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BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Health And Human Services

Changes Needed In Medicare Payments To Physicians Under The End Stage Renal Disease Program

Since July 1973, the Medicare program has covered the cost of treating individuals with end stage renal disease. Total program costs have increased from about $229 million in 1974 to more than $1.8 billion in 1983.

Renal physicians receive a monthly capitation payment for the routine outpatient care they provide to dialysis patients. The formula used to compute the monthly payment overstates physicians' involvement with home dialysis patients when compared with facility patients, resulting in higher monthly rates and additional annual program costs of about $11.8 million.

Special dialysis procedure codes were established for inpatient hospital care, including hospital dialysis visits. Medicare allowances for these visits are considerably higher than those for regular hospital visits, even though the services provided are essentially the same. GAO believes that use of these special codes should be limited.

GAO also believes that a system which pays for outpatient care on the basis of a monthly capitation payment and for inpatient care on a fee-for-service basis is difficult to administer. Adopting a total capitation payment system covering both routine inpatient and outpatient services would be easier to administer and, based on 1981 data, could save about $1.6 million annually in the nine states reviewed.

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

HUMAN RESOURCES
DIVISION

B-210417

The Honorable Margaret M. Heckler
The Secretary of Health and
Human Services

Dear Madam Secretary:

This report discusses the results of our review of physicians' reimbursement in Medicare's End Stage Renal Disease program. The program is administered by the Health Care Financing Administration.

In August 1983, several changes were made in the way renal physicians are reimbursed for the services they provide to program beneficiaries. While the changes corrected some of the deficiencies noted during our review, most can continue to occur. The new reimbursement system continues to reimburse for renal physicians' outpatient care on the basis of a monthly capitation payment and for inpatient care on a fee-for-service basis. Such a system is cumbersome to administer, and we are recommending that the system be changed to a total capitation payment system covering all physicians' routine inpatient and outpatient care provided in connection with beneficiaries' dialysis treatment programs.

As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on action taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of this report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the above-mentioned Committees, the Senate Committee on Finance, the House Committee on Ways and Means, and the House Committee on Energy and Commerce; the Director, Office of Management and Budget; your Inspector General; the Administrator, Health Care Financing Administration; and other interested parties.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY OF
HEALTH AND HUMAN SERVICES

CHANGES NEEDED IN MEDICARE PAYMENTS TO PHYSICIANS UNDER THE END STAGE RENAL DISEASE PROGRAM

D I G E S T

The Medicare program was expanded in 1973 to cover over 90 percent of the people suffering from end stage renal disease (ESRD); that is, persons whose kidneys have permanently ceased to function. To stay alive these persons need to undergo a kidney transplant or receive dialysis treatments to remove body wastes. Most ESRD beneficiaries (about 76 percent in 1983) receive maintenance dialysis, which is provided at a dialysis facility or at home.

Dialysis in either setting is expensive. During 1983 Medicare paid on the average about $24,000 per year to treat a dialysis patient. The ESRD program has grown dramatically over the years--from about 18,000 beneficiaries and costs of $229 million in 1974 to about 89,000 beneficiaries and costs of $1.8 billion in 1983.

Before August 1983, Medicare paid physicians for ESRD-related services under either the "initial" or the "alternative method." The initial payment method varied depending on where a patient received dialysis. For patients who used a dialysis facility, Medicare paid the facility a fixed amount per session to cover physicians' supervisory care during dialysis, and the facility paid the physician. For other care provided to facility dialysis patients, such as when they were hospitalized, physicians were paid a fee for each service provided. For home patients, physicians were also paid on a fee-for-service basis.

Under the alternative method, physicians received a fixed monthly amount per patient for all routine outpatient care--care provided when patients are not hospitalized. The amounts allowed for facility patients were higher than those for home patients. The Health Care Financing Administration (HCFA), which administers Medicare, believed this provided a disincentive for physicians to arrange for the less costly

home dialysis. For inpatient hospital care, physicians usually were paid on a fee-for-service basis.

To reduce this disincentive, HCFA developed a revised payment method under which physicians are paid a monthly capitation rate[1] for routine outpatient care and reimbursed on a fee-for-service basis for inpatient hospital care like the alternative method. The methodology for computing the monthly payments was changed, and physicians now receive the same monthly amount regardless of where dialysis is provided. The single rate increased the monthly amounts paid physicians for home patients and reduced the amounts paid for facility patients.

GAO evaluated HCFA's methodology for deriving the monthly capitation payment amount to see if it accurately reflects the services provided by physicians to ESRD beneficiaries. GAO also evaluated whether physician payments were properly determined.

To gather the information necessary to make these evaluations, GAO conducted work at HCFA headquarters, four of its regional offices, and Medicare's claims processing agents for nine states--Alaska, Arizona, Arkansas, Hawaii, Massachusetts, Nevada, Oregon, Rhode Island, and Washington--which included about 10 percent of all ESRD beneficiaries. GAO also sent questionnaires to a statistically selected national sample of physicians who treat ESRD patients to obtain their views on physician services under the program. Questionnaires were also sent to a statistical sample of beneficiaries in eight of the states reviewed. GAO estimates that Medicare payments for physicians' services provided to ESRD patients totaled about $150 million in 1981.

METHOD OF COMPUTING THE MONTHLY PAYMENTS OVERSTATES PHYSICIANS' INVOLVEMENT WITH HOME PATIENTS

HCFA's methodology for deriving the monthly capitation rate is based on developing an average monthly fee for physicians' involvement with

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[1]A fixed monthly amount per patient.

ESRD facility patients. HCFA used a brief visit per dialysis session (12.4 per month) and one intermediate visit per month to represent the extent of physicians' monthly involvement with ESRD patients. The monthly fee equals the payment rates for these services. The resulting fee is then adjusted for the proportion of home and facility patients and to recognize that physicians generally see home patients less often then facility patients. (See p. 10.)

Since 1974, based on "expert medical advice," HCFA has assumed that, on the average, home patients receive about 70 percent of the physician services received by facility patients and adjusted the monthly fee accordingly. For example, the average monthly rate without adjustment is $194.50, while the adjusted rate is $184.60. Renal physicians are paid the adjusted rate for all their dialysis patients--home and facility. (See p. 11.)

GAO sent questionnaires to randomly selected ESRD beneficiaries and renal physicians to determine how often dialysis patients were seen by physicians. Nationally, the physicians reported that, on the average, home patients were seen about 25 percent as often as facility patients--not the 70 percent assumed by HCFA. Using this lower percentage in HCFA's average monthly payment formula produces an average monthly payment of $170.05 or $14.55 less than the adjusted amount computed by HCFA. Using the lower monthly allowance would reduce Medicare allowed charges for physicians' services by about $11.8 million annually. (See p. 12.)

RENAL PHYSICIANS ALLOWED MORE THAN OTHER PHYSICIANS FOR SIMILAR SERVICES

Physicians use special dialysis procedure codes, established when the ESRD program started, to bill for services provided to hospitalized dialysis patients. Medicare allowances for these codes are based on the patient's condition rather than the service provided, as is normally the case. Using the special codes, ESRD physicians receive higher payment amounts without having to show that the services provided were greater than what is routinely provided hospitalized patients. HCFA and the Medicare carriers--insurance companies that administer

the program for HCFA--have not defined what services physicians should provide to qualify for payment under the special codes. (See p. 18.)

The average daily Medicare amounts allowed renal physicians for their hospital visits were about twice the average amounts which would have been allowed other specialists for hospital visits. (See p. 19.)

HCFA and two carriers found that the services renal physicians provided to hospitalized patients during dialysis visits--brief patient visits, chart reviews, and discussions with hospital staff--were essentially the same as those provided by physicians during a nondialysis hospital visit. On the days no dialysis was performed, the renal physicians were allowed less because they billed for their services using regular hospital visit codes. (See pp. 17 and 20.) GAO estimates that annual savings of about $1.3 million could be achieved in the nine states reviewed by reimbursing physicians for hospital dialysis visits on the basis of hospital visit codes rather than the special dialysis visit codes. (See p. 21.)

INCORRECT PAYMENTS FOR PHYSICIANS' CARE

GAO reviewed whether Medicare payments to physicians for services provided to ESRD beneficiaries in nine states during 1981 were made in accordance with Medicare rules. GAO identified about $721,000 in incorrect payments and another $527,000 in questionable payments covering periods of up to 3 years. Eighty percent of these amounts was paid by Medicare. Medicare carriers generally agreed with GAO's findings and have acted to recover the overpayments.

Most of the incorrect payments resulted from the administrative complexities involved in assuring correct payments when hospitalized ESRD patients receive maintenance dialysis. For example, about $142,000 in overpayments occurred when physicians, who billed on an hourly basis for inpatient care provided during dialysis, were paid for more time than was spent with the patients (see p. 31). Also $137,000 in overpayments to a physician group occurred because it

consistently used higher payment procedure codes than warranted by the patients' conditions (see p. 31).

To prevent future erroneous payments, the Medicare carriers would have to tighten their controls over payments in such situations and intensify their review of claims. However, GAO believes there is a better solution to this problem--covering all routine physician services, both inpatient and outpatient, under the monthly capitation payment. This would eliminate the hourly service and the procedure coding problems related to fee-for-service inpatient billings discussed above. HCFA could also use an all-inclusive monthly capitation rate for routine services to take into account its finding that ESRD physicians provide the same services to hospitalized patients as other physicians do by using average payments for physician inpatient visits in calculating the new rate. (See p. 38.)

HCFA data show that, on the average, ESRD patients are hospitalized 1.6 times per year for an average of 18 days per year. This means that the physician would make an average of 1.5 hospital visits per month to each patient and, based on the average payment to a specialist for a hospital visit, the monthly outpatient capitation payment would have to be increased about $38 to include routine inpatient care. GAO estimates that for the nine states reviewed, Medicare allowed charges for services provided in 1981 would have been reduced about $1.6 million if a capitation payment system covering both outpatient and inpatient services had been used. Medicare costs would have been lower in eight of the states and slightly higher (2.6 percent) in the ninth. (See pp. 39 and 40.)

