with excessive charges. Also, HHS believed that it was important to note that HCFA does not pay billed charges for this type of claim.

Without itemized bills, fiscal intermediaries cannot determine what type or amount of supplies they pay for. While it is true that HCFA does not pay the billed charges for this type of claim, to conclude that the cost settlement process will somehow account for all overpayments is inaccurate. Overpayments will still be made for unnecessary or excessive supplies or those not covered by Medicare.

HHS concurred with our second recommendation and said that it had acted to implement it. The action described, however, appears to be in response to the past expansion of surgical dressing benefits rather than plans for new or expanded Medicare coverage. For example, although agreeing that prepayment edits should be used to prevent inappropriate payment when coverage policy changes, HHS stated that a revised regional medical review policy for the recently expanded surgical benefits will be effective October 1, 1995. HHS also stated that it is important to ensure that the

regional carriers have the flexibility to establish their own edits based on aberrancies found in their region.

While the policies on the expanded surgical dressing benefit need to be implemented as soon as possible to protect benefit dollars, our recommendation would require that medical policies be developed and approved before any further changes in benefit coverage are made. Without medical policies, carriers cannot establish prepayment edits for items newly covered because of changes in Medicare benefits. As we discussed, regional carriers have been paying claims for 29 newly covered dressings for nearly a year and a half without medical policy or prepayment edits—that is, without a review of the claims' reasonableness or medical necessity.

Concerning our recommendation that procedures be established to prevent duplicate payments by carriers and intermediaries, HHS stated that identifying duplicate claims is difficult when they are sent to different part A and part B contractors because the claims are submitted with different codes and supplier numbers and then processed using different payment schedules and processing systems. In what it described as an effective alternative, HHS stated that HCFA currently uses "conflict edits" through the Common Working File system to alert contractors to conflicting payment situations. For example, if part B is being billed for outpatient supplies for a specific date and part A receives an inpatient claim for the same patient covering the same period, the system generates an alert. Questionable claims are then manually reviewed before payment, according to HHS. In the future, with Medicare's new claims processing system, the Medicare Transaction System, HHS stated that it will be simpler to identify duplicate claims because the same system will process part A and part B claims in the same format.

As a result of OBRA 1993, surgical dressings can be identified with the same codes regardless of which contractor, part A or part B, processes and pays a claim. Combining a common identification code with the Common Working File's ability to identify claims for which part A and part B contractors both receive a claim for the same beneficiary covering the same time period allows contractors to easily identify a potential duplicate payment. This ability applies to all medical supplies that use the same identification code. For example, we identified one case in which Medicare paid twice for a supply item using the same code for both the part A and part B contractor.

The Common Working File duplicate payment alert, or conflict edit, does not entirely prevent Medicare from paying for the same item twice. The system generates an alert only when an institutional provider, such as a nursing home or home health agency, has billed the intermediary before the supplier has billed the regional carrier. More importantly, officials at the four DMERCs told us that they do not investigate or review claims identified by the duplicate payment alert. Instead, they pay the claims without reviewing for duplication.

Concerning the matter for congressional consideration, HHS has stated that on several occasions since 1987, it has submitted legislative proposals to the Congress to simplify the process it may use to adjust or limit fee schedule amounts.

HHS also made a number of technical and other comments that we considered in finalizing this report.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties.

Please call me on (202) 512-7119 if you or your staff have any questions about this report. Major contributors are listed in appendix VII.

Sincerely yours,

Sarah F. Jaggar
Director, Health Financing
and Policy Issues

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Abbreviations

DME	durable medical equipment
DMERC	durable medical equipment regional carrier
HCFA	Health Care Financing Administration
HCPC	HCFA Common Procedure Code
HHS	Department of Health and Human Services
OBRA 1993	Omnibus Budget Reconciliation Act of 1993
OIG	Office of Inspector General
VA	Department of Veterans Affairs

Scope and Methodology

To identify the circumstances allowing the payment of unusually high surgical dressing claims, we interviewed OIG officials from HHS and reviewed past OIG and GAO reports on Medicare fraud and abuse problems. We also visited Transamerica, one of the many carriers that processed medical supply claims before the creation of the four regional carriers. This carrier was judgmentally selected.

To determine the adequacy of Medicare's internal controls, we visited Blue Cross of California, a fiscal intermediary that processes claims submitted by institutional providers; and CIGNA, one of the four regional carriers responsible for processing durable medical equipment (DME) and medical supply claims submitted by suppliers. These contractors were judgmentally selected. To supplement work performed at these locations and broaden our areas of analysis, we obtained information on medical supply and surgical dressing claims and payment safeguards from the remaining 42 fiscal intermediaries and three regional carriers. We also discussed the adequacy of contractors' internal controls and obtained information about these controls from HCFA officials at HHS.

In addition, we requested the two contractors that we visited, Blue Cross of California and CIGNA, to review medical records and other documentation for selected high-dollar medical supply claims to determine whether the records supported the need for services or items billed to Medicare. Further, we obtained recommended utilization standards from a trade association for medical supply distributors and a national association of specialty nurses for wound, ostomy, and continence care and compared the standards with actual utilization levels found on claims submitted by suppliers.

We compared the fee schedule that Medicare uses to pay suppliers of surgical dressings with prices obtained from a wholesale surgical dressing supplier, four retail drugstores, the Department of Veterans Affairs, and a HCFA-generated surgical dressing price list. We also reviewed HCFA procedures to determine if any would prevent regional carriers and fiscal intermediaries from paying duplicate claims for medical supplies and surgical dressings.

