Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INDEPENDENT PHYSIOLOGICAL LABORATORIES: CARRIER PERSPECTIVES

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EXECUTIVE SUMMARY

PURPOSE

To document the program vulnerabilities Medicare Part B carriers associate with independent physiological laboratories (IPLs) and report their suggestions on ways to safeguard the Medicare program.

BACKGROUND

The Health Care Financing Administration (HCFA) defines an independent physiological laboratory (IPL) as an entity operating independent of a hospital, physician's office or rural health clinic. Testing modalities performed by IPLs include, but are not limited to, neurological and neuromuscular tests, echocardiograms, ultrasounds, x-rays, pulmonary function tests, cardiac monitoring and nuclear medicine testing.

Initially, Medicare only covered diagnostic tests that were performed by a physician, hospital or other entity certified by the program to perform the test. Beginning January 1979, HCFA decided that diagnostic services performed by these entities qualified for Medicare reimbursement and began assigning provider numbers to IPLs. To date, Medicare has issued approximately 5,000 unique IPL provider numbers. Nearly $129 million was paid to IPL providers in 1996.

Vulnerabilities associated with this industry have been widely recognized by HCFA and its carriers. Both have taken steps to address these vulnerabilities.

METHODOLOGY

The information presented in this report was compiled from a national survey of Medicare carriers. In July 1997, the carriers were asked to complete a mail-in questionnaire for each of their servicing jurisdictions. We received responses from the 27 carriers covering all 58 carrier jurisdictions.

FINDINGS

Carriers Report Numerous Vulnerabilities Associated With IPLs

Medicare carriers are concerned about the vulnerabilities associated with IPLs. They are particularly concerned about IPLs generating fictitious claims and billing for services not rendered. Carriers also report having found falsified physician orders, misrepresented patient diagnosis, double billing, unbundling, carrier shopping, overutilization and non-existent IPL businesses.

Carriers Have Many Ideas On How To Safeguard Medicare From Vulnerabilities Associated With IPLs

The carriers offer a wide variety of solutions to guard against the vulnerabilities they face from IPLs. Severely restricting allowable procedures, requiring HCFA certification or encouraging greater State licensure are believed to be, by almost half of the carriers, the best means of protecting the program from IPL fraud and abuse. Other ideas include: a better definition of what qualifies as an IPL, onsite visits as part of a stricter enrollment process, a national coverage policy, and eliminating Medicare reimbursements to IPLs.

CONCLUSION

The vulnerabilities identified by the carriers are consistent with evidence gathered during site visits made to randomly selected IPLs throughout the country. This information is presented in a companion report, entitled "Independent Physiological Laboratories: Vulnerabilities Confronting Medicare," (OEI-05-97-00240). New regulations, that went into effect on January 1, 1998, may only partially correct these vulnerabilities. Thus, we encourage HCFA to seriously consider the suggestions presented by the carriers on ways to better protect the Medicare program from fraud and abuse.

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INTRODUCTION

PURPOSE

To document the program vulnerabilities Medicare Part B carriers associate with independent physiological laboratories (IPLs) and report their suggestions on ways to safeguard the Medicare program.

BACKGROUND

The Health Care Financing Administration (HCFA) defines an IPL as an entity operating independent of a hospital, physician's office or rural health clinic.[1] Testing modalities performed by IPLs include, but are not limited to, neurological and neuromuscular tests, echocardiograms, ultrasounds, x-rays, pulmonary function tests, cardiac monitoring and nuclear medicine testing. Medicare pays an IPL for diagnostic services if: (1) the IPL meets applicable State and local licensure laws, (2) the services are ordered by a physician, and (3) the services are reasonable and medically necessary.[2]

Initially, Medicare only covered diagnostic tests that were performed by a physician, hospital or other entity certified by the program to perform the test. In January 1979, HCFA decided that IPL services qualified for reimbursement and began enrolling and assigning provider numbers to IPLs.[3]

Since 1979, the number of IPLs in the Medicare program has steadily increased. In 1987, less than 1,700 IPL provider numbers had been issued.[4] Today, there are approximately 5,000 provider numbers. In 1996, the Medicare program paid nearly $129 million to IPL providers.

Vulnerabilities associated with this industry have been widely recognized by HCFA and its carriers. In response to these concerns, some carriers strengthened their enrollment process, adopted more stringent verification procedures, restricted coverage and established utilization guidelines. In one carrier jurisdiction the problems were such that the carrier required all IPLs to re-enroll in 1996 using HCFA's new supplier/provider enrollment application and made onsite visits to business locations at the time of application. They also required IPLs to submit proof of insurance, licensure, equipment ownership, technician credentials and physician supervision which they verified using third-party sources.