CONCLUSIONS

GAO believes that Medicare costs for physicians' services under the ESRD program could be reduced if HCFA changed its reimbursement system. HCFA used 1974 data on physicians' involvement with home and facility patients in computing the monthly capitation payment. GAO believes that more current data are available and should be used.

GAO believes also that renal physicians should be reimbursed for their dialysis care on the basis of services provided rather than the patients' condition as is done under the special dialysis procedure codes. Physicians should be allowed essentially the same amounts for the same or similar services. In addition, a system that reimburses for physicians' outpatient care on the basis of a fixed monthly payment and for inpatient care on a fee-for-service basis is cumbersome to administer.

RECOMMENDATIONS

GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to:

--Adjust the current monthly capitation payment for physicians' outpatient services, taking into consideration GAO's survey data on physicians' involvement with home and facility patients.

--Develop and implement a monthly capitation payment system that reimburses physicians for all routine inpatient and outpatient dialysis care.

If these recommendations to revise the current payment system are not accepted, then GAO recommends that the special dialysis procedure codes be either eliminated and physicians paid on the basis of hospital visit codes or modified to reflect the nature and scope of the services provided.

AGENCY COMMENTS AND GAO'S EVALUATION

The Department of Health and Human Services (HHS) indicated that it supports the concepts of GAO's recommendations to revise the monthly capitation payment rates and to include routine inpatient services in the payment. It did not believe, however, that GAO's data were sufficient to support a change in the payment rates. HHS said it anticipated obtaining data in the future.

When it inquired about the anticipated data on payments to physicians for ESRD related services, GAO was told the data would not be available until the end of 1985 or beginning of 1986. Moreover, the data will not, in GAO's opinion, be very useful for evaluating the extent of physician involvement with dialysis patients because the data will only have limited information on type and frequency of services provided. HHS also expects to obtain some information related to inpatient physicians' services provided to ESRD beneficiaries from demonstration projects it plans to initiate, but this information would not be available for several years.

GAO believes that the information HHS anticipates obtaining in the future should provide a basis for changes to the ESRD program in the distant future. However, GAO has identified ways of obtaining more immediate savings and believes that HHS should act expeditiously to achieve these savings. To GAO's knowledge, its data represent the most current and complete data available. If HHS does not want to act based on these data, it should gather the necessary data and implement GAO's recommendations. (See pp. 13 and 43.)

HHS generally agreed with our recommendation to eliminate or modify the special dialysis procedure codes and stated that it is examining the problem and evaluating the best way to assure that proper payments are made. (See p. 24.)

Contents

ILLUSTRATIONS

ABBREVIATIONS

ARM	alternative reimbursement method
CAPD	continuous ambulatory peritoneal dialysis
CCPD	continuous cycling peritoneal dialysis
ESRD	End Stage Renal Disease
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IPD	intermittent peritoneal dialysis
MCP	monthly capitation payment

CHAPTER 1

INTRODUCTION

This report discusses physician reimbursement under Medicare's End Stage Renal Disease (ESRD) program. The Medicare program, established by title XVIII of the Social Security Act (42 U.S.C. 1395), effective July 1, 1966, assists in paying health care costs for eligible persons age 65 and older. The Social Security Amendments of 1972 (Public Law 92-603) extended Medicare coverage to persons suffering from kidney (renal) failure who either are currently or fully insured under the Social Security Act or are dependents of persons currently or fully insured. Medicare coverage became effective in July 1973 and covers over 90 percent of ESRD patients.

The Medicare program consists of two separate but complementary types of health insurance. Hospital insurance (part A) covers inpatient hospital, skilled nursing facility, and home health care services and is financed primarily by employer and employee payroll taxes. Supplementary medical insurance (part B) covers physician services, outpatient hospital services, and various other noninstitutional services and is financed primarily with federal funds and enrollee premiums. In 1983 premiums covered about 23 percent of part B costs. Under part B, Medicare reimburses the beneficiary or the provider for 80 percent of allowable charges. The remaining 20 percent (the coinsurance amount) is paid by the beneficiary after he or she incurs $75 in covered expenses each year (the deductible amount).

Although ESRD beneficiaries represent only about 0.25 percent of total Medicare part B beneficiaries, in 1983 ESRD payments accounted for about 8.5 percent of part B costs. In fiscal year 1974, the total ESRD program cost was about $229 million for dialysis treatments, transplants, and other services provided to 18,000 beneficiaries under Medicare parts A and B. As of July 1983, ESRD program costs had increased to more than $1.8 billion annually for more than 89,000 beneficiaries. We estimate that physicians' reimbursement for services provided during 1981 to dialysis patients under the ESRD program was about $150 million, or about $2,300 per beneficiary.

Medicare part B is administered by the Department of Health and Human Services (HHS). Within HHS, the Health Care Financing Administration (HCFA) establishes policy and exercises administrative control of Medicare part B. HCFA contracts with 40 insurance companies, called carriers, to administer the part B program, including the ESRD portion. The carriers determine reasonable charges for physician services and review and pay claims on behalf of HCFA. HCFA regional offices monitor carriers' performance, including their claim payments.

RENAL DISEASE AND ITS TREATMENT

When the kidneys fail, waste products build up in the blood stream, causing "uremia." When the onset of uremia is sudden, the condition is referred to as "acute kidney failure." In many cases of acute kidney failure, kidney function returns to normal and medical treatment to remove the waste products (dialysis) needs to be performed only for a short time. If kidney function does not return or is gradually lost, the condition is referred to as "chronic renal failure." ESRD is the late and terminal phase of chronic renal failure, during which the kidneys continue to deteriorate until all kidney functions are lost. ESRD is irreversible, and medical treatment, such as maintenance dialysis, is needed to sustain life.

Two major treatment options are available to the ESRD patient--dialysis or kidney transplant. Dialysis is the usual treatment for most patients (about 73 percent in 1983) and can be performed in a hospital, in an independent dialysis facility, or at home. The percentage of patients who dialyze at home ranges from 60 percent in some states to less than 5 percent in others. Nationally, during 1983, about 19 percent of ESRD dialysis patients dialyzed at home. Dialysis in any setting is expensive; as of December 1983 Medicare paid on the average about $24,000 a year to treat a dialysis patient.

There are two methods of dialysis--hemodialysis and peritoneal dialysis. During hemodialysis, blood is taken from the patient's body and passed through a dialysis machine, which filters out body waste before returning the blood to the patient. During peritoneal dialysis, the blood is filtered within the patient's abdominal cavity without leaving the body. There are three variations of peritoneal dialysis--continuous ambulatory (CAPD), intermittent (IPD), and continuous cycling (CCPD).

Renal physicians[1] provide services to dialysis patients on an inpatient and outpatient basis. Inpatient care is provided after the ESRD beneficiary has been admitted to the hospital, while outpatient care can be provided in a hospital or in an independent dialysis facility. In either setting the beneficiary goes to the hospital or dialysis facility to get dialysis treatments and is not admitted as a patient.

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[1]As used in this report, renal physician refers to internists, nephrologists, or other physicians who treated ESRD patients.

The other way of treating ESRD, kidney transplant, is generally a viable option for any patient who is fit for surgery. The feasibility of a transplant also depends upon the availability of a suitable donated organ. Because younger patients do not tolerate the restrictions of dialysis as well as older patients, they are most likely to receive a transplant.

The prevalence of ESRD in the United States is estimated to be between 200 and 250 persons per million. Based on the experience of Medicare and the Veterans Administration--the two major health financers of ESRD treatment--the incidence of new ESRD patients each year is between 55 and 65 persons per million.

ESRD PROGRAM LEGISLATIVE HISTORY

In the early 1960's, medical technology and treatment for renal disease advanced significantly, but treatment costs were high and treatment availability limited. The decision to admit a patient to a dialysis program was based on economic and social, as well as medical, factors. Many communities and hospitals developed explicit patient selection criteria because of the limited number of renal physicians, transplant surgeons, dialysis machines, and donated organs. The selection process, in effect, became a life and death decision, with the young and potentially employable usually selected for dialysis or transplant.

The Social Security Amendments of 1972 (Public Law 92-603) were enacted in October 1972. Section 299(I) of the law provided access to renal treatment for all persons insured under Social Security. Before the amendments were passed, only persons aged 65 or older who had Medicare coverage were eligible for reimbursement for dialysis services.

The 1978 ESRD Program Amendments (Public Law 95-292) were enacted in June 1978 to promote efficiency and economy in the delivery of renal services by encouraging self-dialysis (home and facility) and kidney transplants. In 1973, about 40 percent of all ESRD patients were dialyzed at home; however, by 1978, the number had decreased to about 10 percent. Because it is generally less expensive, the Congress wanted to encourage home dialysis. Accordingly, the amendments changed eligibility rules by authorizing elimination of the 3-month waiting period for home patients, established a prospective payment system for home dialysis based on paying facilities a target rate,[2] established criteria for in-facility self-care, and increased Medicare coverage for home dialysis supplies and equipment.

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[2]Payment was based on a predetermined fixed rate, not on the actual cost of providing the service.

In 1981 the Omnibus Budget Reconciliation Act (Public Law 97-35) required HHS to develop a prospective payment system for outpatient dialysis services that would further promote home dialysis. The system had to pay for home and facility dialysis under either a composite rate (a single rate for both home and facility patients) or another method that would effectively promote home dialysis.

PHYSICIAN REIMBURSEMENT FOR SERVICES PROVIDED DIALYSIS PATIENTS

Before August 1983, the Medicare program reimbursed physicians for services provided to dialysis patients under one of two methods--the initial method or the alternative reimbursement method (ARM). Under the initial method, in effect since the ESRD program started, the method of payment varied depending on where a patient was dialyzed. For those who dialyzed in a facility, Medicare allowed each facility $12 per dialysis session to cover physicians' supervisory care[3] provided during dialysis. The physicians negotiated with facility officials for their fees and could be paid more or less than the $12 per session depending on their agreement with the facility. In addition, physicians could bill Medicare on a fee-for-service basis for their nonsupervisory outpatient care and for all inpatient care provided to facility patients. For home dialysis patients, physicians were paid on a fee-for-service basis for all their care.