We performed our work between May 1994 and June 1995 in accordance with generally accepted government auditing standards.

Medical Supply Charges Denied

Claim number	Submitted charges	Denied charges	Percent of charges denied
1	$5,737	$5,737	100
2	157	25	16
3	2,404	2,404	100
4	373	373	100
5	752	349	46
6	13,254	262	2
7	1,545	1,545	100
8	400	0	0
9	10,161	8,738	86
10	6,216	680	11
11	7,921	7,194	91
12	21,071	13,154	62
13	6,196	3,206	52
14	1,743	34	2
15	5,965	0	0
16	676	215	32
17	8,218	224	3
18	18,479	8,106	44
19	3,432	3,432	100
20	366	366	100
21	190	0	0
22	2,957	24	1
23	3,607	78	2
24	1,108	1,019	92
25	2,313	2,281	99
26	3,860	2,889	75
27	2,041	1,573	77
28	33,363	33,363	100
29	2,145	2,145	100
30	633	383	61
31	2,871	490	17
32	2,121	344	16
33	7,968	80	1
34	53,869	44,517	83
35	11,331	11,331	100
36	642	0	0

(continued)

Claim number	Submitted charges	Denied charges	Percent of charges denied
37	11,192	149	1
38	6,707	6,707	100
39	18,101	18,101	100
40	481	481	100
41	5,926	5,926	100
42	518	296	57
43	3,876	442	11
44	12,465	176	1
45	6,124	0	0
46	1,059	18	2
47	4,290	4,290	100
Total	**$316,824**	**$193,147**	**61**

Nonmedical Supply Charges Denied

Claim number	Submitted charges	Denied charges	Percent denied
1	$9,328	$7,836	84
2	1,600	0	0
3	5,113	5,113	100
4	2,644	969	37
5	2,665	16	1
6	10,218	7,025	69
7	188	0	0
8	3,315	0	0
9	4,319	0	0
10	3,498	0	0
11	9,612	208	2
12	45,649	5,103	11
13	42,246	0	0
14	9,889	4,940	50
15	620	0	0
16	9,449	945	10
17	6,972	0	0
18	2,556	2,556	100
19	1,335	0	0
20	7,743	0	0
21	2,995	0	0
22	4,850	0	0
23	75,259	75,259	100
24	5,700	0	0
25	2,924	0	0
26	5,494	46	1
27	9,612	45	0
28	3,882	30	1
29	101,710	29,460	29
30	3,272	3,272	100
31	1,340	0	0
32	5,919	22	0
33	2,815	2,815	100
34	19,636	19,636	100
35	519	519	100
36	3,830	0	0
37	6,303	82	1

(continued)

Claim number	Submitted charges	Denied charges	Percent denied
38	4,634	1,277	28
39	10,412	1,059	10
40	514	0	0
41	6,256	6,256	100
Total	**$456,835**	**$174,489**	**38**

Surgical Dressings Covered by Medicare in 1995

HCFA Common Procedure Code	Description and unit of purchase	Newly covered by surgical dressing expansion
A4460	Elastic bandage, per roll (e.g., compression bandage)	X
A4649	Surgical supplies, miscellaneous	
K0154	Wound pouch, each	
K0196	Alginate dressing, wound cover, pad size 16 square inches or less, each dressing	
K0197	Alginate dressing, wound cover, pad size more than 16 but less than or equal to 48 square inches, each dressing	
K0198	Alginate dressing, wound cover, pad size more than 48 square inches, each dressing	
K0199	Alginate dressing, wound filler, per 6 inches	
K0203	Composite dressing, pad size 16 square inches or less, with any size adhesive border, each dressing	X
K0204	Composite dressing, pad size more than 16 but less than or equal to 48 square inches, with any size adhesive border, each dressing	X
K0205	Composite dressing, pad size more than 48 square inches, with any size adhesive border, each dressing	X
K0206	Contact layer, less than 16 square inches, each dressing	X
K0207	Contact layer, more than 16 but less than or equal to 48 square inches, each dressing	X
K0208	Contact layer, more than 48 square inches, each dressing	X
K0209	Foam dressing, wound cover, pad size 16 square inches or less, without adhesive border, each dressing	
K0210	Foam dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	
K0211	Foam dressing, wound cover, pad size more than 48 square inches, without adhesive border, each dressing	

(continued)

HCFA Common Procedure Code	Description and unit of purchase	Newly covered by surgical dressing expansion
K0212	Foam dressing, wound cover, pad size 16 square inches or less, with any size adhesive border, each dressing	
K0213	Foam dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	
K0214	Foam dressing, wound cover, pad size more than 48 square inches, with any size adhesive border, each dressing	
K0215	Foam dressing, wound filler, per gram	X
K0216	Gauze, nonimpregnated, pad size 16 square inches or less, without adhesive border, each dressing	
K0217	Gauze, nonimpregnated, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	
K0218	Gauze, nonimpregnated, pad size more than 48 square inches, without adhesive border, each dressing	
K0219	Gauze, nonimpregnated, pad size 16 square inches or less, with any size adhesive border, each dressing	
K0220	Gauze, nonimpregnated, pad size more than 16 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	
K0221	Gauze, nonimpregnated, pad size more than 48 square inches, with any size adhesive border, each dressing	
K0222	Gauze, impregnated, other than water or normal saline, pad size 16 square inches or less, without adhesive border, each dressing	X
K0223	Gauze, impregnated, other than water or normal saline, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	X
K0224	Gauze, impregnated, other than water or normal saline, pad size more than 48 square inches, without adhesive border, each dressing	X