These efforts by carriers resulted in an overall decrease in the number of IPL services and allowable charges. The number of IPL allowable services decreased 18 percent, from 2.8 million to 2.3 million between 1994 and 1996. During that same period, payments to IPLs also decreased 20 percent, from $162 million to $129 million.

The HCFA has also taken steps to address vulnerabilities presented by IPLs. In May 1996, prior to this study, HCFA implemented a new provider enrollment application (HCFA 855) that includes a special attachment for providers enrolling as IPLs. This new enrollment application

solicits information about the IPL's actual place of business/practice, testing modalities and ownership. On October 31, 1997, HCFA published regulations that create a new entity, independent diagnostic testing facilities (IDTFs), as of January 1, 1998. Entities currently participating in the Medicare program as IPLs will need to meet IDTF enrollment requirements, physician supervision requirements and personnel requirements set forth in the newly published regulations.

METHODOLOGY

The information presented in this report was gathered from a national survey of Medicare carriers. In July 1997, carriers were asked to complete a mail-in questionnaire for each of their servicing jurisdictions. A carrier jurisdiction can be a State, part of a State, a county or a city. We received responses for all 58 carrier jurisdictions from all 27 carriers processing claims at that time.

Carrier jurisdictions were used as the original unit of analysis because coverage and payment policies within a carrier can vary by jurisdiction. This is the result of shifting Medicare carrier contracts and the HCFA stipulation that carriers taking over contracts must honor the previous carrier's policy for 1 year. During our study, several State jurisdictions were in the process of being, or had recently been, transitioned over to a new carrier. However, in reporting the issues they faced with regard to IPLs and possible solutions most carriers did not make distinctions based on jurisdictions. Thus, carrier responses were analyzed, making carriers and not jurisdictions, the unit of analysis in this report.

The survey requested the carriers, in open-ended questions, to describe any vulnerabilities they thought existed in the current enrollment process. It also asked for any other problems they were experiencing with IPLs. They were then asked how the IPL provider enrollment application process could be improved as well as any other policy changes they would like to see in order to protect Medicare from fraud and abuse.

The answers were aggregated and similar responses tallied in order to ascertain which problems seem to be the most prevalent and which solutions had the most salience. In each section, those answers with the greatest responses are presented first, followed in descending order by those that were mentioned less frequently.

We conducted our inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

CARRIERS REPORT NUMEROUS VULNERABILITIES ASSOCIATED WITH IPLS

Medicare carriers are concerned about the vulnerability associated with IPLs. They believe there are many ways in which IPLs are generating fictitious claims in order to bill for services not rendered or to facilitate overutilization of services.

The most prevalent types of potentially fraudulent and abusive billing schemes reported by the carriers include:

- *Billing for services not rendered.*
- *Falsifying physician orders or no physician orders for testing performed.*
- *Misrepresenting patient diagnosis to obtain improper coverage of services.*
- *Misrepresenting services rendered.*
- *Double billing - billing the same service to different carriers, or different IPLs billing for the same service(s) to the same or different carriers.*
- *Offering physicians kickbacks for the referral of patients.*
- *Self-referral arrangements in which the IPL is owned by a physician(s), medical facility and/or other health care provider (potential Stark Violations).*
- *Unbundling - billing separately for services that should be part of a composite rate or monthly capitation payment.*
- *Requesting multiple provider numbers from different carriers to circumvent carrier frequency controls.*
- *Carrier shopping - practice of setting up businesses in high reimbursement carrier jurisdictions*
- *Overutilization.*

Carriers also reported problems with fraud committed by non-existent IPL businesses. One scheme involves fictitious IPLs that obtain multiple provider numbers for billing Medicare. These multiple provider numbers facilitate the perpetration of fraudulent activities.

Carriers also report that fictitious IPLs purchase legitimate IPL businesses and use the patient information obtained to create and submit false claims. They believe that some IPLs also buy patient health insurance claim numbers and use them to bill Medicare for services not rendered.

In some cases, elderly patients may be tricked into providing their numbers. Others sell their number knowing it will be used to fraudulently bill Medicare. In some areas of the country, carriers believe that "recruiters" buy and sell these numbers which are used around the country to defraud the program.

Three carriers report problems with unscrupulous IPLs billing globally (billing for both the performance of the test and the interpretation of the test results) when they have performed only the technical component. This type of fraud is not as obvious as billing for a service never provided. This practice may involve services that have actually been provided to the patient. An IPL can receive a global payment for services rendered by simply omitting the modifier to indicate that only the technical component was performed.

Another way, carriers report, that some IPLs circumvent claims payment safeguards is by misusing unique physician identification numbers, or UPINs. Medicare requires that the ordering physician's UPIN appear on IPL claims. The UPINs are public information and, as such, may be purchased through the Government Printing Office for $28 and from most carriers at a reduced price. Carriers reported that unscrupulous IPLs use UPIN lists they purchase to create fraudulent claims.