Renal physicians were not satisfied with the initial method. Many believed that the initial method discriminated against renal physicians as a group because other physicians were paid for their services directly by Medicare on a fee-for-service basis. Some physicians cited difficulties in negotiating with the facilities for their fees. As a result, the ARM was implemented in July 1974. At the end of 1980 physicians reimbursed under the ARM provided about 75 percent of all dialysis services.

Under the ARM, renal physicians were given a monthly capitation payment (a fixed monthly payment for each patient) for all routine outpatient dialysis care provided to ESRD beneficiaries. Because HCFA had concluded that physicians saw home

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[3]HCFA defined physicians' supervisory care as being available for consultation; evaluating appropriateness of proposed treatment modality; performing pre- and post-dialysis examinations; overseeing the performance of dialysis, including review of laboratory tests and adjustments of dialysis procedures; monitoring patients' medical status and vital signs; determining or adjusting the need for medication and supplies; reviewing and adjusting dietary controls; and reviewing psychosocial issues.

patients less often than facility patients,[4] and that home patients required less physician involvement, a lower monthly rate was paid for home patients. The payment amounts varied geographically, with the maximum monthly amounts allowable being $260 for facility patients and $182 for home patients during the period July 1978 to August 1983. From July 1974 through June 1978, the maximum allowable rate was $240 for facility patients and $168 for home patients.

Under the ARM, renal physicians had the option of receiving the ARM payment for inpatient hospital services or billing separately for such services on a fee-for-service basis. However, when the physician billed separately for inpatient hospital services, carriers were required to reduce the monthly capitation payment by 1/30 for each day during the month the patient was hospitalized.

The MCP system

In August 1983, HCFA eliminated the initial method[5] and the ARM and implemented a new monthly capitation payment (MCP) system for routine outpatient physician services. The new system, like the ARM, makes only one monthly payment for outpatient services. However, MCP eliminated the differences in rates for facility and home patients and changed the method of computing the monthly payment. MCP's single rate increased reimbursement for services to home patients and reduced it for facility patients. Physicians still have the option to accept the MCP payment for inpatient services or to bill on a fee-for-service basis for such services. The payment amounts were computed using 1979 physician charge data and vary by geographical areas. Under MCP the maximum and minimum allowable monthly amounts are $220 and $144, respectively.

Through its single rate, MCP is intended to act as an economic incentive for physicians to promote home dialysis. This is because physicians see home patients less often than facility patients but receive the same monthly payment for both.

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[4]Facility patients receive outpatient dialysis treatment at a dialysis facility or a hospital.

[5]In September 1984 the U.S. District Court for the District of Columbia found that the Secretary had to continue allowing use of the initial method in a form that takes into account requirements, such as promoting the use of home dialysis. National Association of Patients on Hemodialysis v. Heckler, 588 F. Supp. 1108 (D.D.C. 1984).

OBJECTIVES, SCOPE, and METHODOLOGY

The purpose of our work was to evaluate the appropriateness of physician reimbursement under the ESRD program. Specific assignment objectives were to

--determine the cost of physician services for ESRD beneficiaries under the ARM;

--determine the nature of services provided ESRD patients;

--compare carrier reimbursement policies and practices, particularly for services provided to hospitalized ESRD beneficiaries; and

--obtain patient and physician views on various subjects related to ESRD treatment and reimbursement.

Our review was performed in 1983 and 1984 and was conducted at HCFA headquarters and at four of its regional offices, in nine states, and at the five Medicare carriers responsible for paying Medicare part B claims in these states. The nine states were selected because they were located in different parts of the country, they had a high percentage of physicians being reimbursed under the ARM, and one of the states had a large home patient population. In addition, we did limited work at the Medicare intermediaries--insurance companies responsible for paying Medicare hospital claims in the nine states. In 1981 there were about 5,400[6] ESRD beneficiaries in these states, and they were served by 205 renal physicians. The HCFA regions, carriers, and states included in our review are listed below.

HCFA regional offices	Medicare carriers	States
I	Massachusetts Blue Shield	Massachusetts
	Rhode Island Blue Shield	Rhode Island
VI	Arkansas Blue Shield	Arkansas
IX	Aetna Life & Casualty Co.	Arizona
		Hawaii
		Nevada
X	Washington Physicians Service	Washington
	Aetna Life & Casualty Co.	Alaska
		Oregon

[6]As of December 31, 1981, there were about 55,000 ESRD beneficiaries nationwide receiving dialysis treatments.

A limited amount of work was done in another state--Louisiana. However, because we could not obtain usable computer tape data in time for our review, Louisiana was omitted from our review. Although headquarters for Aetna Life and Casualty Company is in Hartford, Connecticut, its Medicare part B activities in the five states were administered through field offices in Phoenix, Arizona; Portland, Oregon; and Honolulu, Hawaii. Our work was conducted at both Aetna headquarters and these three field offices.

Our review focused on physicians reimbursed under the ARM because over 90 percent of the dialysis patients in the states reviewed were treated by such physicians. In addition, the initial method was going to be eliminated, and the reimbursement method under MCP is similar to the ARM which it replaced. Under both methods renal physicians receive a fixed monthly amount per patient for routine outpatient care and a fee for each inpatient service provided.

Our review covered claims for services provided during calendar year 1981. The 1981 data were used because it was the most recent year for which most claims would have been submitted for payment since physicians generally have about 1 year, following the year in which the service was provided, to file claims for reimbursement. To determine the cost and nature of physician services provided to ESRD beneficiaries during 1981, we identified the physicians who received an ARM payment during that year. We then obtained physician claims histories from the carriers to identify the beneficiaries and the nature and extent of renal services provided.

In six states, we reviewed all ARM physicians' claims histories. In the other three states, we reviewed physicians' inpatient claims for a statistically selected random sample of 100 hospitalized ESRD beneficiaries and all claims for outpatient dialysis services. We totaled or statistically projected the physicians' costs for services provided to the ESRD beneficiaries. All projections were made at the 95-percent confidence level. Our review did not cover claims for kidney transplants or related services.

Our approach was to review physicians' claims histories to identify physicians who appeared to be billing for an unusually high number of services or whose charges appeared to be higher than those of other physicians. To obtain an indication of frequency for the questionable cases, we reviewed claims data, patient medical records, and carrier payment histories for selected beneficiaries or physicians. Because the beneficiaries or physicians selected for further analysis were not statistically selected, the results of these analyses cannot be statistically projected.

In conducting our audit work, we did not review the carriers' automated claims processing system to determine the accuracy or completeness of the information they furnished to us. However, we discussed data reliability with carrier and HCFA officials who use the information to determine the extent to which they relied on the information. These officials said that they use the information and are satisfied with its accuracy.

We discussed Medicare's ESRD program payment policies with carrier officials, particularly the policies relating to services provided to hospitalized ESRD patients. To determine differences in carrier payment policies for services provided to ESRD beneficiaries, we reviewed the procedure codes established by the carrier to pay for such services. In addition, we discussed the propriety of specific payments with carrier and HCFA officials and considered their views in preparing our report.

To obtain the views of physicians who provided renal services to ESRD beneficiaries during 1981, we sent a questionnaire to all 288 renal physicians in the 10 states initially included in our review and to a statistically selected random sample of 266 physicians in the other 40 states. By combining both physician groups, we obtained a statistically valid national sample.

To obtain ESRD beneficiaries' views, we sent a questionnaire to 871 beneficiaries in 8 of the 10 states initially included in our review. For the other two states, the names and addresses of ESRD beneficiaries could not be obtained in time for inclusion in our sample. Our sample was selected from the 4,720 beneficiary payment histories that contained 1981 physician charges for renal services. Additional information abstracted from the two questionnaires on the characteristics of renal physician practices and ESRD patients is summarized in appendix I. Information on the physician and beneficiary questionnaire methodology, objectives, response rates, responses, and projections are presented in the supplement to this report.

We obtained comments from HHS and considered its views in finalizing our report. The comments are included as appendix III.

Our review was made in accordance with generally accepted government auditing standards.

CHAPTER 2

NEW CAPITATION RATES OVERSTATE PHYSICIANS' INVOLVEMENT WITH HOME DIALYSIS PATIENTS

On August 1, 1983, HCFA's carriers began to reimburse renal physicians under the MCP system. Under this system, the monthly capitation allowance for routine outpatient care is the same for home and facility patients. HCFA estimated that in fiscal year 1984, the new MCP allowance would reduce allowed charges by about $10 million from what they would have been under the prior ARM system. Our analysis of HCFA's methodology used to develop the MCP rate showed that the weighting factor or ratio used to estimate physician involvement with home and facility patients overstated the physician involvement with home patients.

The weighting of physician involvement for home patients in the HCFA formula assumed that a doctor could treat 10 home patients for every 7 facility patients, or a treatment ratio of 1.4 to 1. On the basis of our survey data on physician-patient contacts, we believe that this ratio is too low. Using the number of patient contacts shown by our survey of physicians as an indicator of physician involvement with home patients, doctors could treat about 3.9 home patients for every facility patient. Therefore the composite MCP rate is too high. Using our weighting factor to compute the MCP allowance would result in a reduction in Medicare allowed costs of about $11.8 million a year.

REIMBURSEMENT SYSTEM FOR OUTPATIENT SERVICES

Section 2145 of the Omnibus Budget Reconciliation Act of 1981 authorizes HHS to reimburse physicians on a basis that effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis. HCFA interpreted this to mean that the Congress believed that the physician, as the primary decision maker on how treatment is to be furnished, can influence a patient's choice of a dialysis setting and that the reimbursement method should be used to encourage home dialysis. In August 1983, HCFA implemented MCP as the only reimbursement system for routine outpatient dialysis care provided by renal physicians. HCFA believes this system, which uses the same reimbursement rate for both facility and home patients, will provide an economic incentive for physicians to encourage home dialysis.