(continued)

HCFA Common Procedure Code	Description and unit of purchase	Newly covered by surgical dressing expansion
K0228	Gauze, impregnated, water or normal saline, pad size 16 square inches or less, without adhesive border, each dressing	X
K0229	Gauze, impregnated, water or normal saline, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	X
K0230	Gauze, impregnated, water or normal saline, pad size more than 48 square inches, without adhesive border, each dressing	X
K0234	Hydrocolloid dressing, wound cover, pad size 16 square inches or less, without adhesive border, each dressing	
K0235	Hydrocolloid dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	
K0236	Hydrocolloid dressing, wound cover, pad size more than 48 square inches, without adhesive border, each dressing	
K0237	Hydrocolloid dressing, wound cover, pad size 16 square inches or less, with any size adhesive border, each dressing	
K0238	Hydrocolloid dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	
K0239	Hydrocolloid dressing, wound cover, pad size more than 48 square inches, with any size adhesive border, each dressing	
K0240	Hydrocolloid dressing, wound filler, paste, per fluid ounce	X
K0241	Hydrocolloid dressing, wound filler, dry form, per pram	X
K0242	Hydrogel dressing, wound cover, pad size 16 square inches or less, without adhesive border, each dressing	
K0243	Hydrogel dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	

(continued)

HCFA Common Procedure Code	Description and unit of purchase	Newly covered by surgical dressing expansion
K0244	Hydrogel dressing, wound cover, pad size more than 48 square inches, without adhesive border, each dressing	
K0245	Hydrogel dressing, wound cover, pad size 16 square inches or less, with any size adhesive border, each dressing	
K0246	Hydrogel dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	
K0247	Hydrogel dressing, wound cover, pad size more than 48 square inches, with any size adhesive border, each dressing	
K0248	Hydrogel dressing, wound filler, paste, per fluid ounce	
K0249	Hydrogel dressing, wound filler, dry form, per gram	X
K0251	Specialty absorptive dressing, wound cover, pad size 16 square inches or less, without adhesive border, each dressing	X
K0252	Specialty absorptive dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	X
K0253	Specialty absorptive dressing, wound cover, pad size more than 48 square inches, without adhesive border, each dressing	X
K0254	Specialty absorptive dressing, wound cover, pad size 16 square inches or less, with any size adhesive border, each dressing	X
K0255	Specialty absorptive dressing, wound cover, pad size more than 16 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	X
K0256	Specialty absorptive dressing, wound cover, pad size more than 48 square inches, with any size adhesive border, each dressing	X
K0257	Transparent film, 16 square inches or less, each dressing	

(continued)

HCFA Common Procedure Code	Description and unit of purchase	Newly covered by surgical dressing expansion
K0258	Transparent film, more than 16 but less than or equal to 48 square inches, each dressing	
K0259	Transparent film, more than 48 square inches, each dressing	
K0261	Wound filler, not elsewhere classified, gel/paste, per fluid ounce	X
K0262	Wound filler, not elsewhere classified, dry form, per gram	X
K0263	Gauze, elastic, all types, per linear yard	X
K0264	Gauze, nonelastic, per linear yard	X
K0265[a]	Tape, all types, per 18 square inches	X
K0266	Gauze, impregnated, other than water or normal saline, any width, per linear yard	X

[a]Before 1995, tape was recorded as HCPC A4454 and the unit of purchase was a roll of tape.

Fee Schedule Prices Compared With Other Available Prices

To estimate total 1995 surgical dressings expenditures, we multiplied the number of surgical dressings purchased by the regional carriers in 1994 by the 1995 fee schedule prices and the other comparison prices. For each category of surgical dressing identified by HCFA Common Procedure Codes (HCPC), we obtained the total units of surgical dressings purchased by all four regional carriers from the regional carrier responsible for compiling and analyzing DME claim data for all four regional carriers. We used this information in conjunction with surgical dressing pricing data to make several pricing comparisons. For all comparisons, estimated expenditures under HCFA's surgical dressing fee schedule were calculated by multiplying the number of units purchased in 1994 by the 1995 fee schedule price for that code. These calculations were done for each HCPC and then totaled to get overall expenditures.

Table V.1 illustrates our comparison of fee schedule prices with wholesale prices. It ranks the categories of surgical dressings from the category in which the fee schedule is the furthest above the wholesale dressing price to the category in which the fee schedule is the furthest below the wholesale price. We obtained wholesale pricing information from a national medical supplier's 1994-1995 mail order catalog. We identified a dressing in 44 of the HCPC surgical dressing categories. We calculated a per dressing, or unit, price for each of the 44 categories by taking the best wholesale price and dividing it by the number of dressings, or units, that would be provided at that price. The prices for each category were multiplied by the number of units of dressings purchased in that category in 1994 to get total expenditures in each category. We used these data to determine what total expenditures would be if HCFA paid wholesale prices rather than the fee schedule prices. As table V.1 indicates, HCFA would pay almost $20 million less for surgical dressings in the 44 categories if it paid the lower wholesale prices.