"Carrier shopping" was also reported as a problem carriers were experiencing with IPLs. By shopping around IPLs identify carriers with liberal coverage and utilization policies and high payment rates. Having identified the area, they can establish a business site and obtain a provider number from the carrier responsible for paying claims. The IPLs can then funnel their claims, regardless of where services were actually performed, through this office.

CARRIERS HAVE MANY IDEAS ON HOW TO SAFEGUARD MEDICARE FROM VULNERABILITIES ASSOCIATED WITH IPLS

During the past 5 years, many carriers have implemented policies to deal directly with the vulnerabilities outlined in the previous section. Given their experience in dealing first-hand with the vulnerabilities associated with IPLs, carriers were asked to offer their suggestions for ways to further strengthen Medicare safeguards.

Limit Allowable Procedures

Almost half of the carriers were in favor of strictly limiting allowable procedures. Many carriers utilized this strategy in their jurisdictions. One carrier only allowed IPLs to bill for non-invasive procedures. Another carrier excluded nuclear testing. Several carriers specified that limiting procedures should be part of a HCFA initiative that would establish national coverage policies and uniform processing guidelines. They argued that this would permit consistency between carriers and remove the incentive for providers intent on gaming the system to carrier shop.

Establish IPL Certification

Two other options, supported by almost half of the carriers, consisted of establishing a HCFA certification program for IPLs and encouraging enhanced State licensure, certification or registration. With a certification program, only IPLs certified by Medicare or the State would be paid and only those procedures certified by Medicare would be payable. As part of a certification program, a small number of carriers thought it would be helpful if HCFA specified the level of MD oversight (general, direct, personal) for each procedure code.

Establish a Clear Definition of What Qualifies as an IPL

Approximately a third of the carriers felt that a clear definition of what characterized an IPL was a necessary starting point for greater fraud and abuse prevention efforts. Carriers desired more guidance from HCFA as to who, and what, qualifies as an IPL. One carrier illustrated this need by posing the question, "if equipment is taken into a patient's home is it an IPL service or home health?" Another stated, "We find ourselves not being able to deny applications for a provider who we feel may not be qualified. The only thing we can do is to monitor them after the number is issued. This always poses a problem in terms of loss of program funds."

Others illustrated their confusion by citing specific references in the Medicare Carriers Manual (MCM). One carrier requested more guidance with reference to MCM 3060.5. This entry states that "tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and...the interpretations." They requested guidance on how to define 'independent.'

Utilize Onsite Verification to Strengthen Enrollment and Monitoring

Similarly mentioned was the need for onsite verification as a normal part of the enrollment process. Nearly half of the carriers report that they perform an onsite visit to some, or all, IPLs as part of their current provider enrollment verification procedures. A small number of carriers mentioned such ideas as re-enrolling all IPLs with a focus on ownership, and random, periodic re-enrollment.

Eliminate IPLs from Medicare Reimbursement

Carriers also suggested that the entire concept of IPLs be eliminated from the regulations. One carrier offered the following logic: "Because IPLs deliver services that determine a course of action in the treatment of a condition, they should be reviewed as physician services and subject to the same guidelines for the payment of physicians."

Other suggestions include: (1) eliminating provider numbers with no activity within the last 6 months, (2) requiring training for personnel and then requiring the submission of technician certification/credentials in the enrollment process (3) having IPLs post a cash bond as a prerequisite for obtaining a provider number, (4) requiring mandatory liability insurance, (5) creating a medical necessity requirement for each code, and (6) verifying the presence of a medical director to make sure they do not exist only on paper.

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CONCLUSION

Carriers are extremely concerned about the vulnerabilities present in the Medicare IPL program. These concerns are consistent with the vulnerabilities outlined in our companion report, entitled, "Independent Physiological Laboratories: Vulnerabilities Confronting Medicare," (OEI-05-97-00240). This report presents evidence from onsite visits made to randomly selected IPLs throughout the country that lends considerable credence to the vulnerabilities identified by the carriers. Given the findings of these reports, we suggest that HCFA seriously consider the solutions the carriers have offered in this report.

ENDNOTES

1. "Quality Assurance In Independent Physiological Laboratories," (OEI-03-88-01400), October 1990.

2. Medicare Carriers Manual, Section 2070.5 and Section 1862 of the Social Security Act.

3. The Health Care Financing Administration determined that IPL services qualified for reimbursement under Section 1861(s)(3) of Title XVII of the Social Security Act.

4. "Quality Assurance In Independent Physiological Laboratories," (OEI-03-88-01400), October 1990.