The MCP system replaced both the initial method and the ARM. Although MCP, like the ARM, makes one monthly payment per

fewer services to home patients, i.e., see them less often than they do facility patients. To recognize this difference, HCFA estimated that a physician can care for about 10 home patients for every 7 facility patients, a ratio of 1.4 to 1. In other words, home patients receive about 70 percent of the physician care provided to facility patients. HCFA then adjusted its preliminary rate for the proportion of home dialysis patients and for the fewer physician services provided to home patients. This adjustment resulted in a nationwide average monthly MCP rate of $184.60 per patient and was computed as follows: $194.50 x .83 = $161.45 (portion weighted for in-facility patients) + ($194.50 x .17) x .70 = $23.15 (portion weighted for home patients). Therefore, $161.45 + $23.15 = $184.60.

According to the explanation accompanying the May 1983 final regulations, a comment on the proposed regulations suggested that the assumption under both the ARM and the new MCP systems that physicians could, on the average, handle 10 home patients in the time that it would take to handle 7 facility patients "lacked any rational justification."

In replying to this comment, HCFA stated:

> "As pointed out in the [Notice of Proposed Rule Making], the 10:7 ratio exists in the present ARM and was based on expert medical advice provided at the time the ARM was established [1974]. Although the comment questioned the basis for the ratio, the comment did not propose any other ratio or provide any information suggesting that the ratio is, in fact, inappropriate. If we are furnished with such information, we will evaluate it and make appropriate changes in the methodology, but until such time we must use some ratio and we believe that it is reasonable to continue using the ARM ratio."

GAO DATA ON PHYSICIAN CONTACTS DO NOT SUPPORT HCFA'S RATIO

Our questionnaire survey on physician/patient contacts showed that HCFA's ratio of 10 to 7 (or about 1.4 to 1) was too low and overstated the relative involvement of physicians with home dialysis patients. Our nationwide survey of 497 physicians treating dialysis patients showed that physicians saw facility patients an average of 12.4[2] times per month and home patients

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[2]This is a projected number, and the sampling error at the 95-percent confidence level is plus or minus 0.5. The most comparable HCFA number is 13.4.

CONCLUSIONS

In the May 1983 final regulation, HCFA acknowledged that the ratio of physician involvement with home patients as compared to facility patients was based on "expert medical advice" provided when the ARM was established in 1974. HCFA also stated that if it was furnished any information suggesting that this ratio is inappropriate, it would evaluate the data and make appropriate changes. We believe our 1982 survey data provide HCFA with such information.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to modify the MCP rate taking into consideration our survey data on relative physician involvement with home and facility patients.

HHS COMMENTS AND OUR EVALUATION

HHS commented (see app. III) that the data we collected will be helpful in examining the appropriateness of the level of physician reimbursement under the MCP rates. However, HHS does not believe our data are sufficient to authorize a reduction in the rate at this time. In addition, HHS said that it anticipates that further information will become available which will be more current and include national experience in the data base. HHS stated that our information would be a useful supplement to the anticipated data.

When we asked HCFA what information it anticipated receiving, we were informed that data for 1983 and 1984 on physician payments for ESRD-related services would be available toward the end of 1985 and 1986, respectively. In our opinion, these data will not be useful for evaluating the extent of physician outpatient contacts or the ratio of contacts with facility patients versus home patients. The only possible data related to these issues included in the anticipated data are the number of contacts by those relatively few renal physicians who billed for outpatient care on a fee-for-service basis, and these data will only be available for the first 7 months of 1983, after which all renal physicians were paid on a monthly capitation basis for all patients.

Our data represent a valid, nationally projectable statistical sample and to our knowledge are the best data available. We believe they are sufficient for HHS to evaluate and make appropriate changes to the current MCP rate. If HHS does not want to reduce the rate based on our data, it should collect whatever additional data it needs and implement our recommendation.

CURRENT REIMBURSEMENT SYSTEM FOR INPATIENT SERVICES

MCP, like the monthly ARM payment, covers all routine physician outpatient services provided to dialysis patients. When a dialysis patient is hospitalized, Medicare will pay for the renal physician's inpatient hospital services on a fee-for-service basis. Because of the high cost of inpatient services and the high rate of hospitalization among dialysis patients, inpatient hospital care represented about 27 percent of the total allowed charges for physician services under the ESRD program in the states reviewed.

According to HCFA data, about 70 percent of ESRD patients were hospitalized at least once during 1981, compared to about 24 percent of all Medicare beneficiaries and 10 percent of the population at large. The average length of a hospital stay for both ESRD patients and all Medicare patients was about 11 days, compared to 8 days for the population at large. For the states in our review, the average length of stay during 1981 for each time an ESRD beneficiary was hospitalized was also about 11 days. During that year, Medicare allowed the renal physicians in these states about $3 million in charges for inpatient hospital visits.

We found that 54 percent of the ESRD patient population in the nine states reviewed were hospitalized at least once during 1981. The average length of time hospitalized during the year was 25 days. In these states, about 27 percent of Medicare's payments to renal physicians were for inpatient services. The inpatient costs and hospitalization data for the states reviewed are summarized below.

RENAL PHYSICIANS ARE ALLOWED MORE THAN OTHER PHYSICIANS FOR INPATIENT VISITS

Renal physicians are allowed more for inpatient services provided during dialysis visits than other physician specialists are allowed for inpatient services provided during hospital visits. A HCFA study showed that the renal physician services provided during inpatient dialysis visits are similar to those provided by other physicians during hospital visits to their patients. Our review showed that the allowed amounts for inpatient dialysis visits are substantially more than those for hospital visits. Renal physicians were allowed about two times more for services provided during dialysis visits than other physician specialists were allowed for services provided during hospital visits.

Inpatient dialysis visits are similar to hospital visits

A HCFA review of physicians' inpatient dialysis care showed that renal physicians provided little direct patient care during inpatient dialysis treatments. A summary of the review issued in July 1983[2] states, in part, that

> ". . . physicians provided little or no direct services during dialysis. Both the documented evidence and discussions with dialysis personnel confirmed that generally physicians did not personally supervise or perform the dialysis treatments. Physicians, however, are reimbursed as if they performed the dialysis treatments . . . We found that these services should be considered patient management services, since they usually consist of brief patient visits, a chart review and when necessary discussion with staff."

HCFA also noted that the services renal physicians provided on days when patients were dialyzed differed little from those provided on other days. However, according to the summary, on the days without dialysis renal physicians were allowed less because they billed for their services under hospital visit procedure codes. As a result, a renal physician would be allowed $250 for a visit to a hospitalized patient on a dialysis treatment day and $30 for a similar visit the next day when no dialysis was performed. The summary report also noted that the

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[2]HCFA's inpatient care review was conducted in six states--California, Florida, Illinois, New Jersey, New York, and Oregon--and covered services provided by 59 physicians for 435 ESRD patients during calendar year 1980.

primarily inpatient dialysis visits and hospital visits--ranged from $21 to $72 in the states reviewed. Assuming that the services provided were equivalent to those normally provided during initial and follow-up hospital visits, we computed the average daily amounts[3] which would have been allowable to other medical specialists for such services using 1981 Medicare prevailing charge data. A comparison of these data show that medical specialists in eight of the nine states would have received substantially less than renal physicians for their services.

The following table compares the average daily amounts allowed renal physicians for inpatient hospital visits provided during 1981 and the average daily amounts which would have been allowed other medical specialists for similar services.

State	Average number of hospital days per hospitalized beneficiary	Average daily amounts allowed renal physicians per hospital beneficiary	Average daily amounts allowable to other medical specialists[a]
Alaska	16	$58	$35
Arizona	26	48	21
Arkansas	25	42	22
Hawaii	24	72	31
Massachusetts	29	39	22
Nevada	19	64	27
Oregon	22	49	19
Rhode Island	22	21	26
Washington	21	48	24

[a]The amounts allowed to medical specialists for hospital visits are generally higher than the amounts allowed to general practitioners for the same services.

Physicians not present during dialysis

To determine the nature and extent of the services renal physicians provided during dialysis visits and to confirm the results of the HCFA study, we reviewed medical records for

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[3]Computed by taking an average of the 1981 prevailing charges for all initial and follow-up hospital visits as published by HCFA.

visit, carrier officials told us that they considered the services provided during a dialysis visit essentially the same as those provided during a hospital visit.

The carrier for Texas started to limit reimbursement for renal physicians' inpatient dialysis visits in August 1983. A carrier official advised us that after HCFA regional officials suggested that payments for acute inpatient dialysis visits were excessive, the carrier made a review of renal physicians' claims for these visits. The review showed that the care provided by renal physicians during inpatient dialysis visits was essentially the same as that provided by other physicians during hospital visits. During 1982 the renal physicians were allowed from $136 to $250 per inpatient dialysis visit, compared to about $14 to $55 for hospital visits.

The carrier official stated that, as a result of its review, the carrier changed its reimbursement practices and discontinued using acute dialysis procedure codes. Under the carrier's new reimbursement procedures, unless the physician can show that more care was provided than what is usually provided during a routine hospital visit, renal physicians are reimbursed for their dialysis visits under regular hospital visit codes and, accordingly, allowed the same amounts as other physicians. The official also stated that when the more intensive care dialysis procedure codes are used, the higher level of care claimed must be justified by the physician or by the patient's hospital records.