Table V.1: Fee Schedule Compared With the Lowest Wholesale Prices

Number of dressings compared	HCFA Common Procedure Code	1995 fee schedule prices	Lowest wholesale prices	Fee schedule relationship to wholesale prices[a]	Number of units purchased in 1994	Estimated fee schedule expenditures	Estimated wholesale expenditures	Potential savings from lowest wholesale purchases
1	K0220	$2.32	$0.19	12.21	26,655	$61,840	$5,064	$56,775
2	K0240	11.03	2.65	4.16	21,885	241,392	57,995	183,396
3	K0248	14.63	3.56	4.11	744,953	10,898,662	2,652,033	8,246,630
4	K0209	6.75	1.79	3.77	577,012	3,894,831	1,032,851	2,861,980
5	K0197	14.81	3.97	3.73	47,500	703,475	188,575	514,900
6	K0263	0.26	0.07	3.71	2,782,913	723,557	194,804	528,753
7	K0262	0.99	0.27	3.67	118,860	117,671	32,092	85,579
8	K0222	1.91	0.54	3.54	170,527	325,707	92,085	233,622
9	K0196	6.62	1.88	3.52	262,137	1,735,347	492,818	1,242,529
10	K0249	0.78	0.24	3.25	179,119	139,713	42,989	96,724
11	K0257	1.38	0.44	3.14	156,359	215,775	68,798	146,977
12	K0238	20.53	8.03	2.56	7,357	151,039	59,077	91,963
13	K0259	9.85	3.92	2.51	87,202	858,940	341,832	517,108
14	K0203	3.77	1.58	2.39	144,542	544,923	228,376	316,547
15	A4454[b]	2.18	1.03	2.12	6,248,901	13,622,604	6,436,368	7,186,236
16	K0212	8.74	4.32	2.02	120,830	1,056,054	521,986	534,069
17	K0224	3.25	1.64	1.98	23,525	76,456	38,581	37,875
18	K0223	2.17	1.14	1.90	235,851	511,797	268,870	242,927
19	K0251	1.80	0.95	1.89	197,421	355,358	187,550	167,808
20	K0237	7.12	3.82	1.86	14,725	104,842	56,250	48,593
21	K0229	3.25	1.84	1.77	769,838	2,501,974	1,416,502	1,085,472
22	K0236	24.54	14.83	1.65	7,754	190,283	114,992	75,291
23	K0211	26.46	18.00	1.47	37,113	982,010	668,034	313,976
24	K0243	11.10	7.64	1.45	289,106	3,209,077	2,208,770	1,000,307
25	K0258	3.87	2.72	1.42	502,244	1,943,684	1,366,104	577,581
26	A4460	1.00	0.73	1.37	84,803	84,803	61,906	22,897
27	K0234	5.89	4.30	1.37	182,247	1,073,435	783,662	289,773
28	K0245	6.54	4.99	1.31	46,441	303,724	231,741	71,984
29	K0264	0.44	0.34	1.29	5,592,523	2,460,710	1,901,458	559,252
30	K0247	21.42	16.78	1.28	2,373	50,830	39,819	11,011
31	K0204	3.18	2.58	1.23	192,766	612,996	497,336	115,660
32	K0242	5.47	4.53	1.21	416,099	2,276,062	1,884,928	391,133
33	K0255	2.73	2.58	1.06	46,859	127,925	120,896	7,029

(continued)

Number of dressings compared	HCFA Common Procedure Code	1995 fee schedule prices	Lowest wholesale prices	Fee schedule relationship to wholesale prices[a]	Number of units purchased in 1994	Estimated fee schedule expenditures	Estimated wholesale expenditures	Potential savings from lowest wholesale purchases
34	K0199	4.76	4.59	1.04	216,512	1,030,597	993,790	36,807
35	K0154	11.98	13.26	0.90	12,161	145,689	161,255	(15,566)
36	K0254	1.10	1.58	0.70	18,837	20,721	29,762	(9,042)
37	K0219	0.86	1.39	0.62	66,828	57,472	92,891	(35,419)
38	K0246	8.93	16.95	0.53	25,157	224,652	426,411	(201,759)
39	K0214	9.27	22.30	0.42	3,415	31,657	76,155	(44,497)
40	K0253	0.81	2.57	0.32	593,349	480,613	1,524,907	(1,044,294)
41	K0241	2.31	7.52	0.31	4,606	10,640	34,637	(23,997)
42	K0216	0.07	0.23	0.30	23,790,031	1,665,302	5,471,707	(3,806,405)
43	K0252	0.49	1.62	0.30	1,103,586	540,757	1,787,809	(1,247,052)
44	K0217	0.39	1.30	0.30	1,918,607	748,257	2,494,189	(1,745,932)
Total					**48,091,529**	**$57,113,852**	**$37,388,654**	**$19,725,197**

[a]The figures in this column compare the wholesale prices with the fee schedule prices. If the figure in this column is 1, the lowest wholesale price and fee schedule price are the same. Figures greater than 1 indicate the number of times that the fee schedule price is greater than the lowest wholesale price. For example, the fee schedule price for K0220 ($2.32) is 12.21 times greater than the wholesale price ($.19). In contrast, figures less than 1 indicate that the fee schedule is lower than the lowest wholesale price.

[b]Before 1995, tape was recorded as HCPC A4454 and the unit of purchase was a roll of tape. We used the pricing and utilization data for HCPC A4454 to estimate 1995 expenditures.

Table V.2 illustrates our comparison of fee schedule prices with the lowest available retail prices. The table ranks the categories of surgical dressings from the dressing category in which the fee schedule is the furthest above the lowest retail dressing price to the category in which the fee schedule is the furthest below the lowest retail price. We used the surgical dressing price lists HCFA developed to establish the surgical dressing fee schedule prices. HCFA had a price list for 44 surgical dressing categories with prices stated at the 1992 base year price. We identified the lowest price dressing in each of the 44 surgical dressing categories and inflated the prices to 1995 levels using the inflation factors established by the Congress. We then multiplied the lowest retail prices for each category by the number of units purchased in those categories in 1994. We totaled the expenditures in all categories and compared this figure with what HCFA would pay using the 1995 fee schedule. As table V.2 illustrates, HCFA would pay over $22 million

less for surgical dressings in the 44 categories if it paid the lowest retail price.

Table V.2: Fee Schedule Compared With Lowest Retail Prices

Number of dressings compared	HCFA Common Procedure Code	1995 fee schedule prices	Lowest retail prices	Fee schedule relationship to lowest retail prices[a]	Number of units purchased in 1994	Estimated fee schedule expenditures	Estimated lowest retail expenditures	Potential savings from lowest retail purchases
1	K0245	$6.54	$0.66	9.85	46,441	$303,724	$30,651	$273,073
2	K0203	3.77	0.42	8.88	144,542	544,923	60,708	484,216
3	K0264	0.44	0.10	4.49	5,592,523	2,460,710	542,475	1,918,235
4	K0242	5.47	1.30	4.22	416,099	2,276,062	540,929	1,735,133
5	K0216	0.07	0.02	3.22	23,790,031	1,665,302	475,801	1,189,502
6	K0254	1.10	0.35	3.16	18,837	20,721	6,593	14,128
7	K0243	11.10	3.66	3.04	289,106	3,209,077	1,058,128	2,150,949
8	K0263	0.26	0.09	2.99	2,782,913	723,557	250,462	473,095
9	K0211	26.46	10.22	2.59	37,113	982,010	379,295	602,715
10	K0257	1.38	0.53	2.59	156,359	215,775	82,870	132,905
11	K0219	0.86	0.36	2.39	66,828	57,472	24,058	33,414
12	K0212	8.74	3.69	2.37	120,830	1,056,054	445,863	610,192
13	K0262	0.99	0.44	2.27	118,860	117,671	52,298	65,373
14	K0259	9.85	4.35	2.26	87,202	858,940	379,329	479,611
15	K0238	20.53	9.56	2.15	7,357	151,039	70,333	80,706
16	K0196	6.62	3.13	2.11	262,137	1,735,347	820,489	914,858
17	K0235	15.16	7.29	2.08	27,368	414,899	199,513	215,386
18	K0258	3.87	1.95	1.99	502,244	1,943,684	979,376	964,308
19	K0248	14.63	7.48	1.96	744,953	10,898,662	5,572,248	5,326,414
20	K0222	1.91	0.98	1.95	170,527	325,707	167,116	158,590
21	K0224	3.25	1.85	1.76	23,525	76,456	43,521	32,935
22	K0209	6.75	3.92	1.72	577,012	3,894,831	2,261,887	1,632,944
23	K0236	24.54	14.32	1.71	7,754	190,283	111,037	79,246
24	K0237	7.12	4.29	1.66	14,725	104,842	63,170	41,672
25	K0223	2.17	1.37	1.58	235,851	511,797	323,116	188,681
26	K0234	5.89	3.97	1.48	182,247	1,073,435	723,521	349,914
27	K0220	2.32	1.58	1.47	26,655	61,840	42,115	19,725
28	K0210	17.94	12.48	1.44	98,034	1,758,730	1,223,464	535,266
29	K0199	4.76	3.55	1.34	216,512	1,030,597	768,618	261,980
30	K0253	0.81	0.61	1.33	593,349	480,613	361,943	118,670

(continued)

Number of dressings compared	HCFA Common Procedure Code	1995 fee schedule prices	Lowest retail prices	Fee schedule relationship to lowest retail prices[a]	Number of units purchased in 1994	Estimated fee schedule expenditures	Estimated lowest retail expenditures	Potential savings from lowest retail purchases
31	K0251	1.80	1.39	1.29	197,421	355,358	274,415	80,943
32	K0244	35.38	27.90	1.27	75,058	2,655,552	2,094,118	561,434
33	K0229	3.25	2.80	1.16	769,838	2,501,974	2,155,546	346,427
34	K0204	3.18	2.82	1.13	192,766	612,996	543,600	69,396
35	K0240	11.03	9.80	1.13	21,885	241,392	214,473	26,919
36	K0217	0.39	0.35	1.12	1,918,607	748,257	671,512	76,744
37	K0197	14.81	13.24	1.12	47,500	703,475	628,900	74,575
38	K0249	0.78	0.73	1.07	179,119	139,713	130,757	8,956
39	K0246	8.93	8.60	1.04	25,157	224,652	216,350	8,302
40	K0241	2.31	2.26	1.02	4,606	10,640	10,410	230
41	K0247	21.42	21.19	1.01	2,373	50,830	50,284	546
42	K0255	2.73	2.72	1.00	46,859	127,925	127,456	469
43	K0214	9.27	9.27	1.00	3,415	31,657	31,657	0
44	K0252	0.49	0.50	0.98	1,103,586	540,757	551,793	(11,036)
Total					**41,946,124**	**$48,089,936**	**$25,762,198**	**$22,327,741**

[a]The figures in this column compare the lowest retail prices with fee schedule prices. If the figure in this column is 1, the lowest retail price and fee schedule price are the same. Figures greater than 1 indicate the number of times that the fee schedule price is greater than the lowest retail price. For example, the fee schedule price for K0245 ($6.54) is 9.85 times greater than the lowest retail price ($.66). In contrast, figures less than 1 indicate that the fee schedule is lower than the lowest retail price.