We do not believe that renal physicians should be allowed to routinely use special dialysis procedure codes to bill for their hospital visits to renal patients on the days they are dialyzed. The special codes allow renal physicians to receive substantially more money than other physicians for essentially the same services. In the nine states reviewed, Medicare allowed about $1.9 million for inpatient dialysis visits made during 1981. If all these visits had been reimbursed as follow-up hospital visits, we estimate the total amount allowed would have been about $600,000, or a savings of about $1.3 million.[5]

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[5]Our savings was computed as follows. For each state the average amount allowed during calendar year 1981 for follow-up hospital visits was computed. This amount was then multiplied by the number of inpatient dialysis visits allowed during the year. The resulting amount was then compared to the total amount allowed by Medicare for inpatient dialysis visits.

HCFA COMMON PROCEDURE CODING SYSTEM

During 1983, Medicare carriers started implementing a national reimbursement coding system for physicians' services. The new system is based on procedure codes and terminology developed by the American Medical Association, insurers, state agencies, and Medicare contractors to meet the claims processing needs of the Medicare and Medicaid programs. As of July 1984, about half of the Medicare carriers had implemented the new system; the other half are expected to complete the changes by mid-1985. The new system includes procedure codes for physicians' services provided to dialysis patients.

HCFA officials told us that the new system will not preclude carriers from using the special dialysis procedure codes because the carriers have the option of using local codes in situations when they believe the new codes are not adequate.

CONCLUSIONS

The reimbursement codes for inpatient hospital dialysis visits reflect the patients' condition rather than the services provided, the usual way of determining Medicare reimbursement. HCFA and some carriers found that the services renal physicians provided to hospitalized renal patients during dialysis visits are essentially the same as those provided by other physicians during hospital visits to their patients. However, the average amounts Medicare allowed renal physicians for inpatient hospital visits, including visits during dialysis, were in most instances about two times more than other physician specialists were allowed for their hospital visits.

RECOMMENDATION TO THE SECRETARY OF HHS

As discussed in chapter 5, we believe that establishing a total capitation system for all routine inpatient and outpatient care would be a better solution for paying for routine inpatient care than the present fee-for-service system. However, if the recommendation for a total capitation system is not accepted, we recommend that the Secretary direct the Administrator of HCFA to either

- --eliminate the special dialysis visit procedure codes and pay physicians for the services provided to hospitalized ESRD patients during dialysis on the basis of hospital visit codes or

- --modify the dialysis visit codes to reflect the nature and scope of physician services provided during dialysis and the amounts other physicians receive for the same or similar services.

CHAPTER 4

INCORRECT PAYMENTS FOR PHYSICIANS' CARE

During our review we found several instances in which the carriers had incorrectly paid renal physicians for services provided to ESRD beneficiaries. The incorrect payments resulted in about $721,000 in overpayments, 80 percent of which was paid by Medicare and the other 20 percent is the responsibility of the beneficiaries. About $36,000 of the overpayments involved monthly capitation payments, whereas about $685,000 involved fee-for-service payments. Another $527,000 in questionable fee-for-service payments were referred to the HHS Inspector General for further review. As of December 1984 the amount of overpayments involved had not been determined.

The overpayments were due primarily to limited review of physicians' claims and/or improper physician billing practices. However, we believe that a reimbursement system which pays for outpatient care on a capitation basis and for inpatient care on a fee-for-service basis is inherently difficult to administer and contributes to overpayment problems.

Carrier officials generally agreed with our findings and acted to collect the overpayments and prevent their recurrence. The overpayments made to physicians under the initial method will not recur because the MCP system eliminated that method. However, the overpayments made to ARM physicians could recur because of the similarities between the ARM and MCP systems. The MCP system will continue to pay for routine outpatient care through a monthly capitation payment and for inpatient care on a fee-for-service basis.

INCORRECT PAYMENTS INVOLVING MONTHLY CAPITATION PAYMENTS

During our review we found several instances in which carriers made incorrect payments involving renal physicians' monthly capitation payments. The incorrect payments resulted in about $36,000 in overpayments and consisted of (1) $26,000 for incorrect adjustment of the monthly capitation payments for periods when the patient was hospitalized and (2) about $10,000 for incorrect payments of the monthly ARM payment.

State	Number of hospital stays[a]	Number of months incorrectly paid	Error rate	Total amount of overpayments[a]
Alaska	47	19	.40	$ 417
Arizona	1,085	493	.45	14,963
Hawaii	595	175	.29	3,826
Nevada	279	51	.18	1,693
Oregon	960	175	.18	3,565
Rhode Island	269	44	.16	1,238
Total	3,235	957	.30	$25,702

[a]All amounts for Arizona, Hawaii, and Oregon are projections based on payment data for a statistical sample of 100 hospitalized patients in each state. All projections were made at the 95-percent confidence level. The amounts for Alaska, Nevada, and Rhode Island are based on an analysis of payment data for all hospitalized patients.

In July 1983 HCFA revised its carrier manual to clarify its instructions on adjusting the monthly capitation payment for the number of days a patient is hospitalized. Furthermore, we were advised that this item will be incorporated in the criteria used to evaluate carrier performance. These actions should help alleviate this problem.

Incorrect payments of monthly capitation payments

Physicians in Arkansas, Hawaii, and Massachusetts were incorrectly reimbursed ARM payments. The incorrect payments resulted in the following overpayments, all of which were referred to the carriers for collection.

--In Hawaii, the carrier incorrectly computed a physician's monthly ARM allowance, allowing an extra $11 per month per patient. To compute the allowance, the carrier used the prevailing rate instead of the physician's customary charge which was lower, therefore the monthly allowance was $11 higher than it should have been. Total 1981 estimated overpayments for the physician were $2,250.

--The carriers for Arkansas and Massachusetts computed physicians' monthly ARM payments by multiplying the number of days billed by the average daily ARM rate. To determine the daily rates, the carriers divided the total monthly amount allowed by 30. The carriers, however, did

To determine the prevalence of this billing practice, we reviewed physicians' inpatient dialysis charges for six beneficiaries. During July and August 1981, the physicians billed and were paid for 151 inpatient dialysis visits. We reviewed the supporting documentation for 148 of the claims and found that 123 (or over 80 percent) of the services were outpatient care and that only 25 claims should have been for inpatient care. We could not determine on what basis the three remaining services were provided because the pertinent records could not be located.

We discussed this billing practice with carrier and HCFA officials in August 1982, and they agreed that inaccurate charges had been submitted and paid. The carrier agreed to review the physicians' payment records to determine the extent of the overpayments made and to take collection action. The carrier subsequently advised us that it had stopped paying the physicians for outpatient care billed as inpatient dialysis visits. However, because of the possibility that the outpatient services were intentionally billed as inpatient services, the carrier referred this matter to HHS' Office of Inspector General, Office of Investigation, in August 1983 for further review. As of December 1984, the case was still under review, and the total amount of overpayments had not been determined.

In Massachusetts we also found instances in which renal physicians were incorrectly paid for their outpatient care because they billed and were reimbursed for the services as inpatient care. The incorrect payments resulted in the following overpayments, all of which were referred to the carrier for collection.

--Outpatient services provided by initial method physicians for a 2-week period following a patient's discharge from a hospital were routinely billed and paid for as inpatient services. Charges for such services are covered as part of the hospital's dialysis treatment rate and are not reimbursable as separate charges. We estimate that over a 2-year period, the overpayments based on allowed charges resulting from this practice totaled about $30,000.

--Eleven physicians were allowed charges for inpatient hospital services when their claims did not indicate that the patients were hospitalized. Total estimated 1981 overpayments to these physicians based on allowed charges were about $19,000.

Inpatient routine care incorrectly paid for as acute care

Our analysis of the billing practices for two physician groups in Nevada showed that the physicians in one group consistently billed for their inpatient dialysis visits under the acute dialysis procedure codes, which had a higher allowance than the codes for chronic visits. In 1981, the physicians in that group were allowed about $230,000 for acute dialysis visits (about 82 percent of all their inpatient dialysis visits) and about $10,125 for chronic dialysis visits. The physicians in the second group were allowed $12,300 for acute dialysis visits and $94,725 for chronic dialysis visits (about 98 percent of all their inpatient dialysis visits).

Our review of medical records for beneficiaries treated by the first physician group disclosed several dialysis visits for which the acute classification did not appear to be appropriate. For example, an ESRD beneficiary was hospitalized 8 days for an infected foot and received four dialysis treatments during this stay. His renal physician billed for four acute inpatient dialysis sessions and was reimbursed $1,400. The dialysis nurse's notes indicate that the patient was not experiencing any difficulties during any of the dialysis sessions. The physician's note on the discharge summary indicates that the dialysis treatments given during the hospital stay were routine maintenance treatments, yet all four were billed as acute inpatient dialysis treatments.

After analyzing medical records for eight patients, we asked the carrier to review the group's billing practices. The carrier reviewed the claims submitted by this group for a 28-month period, starting with January 1980 claims. The carrier found that from January 1980 through December 1981, 50 to 60 percent of the group's billings for acute dialysis visits were incorrect. As a result of its review, the carrier reduced the group's billings to chronic dialysis visits and recovered about $110,000 in overpayments involving allowed charges of $137,000. The carrier also placed the group on prepayment review, which means that all dialysis service claims submitted by the group will be subjected to extraordinary review before payment is made.

Carrier pays claims for unsupported hourly charges

The carrier for Arizona and Hawaii had established special dialysis procedure codes that allowed reimbursement on an hourly basis for physician services provided during dialysis treatment. The carrier routinely paid claims for hourly services

The carrier for Arizona also allowed physicians' charges for both acute dialysis sessions and acute hourly dialysis services involving the same patient during the same dialysis session. A carrier official told us that they have no guidelines on the amount of time a physician should spend with a patient before both procedure codes are allowed during the same dialysis session. At the time of our review, the allowable amounts for these procedure codes were $123 per dialysis session and $48.70 per hour.

We reviewed the carrier's physician payment histories for all Arizona renal physicians and found that, during 1981, three physicians had billed for acute dialysis sessions and had also billed for acute hourly dialysis services for the entire length of the same dialysis sessions. For example, one physician billed Medicare $422 for 4 hours of services and $300 for an acute inpatient dialysis visit for the same session and was allowed $503 for these services. The patient's records showed that the dialysis treatment started at 9:25 a.m. and ended at 12:25 p.m. The dialysis nurse noted on the dialysis record that the physician visited the patient at 10:10 a.m., or 2 hours and 15 minutes before the treatment ended.

In February 1983, we discussed these hourly billing practices with carrier officials who agreed to look into the matter. However, because of the possibility of questionable billing practices, we referred the matter to HHS' Inspector General in June 1983 for further investigation. In April 1984, the Regional Inspector General for Investigation advised us that our information had been referred to the carrier for validation. He advised us also that the carrier had completed its review of Arizona physicians and the problems found related to a (1) lack of documentation for services rendered and (2) misunderstanding of proper billing procedures. The carrier reviewed a total of eight physicians including the three we identified. Medicare overpayments of about $104,000, involving allowed charges of $130,000, were recovered from the eight physicians. In October 1984, we were advised that the carrier's review of Hawaii physicians was completed and Medicare overpayments of about $9,600 involving allowed charges of $12,000 had been recovered.

Multiple services provided to same patient

The carriers in seven of the nine states covered by our review reimbursed renal physicians for multiple visits provided to the same patient on the same day without obtaining appropriate justifications, even though Medicare policy allows payments for such visits only when medically justified. Some of the carriers reimbursed physicians for an acute inpatient dialysis visit, in

made adequate postpayment reviews of renal physicians' claims during the time of our review.

Charges allowed for acute care provided on the day patients were discharged from the hospital

Our initial review of claims histories showed that carriers reimbursed renal physicians for acute inpatient dialysis visits on the day patients were discharged from the hospital, even though the two events appear to be mutually exclusive; that is, a physician normally would not discharge an acutely ill patient. We believe that in most of these instances, the carriers should have allowed a routine follow-up hospital visit.

We reviewed payment histories for ESRD beneficiaries hospitalized during 1981 in four states to identify claims for acute dialysis visits on the day of discharge. Our review covered histories for all hospitalized ESRD beneficiaries in three of the states and those of a sample of beneficiaries in the fourth state. We identified 339 instances in which physicians were paid for acute dialysis services provided to a patient on the day of his or her discharge. The following schedule shows by state the number of cases involved and the estimated amount of overpayment.

We are not making a recommendation concerning the overpayments noted because our findings were discussed with HCFA and carrier officials, and for the most part, they agreed with our findings and carrier officials took or agreed to take action to collect the overpayments and prevent their recurrence. In addition, as discussed in chapter 5, we believe that the establishment of a total capitation system for all routine inpatient and outpatient physician care would correct many of the payment errors noted during our review.

--develop more specific criteria and appropriate claims review procedures to prevent incorrect payment of physicians' claims for inpatient and outpatient dialysis care.

CHARACTERISTICS OF A TOTAL CAPITATION SYSTEM

A total capitation system would provide renal physicians a monthly fee for all routine inpatient and outpatient renal services provided as part of the medical management and treatment of dialysis patients. The same amounts would be paid for each patient, whether treated at home or in a facility, to preserve the incentive to promote home dialysis. Separate fee-for-service billings would be allowed only for medically necessary, nonroutine renal or nonrenal related care.

Monthly payment computation

The monthly payment allowed under a total capitation system would include an amount for the routine inpatient care provided during hospitalization. HCFA data for 1981 show that ESRD patients were hospitalized 1.6 times during the year; the average length of stay per admission was 11 days. Based on these data, we calculated that a factor of 1.5 visits[1] could be added to the monthly payment for inpatient care.

Using HCFA's methodology, we recomputed an average total monthly capitation payment of about $208, an increase of about $38 over the amount we previously computed (see p. 12 of this report). This computation is based on (1) the nationwide average MCP rate estimated by HCFA as adjusted for our home patient weighting factor (see ch. 2), (2) the 1.5 factor for inpatient visits multiplied by the nationwide average 1981 allowed charge for a hospital visit, and (3) the assumption that all inpatient physician services provided during 1981 were routine services.

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[1]This factor was derived as follows: 1.6 stays multiplied by 11 days divided by 12 months equals 1.5 visits per month. The current MCP is based on Medicare allowed charges for office visits. Including inpatient hospital care in the MCP would require the use of Medicare allowed charges for hospital visits which are generally higher than those for office visits. Therefore, in a revised MCP computation formula, the factor would be slightly higher than 1.5. In this report, for computing our savings estimates and in estimating the change in the monthly MCP rate, we included the average Medicare allowed charges for hospital visits.

Effect of MCP and Total Capitation Systems on Deficiencies Noted

	Deficiency	Effect of MCP	Effect of total capitation system
1.	Monthly capitation payments not correctly reduced for hospitalization periods	No effect	Eliminates need for monthly adjustments
2.	Incorrect payments of monthly capitation payments	No effect	Eliminates except for those dealing with rate computation
3.	Outpatient services incorrectly paid for as inpatient hospital care	No effect	Eliminates most inpatient charges and chances for errors
4.	Duplicate payments for physicians' outpatient care under initial method	Eliminated initial method	Corrected by MCP
5.	Inpatient routine care incorrectly paid for as acute care	Limited effect[a]	Eliminates most inpatient charges and chances for errors
6.	Claims paid for unsupported hourly charges	No effect	Same as 5
7.	Multiple services provided to same patient	No effect	Same as 5
8.	Charges allowed for acute care provided on the day patients were discharged from the hospital	Limited effect[a]	Same as 5

[a]Although the MCP system does not eliminate this deficiency, recent changes in HCFA instructions, if properly implemented, should reduce the allowances for inpatient dialysis visits (see p. 22).

CONCLUSIONS

The MCP reimbursement system currently being used is similar to the ARM system it replaced. We believe the ARM system was difficult to administer. Unless carriers' payment controls and physicians' billing practices are improved, payment errors of the type noted by our review will continue.

Even with the implementation of better controls, the current system which reimburses physicians for routine outpatient care on the basis of a monthly capitation payment and inpatient services on a fee-for-service basis will continue to be cumbersome to administer. We believe that administration of the program could be improved and program costs reduced if a total capitation system, which covers both routine inpatient and outpatient physician dialysis care, was adopted as an alternative to the present system.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to develop and implement a total capitation system to reimburse renal physicians for all routine physician services provided to ESRD beneficiaries. Such a system should be based on the current MCP rates adjusted for home patient care and the value of routine hospital visits, as discussed in chapters 2 and 3.

HHS COMMENTS AND OUR EVALUATION

HHS commented that it was interested in exploring alternative ways to pay physicians for inpatient hospital services provided to ESRD beneficiaries and stated that our data will be helpful if taken in combination with additional future data. HHS said that in early 1985 it would begin a 3-year demonstration project on a beneficiary incentive competitive bidding model in two areas and would in the future test other innovative models to pay for ESRD maintenance dialysis services. HHS said that these demonstrations would be the first steps toward implementing its objective to explore competitive approaches for the payment of ESRD services.

Although these future demonstrations should provide useful information for future changes in the ESRD program, we believe that we have identified a means for reducing Medicare's ESRD costs immediately and that HHS should act on our recommendation. Also, we note that the specific demonstration project cited by HHS involves outpatient dialysis, not payments for physician inpatient dialysis care. We reviewed HCFA's current status report

Our data include renal physicians' inpatient dialysis visits and their other hospital visits. These two types of visits covered virtually all of the renal physicians' charges for inpatient care. As discussed above, HCFA has found that inpatient dialysis visits are essentially the same as inpatient hospital visits, so our recommendation would cover almost all inpatient care furnished by renal physicians and those that are not could be billed separately. Also, as pointed out on page 20, some carriers already pay renal physicians on the basis of inpatient hospital visits for inpatient dialysis visits. Because almost all renal physicians' inpatient visits are, according to HCFA's study, equivalent to initial or follow-up hospital visits and because HCFA has data on the average number of hospital admissions and lengths of stay for ESRD patients, we believe HCFA has sufficient data to develop and implement a total capitation payment system for ESRD physician services.

The number of physicians in a group ranged from two to at least nine. The remaining 98 physicians (or 28 percent of the total responding) were in practice alone.

Physician patient load

We estimate the average ESRD patient load for a physician to be 30 patients.[2] When the percent of a physician's practice devoted to ESRD patients increased, average ESRD patient loads also increased, as indicated by the following table:

Percent of physicians' practice spent on ESRD	Average ESRD patient load per physician
1 - 20	9.7
21 - 40	21.7
41 - 60	28.8
61 - 80	39.4
81 - 100	45.3

Physicians in practice alone reported having smaller average patient loads than physicians in group practices, an average of 23.2 versus 29.1 ESRD patients per physician. Physicians in practice alone generally saw their facility and hospitalized patients less frequently and their home patients more frequently than physicians in group practices. This may be caused, at least in part, by physicians in group practices seeing each other's facility and hospital-based patients.

Physician contact during dialysis

The number of monthly physician contacts with dialysis patients is discussed in chapter 2. However, analysis of the physicians' responses showed that physician contacts during dialysis varied by dialysis setting. A total of 216 physicians reported treating dialysis patients at free-standing facilities as compared to 208 physicians who used hospital-based facilities. Fifty-nine percent (or 127) of the 216 physicians reported seeing their patients during each dialysis session. Conversely, of the 208 physicians who reported treating patients at hospital-based facilities, 146 (or 70 percent) reported seeing their patients during each dialysis session.

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[2]At the 95-percent confidence level, the estimated average ESRD patient load was 30 plus or minus 8.2.

Dialysis setting and mode	Estimated number of monthly telephone contacts[a]
Home--IPD	0.6
Home--hemodialysis	1.8
Free-standing facility-- all modes	1.9
Home--CCPD	2.2
Home--CAPD	2.3
Hospital-based facility-- all modes	2.5

[a]In all instances the sampling error at the 95-percent confidence level was plus or minus 0.1.