Table V.3 illustrates our comparison of fee schedule prices with the lowest retail drugstore prices for similar dressings. The table ranks the categories of surgical dressings from the category in which the fee schedule is the furthest above the lowest retail drugstore dressing price to the category in which the fee schedule is the furthest below the lowest retail drugstore price. We obtained the actual drugstore prices by visiting and pricing surgical dressings at four retail drugstores in the Los Angeles area. We identified and priced dressings in nine of the surgical dressing categories and determined the lowest per dressing price in each of the nine dressing categories. These figures were then multiplied by the number of units purchased in those categories in 1994. We totaled the expenditures in each category and compared this figure with what HCFA would pay using the 1995 fee schedule. As the table illustrates, HCFA would pay over $2 million

less for surgical dressings in the nine categories if it paid the lower drugstore prices.

Table V.3: Fee Schedule Compared With Lowest Retail Drugstore Prices

Number of dressings compared	HCFA Common Procedure Code	1995 fee schedule prices	Lowest actual retail prices	Fee schedule relationship to lowest retail drugstore prices[a]	Number of units purchased in 1994	Estimated fee schedule expenditures	Estimated lowest retail expenditures	Potential savings from actual retail purchases
1	K0222	$1.91	$0.51	3.74	170,527	$325,707	$86,969	$238,738
2	K0257	1.38	0.52	2.65	156,359	215,775	81,307	134,469
3	K0219	0.86	0.55	1.56	66,828	57,472	36,755	20,717
4	A4454[b]	2.18	1.47	1.48	6,248,901	13,622,604	9,185,884	4,436,720
5	K0252	0.49	0.47	1.04	1,103,586	540,757	518,685	22,072
6	K0217	0.39	0.40	0.97	1,918,607	748,257	767,443	(19,186)
7	K0263	0.26	0.33	0.78	2,782,913	723,557	918,361	(194,804)
8	K0216	0.07	0.17	0.41	23,790,031	1,665,302	4,044,305	(2,379,003)
9	A4460	1.00	3.87	0.25	84,803	84,803	328,188	(243,385)
Total					**36,322,555**	**$17,984,235**	**$15,967,898**	**$2,016,337**

[a]The figures in this column compare the lowest drugstore prices with fee schedule prices. If the figure in this column is 1, the lowest retail drugstore price and fee schedule price are the same. Figures greater than 1 indicate the number of times that the fee schedule price is greater than the lowest retail drugstore price. For example, the fee schedule price of K0222 ($1.91) is 3.74 times greater than the lowest retail drugstore price ($.51). In contrast, figures less than 1 indicate that the fee schedule is lower than the lowest retail drugstore price.

[b]Before 1995, tape was recorded as HCPC A4454 and the unit of purchase was a roll of tape. However, in 1995 a new HCPC (K0265) and description of tape were developed. We used the pricing and utilization data for HCPC A4454 to estimate 1995 expenditures.

Table V.4 illustrates our comparison of fee schedule prices with the price VA pays for similar dressings. The table ranks the categories of surgical dressings from the category in which the fee schedule is the furthest above the VA price to the category in which the fee schedule is the furthest below the VA price. We obtained surgical dressing supply and price lists from one of the VA's Medical Centers in the Los Angeles area. We identified dressings and calculated per dressing, or unit, prices in nine of the surgical dressing categories. We multiplied the lowest per dressing price in each category by the number of units purchased in those categories in 1994. We totaled the expenditures in each category and compared this figure with what HCFA would pay using the 1995 fee schedule. As table V.4 illustrates,

HCFA would pay over $9 million less for dressings in the nine categories if it paid VA's lower prices.

Table V.4: Fee Schedule Compared With Department of Veterans Affairs Lowest Purchase Prices

Number of dressings compared	HCFA Common Procedure Code	1995 fee schedule prices	Lowest VA purchase prices	Fee schedule relationship to lowest VA prices[a]	Number of units purchased in 1994	Estimated fee schedule expenditures	Estimated VA expenditures	Potential savings from lowest VA purchases
1	K0220	$2.32	$0.04	58.00	26,655	$61,840	$1,066	$60,773
2	K0257	1.38	0.06	23.00	156,359	215,775	9,382	206,394
3	K0219	0.86	0.04	21.50	66,828	57,472	2,673	54,799
4	K0224	3.25	0.48	6.77	23,525	76,456	11,292	65,164
5	K0253	0.81	0.16	5.06	593,349	480,613	94,936	385,677
6	A4460	1.00	0.41	2.44	84,803	84,803	34,769	50,034
7	K0223	2.17	0.92	2.36	235,851	511,797	216,983	294,814
8	A4454[b]	2.18	1.05	2.08	6,248,901	13,622,604	6,561,346	7,061,258
9	K0258	3.87	1.87	2.07	502,244	1,943,684	939,196	1,004,488
Total					**7,938,515**	**$17,055,044**	**$7,871,643**	**$9,183,401**

[a]The figures in this column compare the lowest VA prices with fee schedule prices. If the figure in this column is 1, the lowest VA price and fee schedule price are the same. Figures greater than 1 indicate the number of times that the fee schedule price is greater than the lowest VA price. For example, the fee schedule price of K0220 ($2.32) is 58 times greater than the lowest VA price ($.04).