Type of care physicians provide

Questionnaire responses also showed that physicians provided a variety of outpatient care to dialysis patients. We asked physicians the following question about the types of care provided to ESRD patients:

> "In your ESRD medical practice, on the average, what amount of the following types of care related to renal disease did your medical practice's dialysis patients receive from any dialysis physician during the past 6 months?"

The physicians were asked to quantify the care by little or no amount, some amount, moderate amount, great amount, or very great amount. For facility patients, physicians reported spending the most time on consultations with nurses about ESRD patients and the least amount of time on consultations with other physicians. For home patients, physicians spent the most time consulting with the patients about their care, progress, etc., and the least amount of time consulting with other physicians about their home patients. The table below shows the types of physician care provided ESRD patients in accordance with the amount of time physicians reported spending.

Dialysis setting	Number of beneficiaries	Percent
Free-standing facility	260	45.1
Hospital-based facility	176	30.5
Home	141	24.4
Total	577[a]	100.0

[a]Six of the 583 beneficiaries who reported did not indicate where they received dialysis treatments.

Most beneficiaries reported receiving hemodialysis treatments. The following table summarizes the types (mode) of dialysis received by the beneficiaries in our sample.

Mode of treatment	Number of beneficiaries	Percent
Hemodialysis	467	85.5
CAPD	62	11.4
CCPD	10	1.8
IPD	7	1.3
Total	546[a]	100.0

[a]Thirty-seven beneficiaries did not indicate the type of dialysis treatments they received.

Comparison of beneficiary and physician responses

The beneficiaries' responses concerning the amount of time physicians spend with them differed from the information provided by physicians. The beneficiaries reported that physicians see them less frequently and spend less time with them than physicians reported in their responses. We compared the beneficiary responses with those received from 128 physicians in the eight states covered by our beneficiary sample. Beneficiary responses to our question on the amount of direct time physicians spend with them differed significantly from those of the physicians, as shown in the following data.

Comparison of Time Reported for Dialysis Facility Patients

Length of time	Reported by physicians: Number of responses	Reported by physicians: Percent	Reported by beneficiaries: Number of responses	Reported by beneficiaries: Projected percent	Sampling error[a]
Less than 15 minutes	1	1.5	64	30.0	6.6
15 to 30 minutes	0	0	65	22.0	5.9
30 to 60 minutes	4	6.0	42	15.3	5.4
1 to 2 hours	20	29.9	48	19.2	5.6
2 or more hours	42	62.7	30	13.5	5.0
Total	67	100.1	249	100.0	

[a]All sampling errors were calculated at the 95-percent confidence level. The sampling error represents the range (+ or -) about the projected percentages within which 95 percent of the values would fall if a larger sample had been taken.

Comparison of Time Reported for Hospital-Based Facility Patients

Length of time	Reported by physicians: Number of responses	Reported by physicians: Percent	Reported by beneficiaries: Number of responses	Reported by beneficiaries: Projected percent	Sampling error[a]
Less than 15 minutes	0	0	48	37.4	11.8
15 to 30 minutes	2	2.1	41	25.2	11.0
30 to 60 minutes	4	4.2	23	14.3	9.1
1 to 2 hours	9	9.4	20	10.6	6.4
2 or more hours	81	84.4	20	12.5	7.8
Total	96	100.1	152	100.0	

[a]See footnote above.

APPENDIX II

CODE DESCRIPTIONS AND RATES

FOR INPATIENT DIALYSIS SERVICES

IN EACH STATE REVIEWED

State	Carrier	Type of dialysis procedure	Average amount allowed per service
Alaska	Aetna Life & Casualty Co.	Class I (stable patient) - a single patient evaluation, dialysis order writing, and availability to answer questions. Basically, a supervisory fee for a minimally complicated situation.	$100
		Class II - stable patient with complex medical problems. Multiple physician evaluations required.	200
		Class III - seriously ill patient, unstable and physician in attendance during the entire dialysis session.	400
		Class IV - critically ill patient, unstable and physician in attendance during the entire dialysis session.	Not used
Arizona	Aetna Life & Casualty Co.	Chronic inpatient dialysis per session.	58
		Acute dialysis with patient in critical condition per session.	105
		Acute dialysis with patient in critical condition per hour.	48

State	Carrier	Type of dialysis procedure	Average amount allowed per service
Nevada	Aetna Life & Casualty Co.	Hemodialysis service for hospitalized chronic renal failure patient who is hospitalized because of an intercurrent illness or for a problem related or unrelated to chronic renal failure.	$ 67
		Acute renal failure and/or intoxification-initial hemodialysis.	667
		Second dialysis.	450
		Third dialysis.	379
		Fourth hemodialysis through end of second week, per treatment.	347
		Third through end of sixth week, per treatment.	100
Oregon	Aetna Life & Casualty Co.	Class I (stable patient) - a single patient evaluation, dialysis order writing, and availability to answer questions. Basically, a supervisory fee for a minimally complicated situation.	76
		Class II - stable patient with complex medical problems. Multiple physician evaluations required.	143
		Class III - seriously ill patient, unstable and physician in attendance during the entire dialysis session.	281

APPENDIX III

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

OCT 30 1984

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report "Changes Needed In Medicare Payments To Physicians Under The End Stage Renal Disease Program." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

- eliminated and physicians reimbursed for the services provided to hospitalized ESRD patients during dialysis on the basis of hospital visit codes; or

- modified to reflect the nature and scope of physician services provided during dialysis and the amounts other physicians receive for the same or similar services.

Department Comment

We generally agree with this recommendation, as payment levels must be related to the physicians' services actually furnished. We are currently examining this problem and evaluating the best approach to assure that proper program payments are made. The GAO information will be useful in making this determination.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to develop and implement a total capitation system to reimburse renal physicians for all routine physician services provided to ESRD beneficiaries. Such a system should be based on the current MCP rates adjusted for home patient care and the value of routine hospital visits, as discussed in chapters 2 and 3.

Department Comment

As discussed in our comments to the previous recommendations, we believe this data will be helpful if taken in combination with additional future data. In the case of physicians' inpatient dialysis services, the report itself acknowledges that the GAO review did not take into account the services which were more complex than a followup or initial hospital visit. These levels of a hospital visit would probably not be appropriate for all hospitalized ESRD patients, especially if complications are present. Without knowing the level and frequency of these more intense services, we would not have a reasonable basis for adjusting the MCP to include payment for inpatient services.

Furthermore, the recommendation would allow separate payment for other than routine inpatient dialysis services. As a practical matter, this is a virtually impossible distinction for the carriers to administer uniformly throughout the country. Physicians will assert that most care they furnish to dialysis inpatients is not routine due to the patient's renal condition.

We anticipate that further data will become available on the level and frequency of physicians' inpatient dialysis services, and we believe the GAO data will help in broadening that data base. In addition, HCFA will be implementing demonstrations to test innovative models for paying for ESRD maintenance dialysis services. This is HCFA's first step toward implementing the Department's objective to explore competitive approaches for the reimbursement of ESRD services under Medicare. This first of such demonstrations will test a beneficiary incentive competitive bidding model in the Denver, Colorado and Riverside, California areas. This demonstration is scheduled to begin in early 1985 and continue for 3 years. We are also interested in pursuing demonstrations under which all ESRD related services would be paid for under a capitation basis.

patient to physicians for routine outpatient care, MCP eliminated the different monthly rates for facility and home patients. The single composite rate had the effect of increasing the monthly amounts paid physicians for home patients and reducing the amount for facility patients. The maximum allowable amounts were reduced from $260 to $220 for facility patients and increased from $182 to $220 for home patients. The minimum allowable amounts were decreased for facility patients from $180 to $144 and increased for home patients from $126 to $144.

In our December 1982 nationwide survey of physicians treating dialysis patients, we asked 497 physicians if they thought that a higher reimbursement rate for facility patients was an incentive to dialyze patients in facilities. About 52 percent (or 173) of the 334 physicians who answered this question did not think that a higher rate was an incentive; however, about 38 percent (or 128) of the physicians said they thought that it was, and the other 10 percent had no opinion. A single rate which pays the same amount for both home and facility patients has the potential to increase the number of home patients because they are not seen as often by their physicians and the physicians receive the same monthly amount.

METHODOLOGY USED TO DEVELOP THE MCP RATE

The May 1983 final regulations to implement section 2145 defined the method for setting the physicians' monthly capitation payment. Because the same monthly rate is paid for both facility and home patients, the same number of contacts (13.4 per month) was used to calculate the reimbursement rate for both. The 13.4 is based on the estimated number of times ESRD patients are dialyzed each month--149 times a year or 12.4 times a month--plus one monthly "intermediate follow-up office visit." Although HCFA does not expect a physician to see a patient during each dialysis session, it used the 13.4 contacts to represent the physician's average monthly involvement (contacts and supervision) with a dialysis patient. HCFA believes that 13.4 contacts adequately represents the extent of physician services provided to dialysis patients in a month.

Using the above data, HCFA computed a preliminary nationwide monthly average allowance of $194.50.[1] In developing the final rate, HCFA recognized that physicians generally provide

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[1]The amount was derived by multiplying the 12.4 contacts by $14.07 (the average prevailing charge for a medical specialist's brief follow-up office visit) + $20.03 (the average prevailing charge for an intermediate follow-up office visit).

3.2[3] times per month. Based on these data, physicians indicated that they could treat about 12 home patients for every 3 facility patients.

Our data provide a treatment ratio of 3.9 to 1 instead of the 1.4 to 1 ratio used by HCFA. Using the same approach as HCFA, we computed an average MCP rate based on our data. Our computation resulted in an average nationwide MCP rate of $170.05[4] or $14.55 less than the current average MCP rate of $184.60. We estimate that this adjustment would reduce total annual MCP allowances by about $11.8 million.[5]

In our nationwide survey of renal physicians, we asked the physicians if they thought that HCFA's ratio of 10 home patients for every 7 facility patients was appropriate. About 64 percent of the physicians said that the ratio was about right, and the other 36 percent disagreed. The physicians who disagreed were asked to indicate what ratio they thought would be more appropriate. The ratios proposed by these physicians were combined and projected to 10 to 7, which is the same as what the other physicians agreed to.