[b]Before 1995, tape was recorded as HCPC A4454 and the unit of purchase was a roll of tape. However, in 1995 a new HCPC (K0265) and description of tape were developed. We used the pricing and utilization data for HCPC A4454 to estimate 1995 expenditures.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL 18 1995

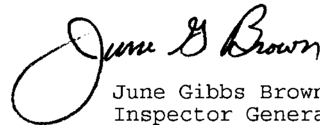
Ms. Sarah F. Jaggar
Director, Health Financing and
Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Jaggar:

Enclosed are the Department's comments on your draft report, "Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,



June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services (HHS)
on the General Accounting Office (GAO) Draft Report,
"Medicare: Excessive Payments for Medical Supplies
Continue Despite Improvements"

Overview

We have reviewed the draft GAO report which explores Medicare's payment for medical supply claims. This report suggests that the Health Care Financing Administration (HCFA) could save money by establishing procedures to itemize supplies on claims submitted for payment; preventing duplicate payments, and identifying high-dollar and high-volume claims for review prior to payment.

Several ongoing Medicare initiatives are already addressing the problems highlighted in this report. For example, a new entity, the statistical analysis durable medical equipment regional carrier (SADMERC), was established to be a repository for all durable medical equipment (DME) regional carrier processed claims information. The four regional carriers and HCFA are utilizing SADMERC data to identify suspicious suppliers and high-dollar/high-volume claims for prepayment review.

Additionally, DME regional carriers use prepayment screens to detect egregious utilization of a supply item. When trends and patterns with the potential for overutilization are identified, DME regional carriers request medical necessity documentation when claims are submitted to determine if quantities are reasonable and necessary prior to payment. In the post-payment situation, DME regional carriers conduct comprehensive medical reviews on suppliers whose post-billing patterns indicate a potential for overutilization and collect overpayments when appropriate.

RECOMMENDATIONS TO THE SECRETARY OF HHS

The Secretary should direct the Administrator of HCFA to:

-- require that bills itemize supplies;

Department Comment

We do not concur with this recommendation. HCFA assessed the benefit of requiring providers to itemize home health supply bills. The cost and additional burden to providers and Medicare contractors outweigh the value of the itemization. As an

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alternative, we believe that significant abuse can be identified if high-dollar supply claims are reviewed prior to payment. We are evaluating the value of requiring fiscal intermediaries to utilize edits to suspend excessive charges for review. Also, it is important to point out that HCFA does not pay the billed charges for these claims.

Final payment is based on the provider's cost report. Therefore, while some over- payments may be made on an interim basis, the losses are significantly exaggerated if the interim payment of billed charges is considered to be the Medicare payment.

GAO Recommendation

-- develop and implement prepayment review policies as part of the process of implementing any new or expanded Medicare coverage; and

Department Comment

We concur with the recommendation and have developed two processes which implement it. The first is the development and implementation of regional medical review policy (RMRP), and second is the use of prepayment edits. We also agree that prepayment edits should be used to prevent inappropriate payment when coverage policy changes. The revised RMRP, to accompany the recent expansion of the surgical dressing benefit, has been included in the DME regional carriers' June provider bulletin and will be effective October 1, 1995. In this instance, additional time was needed to allow the provider community and the surgical dressing industry to comment on the proposed policy. Since the expansion of the DME benefit, regional carriers have been using prepayment edits to determine whether newly covered surgical DME dressings are medically necessary. It is important to ensure that the DME regional carriers are given the flexibility to establish their own edits based on the aberrancies found in their region.

GAO Recommendation

-- establish procedures to prevent duplicate payments by fiscal intermediaries and carriers.

Department Comment

Duplicate claims are detected and payment is denied when the claims are submitted to the same contractor. It is difficult, in the current systems environment, to identify duplicate claims when they are sent to different Part A and Part B contractors. This is because the claims are submitted with different codes and supplier numbers and then

processed using different payment schedules and processing systems. As an effective alternative, HCFA currently utilizes conflict edits through the Common Working File to alert contractors to conflicting payment situations. For example, if Part B is being billed for outpatient supplies for a specific date and Part A receives an inpatient claim for the same patient over the same period of time, an alert is generated. Questionable claims are then manually reviewed prior to payment. In the future, with Medicare's new claims processing system, the Medicare Transaction System, it will be simpler to identify duplicate claims because Part A and Part B claims will be processed in the same format by the same system.

MATTER FOR CONGRESSIONAL CONSIDERATION

The fee-schedule approach to setting prices provides a good starting point for setting appropriate Medicare prices. HCFA, however, 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 providing for HCFA or its carriers to promptly modify prices for DME and other medical supplies. To work effectively, however, HCFA or the carriers must devote adequate resources to routine price monitoring.

Department Comment

Section 1834 of the Social Security Act (the Act) prescribes fee schedule payment methodologies for DME, prosthetics, and orthotics. These fee schedules preceded the surgical dressing fee schedules by a number of years and are also calculated using base year reasonable charges, increased by covered item update factors set by law. Only HCFA has the authority to limit the fee schedules for DME, prosthetics, and orthotics and the process for establishing such limits is very cumbersome. Moreover, the statutory authority that allows HCFA to adjust these payment amounts does not apply to surgical dressings. Therefore, neither HCFA nor the carriers has any authority to adjust or limit the fee schedule amounts for surgical dressings. As a result, any comparisons between what Medicare pays for surgical dressings and what other payors such as the Department of Veterans Affairs pay for surgical dressings cannot be used to adjust Medicare payment amounts. The other payors are not bound by the payment methodology set forth in section 1834(i) of the Act.

Now on p. 13.

On page 26 of the report, it is suggested that Congress should provide HCFA and the carriers with the authority to adjust or limit Medicare fee schedule amounts for surgical dressings. On several occasions since section 1834 of the Act was added in 1987, the Department has submitted legislative proposals to Congress to simplify the process that can be used by HCFA to adjust or limit the fee schedule amounts required by section 1834 of the Act.

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Other Comments

The report discusses the problems associated with a lack of published medical review policies for surgical dressings and urological supplies. Both of these polices have been officially released by the DME regional carriers and have been published in the June issue of the DME regional carriers supplier manuals. The DME regional carriers will now be able to apply specific utilization parameters to claims for these items, which will result in more accurate and appropriate coverage and payment decisions. It should be noted that since the beginning of the transition to the DME regional carriers in October 1993, the DME regional carriers have established a great number of medical review policies, all of which were reviewed extensively by HCFA in order to ensure that they did not conflict with any statutory provisions or national Medicare policies.

Now on p. 10.

Additionally, on Page 19 of the report, it is stated that "Medicare's fee schedule payments for surgical dressings are generally excessive when compared to wholesale prices, prices paid by the Department of Veterans Affairs, and even retail prices. Overall, we estimate that HCFA could save substantial amounts if its fee schedule was calculated on the basis of lower available prices." Section 1834(i) of the Act very explicitly dictates the methodology that Medicare must use to establish payment rates for surgical dressings. The fee schedule amounts are based on average reasonable charges from Calendar Year 1992, increased by the covered item updates provided in the law.

The carriers used 1992 retail prices obtained from catalogues to establish the base fee schedule amounts for surgical dressings for which we did not have historical reasonable charge data. As the report indicates, these data were used in lieu of 1992 reasonable charge data which do not exist for most surgical dressing codes because new codes were added to the HCFA Common Procedures Coding System (HCPCS) after 1992.

The 1992 retail prices are the best estimate of Medicare reasonable charges in 1992.

Also, in accordance with the statute, the base fee schedule amounts must be increased by covered item update factors.

Technical Comments

- Throughout the report, surgical dressings are considered a type of medical supply. However, as indicated in section 1861(s)(5) of the Act, surgical dressings are included in the category of "medical and other health services."

- The report does not define "medical supplies." This term is not defined in the Medicare statute. HCFA considers medical supplies to be those items (other than accessories)

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that are associated with DME or prosthetics and orthotics except in the special context of home health services. For example, oxygen is a medical supply associated with an oxygen concentrator under the DME benefit.

Text revised. Now on p. 2.

Now on p. 5.

- On page 3, the report notes that the Medicare contractors pay medical supply claims without knowing specifically what they are being asked to pay for. The sentence would be more accurate if the word "contractors" was replaced with "fiscal intermediaries." The report indicates on page 9 that this is a problem with the fiscal intermediaries, rather than the regional carriers.

Now on p. 3.

- On page 5, the last paragraph notes that a significant number of new surgical dressing codes were added with the expansion of the surgical dressing coverage policy. These new codes were added to more specifically identify items and thus, prevent the grouping of items under less specific codes. This provides for more accurate pricing.

Paragraph deleted.

- On page 7, the last paragraph states that HCFA did no oversight of reasonable charges. This is not true; regional offices annually review the reasonable charge schedules and fee schedules.

Text revised. Now on p. 7.

- On page 14, the report states that " . . . most claims for surgical dressings that do not have payment policies are being paid and will continue to be paid without a routine review to determine whether the amount of dressings billed are reasonable or medically necessary." The report also states that " . . . payment policies will be adopted by September 1995." These sentences are confusing since a payment policy or methodology must exist in order for claims to be paid by the regional carriers. It appears that the report confused payment policies with coverage policies (i.e., the regional medical review polices established by a DME regional carrier).

Now on p. 11.

- On page 22, the footnote states that OBRA 1987 eliminated the carriers' inherent reasonableness authority for DME, prosthetics and orthotics. The report does not indicate if the carriers or the Secretary has inherent reasonableness authority for surgical dressings. We believe that under current law, neither the carriers nor the Secretary has inherent reasonableness authority for surgical dressings.

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Text revised. Now on p. 13.

- On page 25, the report concludes that "Many claims for surgical dressings do not include sufficient detail for Medicare contractors to assess what they are being asked to pay for . . ." As indicated previously, the sentence would be more accurate if the word "contractors" was replaced with "fiscal intermediaries."

Text revised. Now on p. 13.

- On page 26, we suggest that the first recommendation should require that Part A claims itemize supplies since Part B claims already include HCPCS codes.

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