The responses to these two questions on the appropriateness of the 10 to 7 ratio are subjective, based on the physicians' opinions, whereas those to the question on number of physician contacts with patients are not as subjective because they are based on the physicians' experience. We believe that the data on the number of contacts reported by the physicians, which were used in our computation, when compared to the views of beneficiaries represent a conservative measurement of the relative involvement of physicians with home and facility patients. The beneficiaries' responses to our questionnaire survey show a treatment ratio of 7.8 to 1.

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[3]This is a projected number, and the sampling error at the 95-percent confidence level is plus or minus 0.1. The most comparable HCFA number is 9.4 (13.4 x .70).

[4]This was computed as follows: $194.50 x .83 = $161.45 (portion weighted for in-facility patients) $194.50 x .17 x .26 = $8.60 (portion weighted for home patients) and $161.45 + $8.60 = $170.05. Twenty-six percent (.26) represents the weighting attributable to home patients.

[5]This amount was computed as follows: $14.55 x 12 months = $174.60 annual savings for each dialysis patient; $174.60 x 67,570 (the number of dialysis patients as of December 31, 1983) = $11.8 million.

CHAPTER 3

RENAL PHYSICIANS ARE ALLOWED MORE THAN OTHER PHYSICIANS FOR SIMILAR SERVICES

In addition to monthly capitation payments for routine outpatient care, Medicare allows renal physicians to bill on a fee-for-service basis for inpatient hospital care. Renal physicians have billed for their inpatient care under this type of system since the ESRD program began. Neither the ARM nor the MCP method changed this procedure. The fee-for-service payments to renal physicians for dialysis care provided while their patients are hospitalized are based on special dialysis procedure codes established by carriers after consultation with the renal physicians in their areas. These special codes generally relate to the patient's condition, i.e., the patient's condition is either acute, chronic, stable, or unstable. The procedure codes usually used for Medicare reimbursement purposes, such as surgical procedures or office and hospital visits, generally describe the services provided.

HCFA and two carriers found that the services provided by renal physicians during inpatient dialysis visits were essentially the same as those provided by other physicians during a hospital visit. However, because carriers allow substantially more for an inpatient dialysis visit than for a hospital visit, renal physicians are allowed more than other physicians for essentially the same services. In the nine states reviewed, if renal physicians had been reimbursed on the basis of follow-up hospital visits instead of inpatient dialysis visits, Medicare allowed charges for the inpatient dialysis visits made during calendar year 1981 would have been reduced by about $1.3 million or by about 40 percent.

In 1983 HCFA issued instructions clarifying the term "acute dialysis." The instructions, however, do not show what services must be provided to justify reimbursement under inpatient dialysis procedure codes which continue to be based on patients' condition rather than on services provided. In addition, carriers started implementing a national reimbursement coding system including new codes for physicians' dialysis services. This new system does not preclude the continued use of the previously established special dialysis codes.

1981 Allowed Charges for Inpatient Dialysis Care and Hospitalization Data for ESRD Patients

State	Total allowed inpatient charges	Total number of ARM patients	Number of ARM patients hospitalized	Percent hospitalized	Number of days hospitalized
Alaska	$ 17,593	46	19	41	304
Arizona[a]	591,105	681	478	70	12,433
Arkansas	109,842	197	105	53	2,660
Hawaii[a]	471,414	607	273	45	6,568
Massachusetts	922,842	1,526	810	53	23,491
Nevada	190,727	246	155	63	2,967
Oregon[a]	400,078	577	387	67	8,143
Rhode Island	70,990	401	152	38	3,346
Washington	301,781	674	297	44	6,293
Total	$3,076,372	4,955	2,676	54	66,475

[a]The data for these states were projected from a random sample of 100 hospitalized ESRD patients in each state. All projections were made at the 95-percent confidence level.

During 1981, most of the ESRD patients in the nine states reviewed were treated by physicians reimbursed under the ARM. For physicians who did not elect to bill separately on a fee-for-service basis for inpatient services, the maximum allowed charge was $8.66 per day for inpatient services. When physicians billed on a fee-for-service basis, they could receive reimbursement for an initial hospital visit and one or more follow-up hospital and dialysis visits. For example, in Nevada, a renal physician remaining on the ARM for inpatient services would be allowed about $88 during the average 11-day hospital stay.[1] The same physician billing on a fee-for-service basis would be allowed about $630 as follows.

Type of service	Average allowable amount
One initial hospital visit	$ 80
Six dialysis visits	400
Five follow-up hospital visits	150
Total	$630

[1]Under MCP, the allowed charges would have been about $80.63, because the maximum amount allowable would have been $7.33 per day.

inpatient services provided by renal physicians were similar to those provided by other physicians during their hospital visits. The summary report stated that the amounts allowed for physician reimbursement of inpatient dialysis services which range from $30 to $750 appear excessive, compared to the allowances for similar medical services ($20 to $103) by other physician specialists.

Special procedure codes established for dialysis care

When the ESRD program started in 1973, carriers established special dialysis procedure codes for dialysis care. Because the carriers did not have the necessary information to define inpatient dialysis services or to establish reasonable charges, they consulted with the local renal physician community and adopted the dialysis procedure codes and allowable amounts essentially as recommended by the physicians.

The dialysis procedure codes were based on patient condition, which does not conform with Medicare's definition of physician services. Section 1861(q) of the Social Security Act defines physician services as "professional services performed by physicians including surgery, consultation and home, office and institutional calls . . . ." HCFA has interpreted this to mean that physician services must be identifiable services to particular patients. HCFA and the carriers generally have not defined what service(s) a physician should provide to obtain reimbursement under these unique dialysis codes.

The dialysis procedure codes used by the carriers generally describe the patient's condition as acute or chronic renal failure with or without complicating illness. Some used the terms "stable" or "unstable," while others used terms that describe the sequence of the dialysis treatments, i.e., initial dialysis, second and third dialysis, etc., none of which describe the services provided.

The number of dialysis procedure codes in use and the payment allowances vary significantly. For example, the average amounts allowed for dialysis services in the nine states reviewed ranged from $25 to $667 per service. Appendix II shows the dialysis procedure codes used for inpatient dialysis visits and the average amounts allowed in the states reviewed.

Comparison of amount allowed for hospital visits

The average daily amounts allowed the renal physicians included in our review for their inpatient dialysis care--

29 beneficiaries[4] treated by 14 physicians in four states. These physicians were reimbursed for a total of 148 acute inpatient dialysis visits.

The medical records did not show that a physician was present during 111 (or 75 percent) of the 148 dialysis treatments. For the other 37 treatments, the records indicated that a physician was present at some time during the dialysis treatment, but did not show the duration of the visits or the nature or extent of services provided.

The following are examples of physicians who received payments for acute inpatient dialysis visits when the medical records did not show that the physicians saw the patient during each dialysis session.

--An Oregon beneficiary was hospitalized for rejection of a transplanted kidney. The patient received three dialysis treatments during the hospitalization. His renal physician was allowed a total of $450 for three acute inpatient dialysis visits. The related dialysis logs did not show that the physician was present during any of these treatments.

--An Arizona beneficiary was hospitalized for light headedness, nausea, and a dull chest pain. The medical record noted that at the time of admission, the patient appeared to be suffering from a heart block. During hospitalization the patient received five dialysis treatments. The renal physician was allowed $500 for five acute inpatient dialysis visits and $900 for 9 hours of care provided during the five treatments. Notations in the dialysis log showed that the physician was present during a portion of three of the five dialysis treatments, but did not indicate whether the physician was present during the other two treatments. The duration of these visits and the services provided were not noted. The dialysis log did not indicate that the patient was experiencing difficulties during any of these dialysis treatments.

Some carriers limit reimbursement for renal physician visits

The Rhode Island carrier allowed renal physicians $25 for each inpatient dialysis visit. Although this amount was slightly more than the amount allowed for a follow-up hospital

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[4]These beneficiaries were judgmentally selected after reviewing physicians' payment histories.

Our estimated savings will be reduced by any charges allowed at a rate higher than a follow-up hospital visit. Because of differences in procedure codes and inadequate definition of what services should be performed to qualify for reimbursement under each code, we cannot determine how many services would be allowed at a higher rate.

CORRECTIVE ACTION TAKEN BY HCFA

In July 1983, HCFA issued revised instructions which clarified the term "acute dialysis." The instructions define acute dialysis as

> "Dialysis given to patients who are not ESRD patients but who require dialysis because of temporary kidney failure due to sudden trauma; e.g. traffic accident or ingestion of certain drugs."

The instructions refer to dialysis furnished to hospitalized ESRD patients as "inpatient dialysis."

The new instructions, however, do not discuss the use of acute dialysis procedure codes for ESRD patients or prevent carriers from reimbursing renal physicians under acute dialysis procedure codes. The instructions also do not discuss the use of chronic dialysis procedure codes or state that physicians' reimbursement for services provided to ESRD patients during inpatient dialysis should be based on the services rendered, rather than the patient's condition.

To determine if the carriers continued paying physicians for acute inpatient dialysis visits after the revised instructions were issued, we reviewed claims histories for the 42 renal physicians in Arizona, Hawaii, and Oregon who had billed for at least one inpatient dialysis visit after September 1983. The histories covered physicians' claims submitted from August 1 to December 31, 1983. In Arizona, we did not find any billings using the acute inpatient dialysis visit codes. In Hawaii, five physicians were still being paid for acute inpatient dialysis services provided to ESRD patients. In Oregon, HCFA's revised instruction did not affect renal physicians' billing practices because the dialysis procedure codes used for inpatient dialysis services make no distinction between acute and chronic care. (See app. II for descriptions of the codes used in Oregon.) However, carrier officials advised us on October 19, 1983, that they were changing their procedure codes to reflect the difference between acute and chronic care.

HHS COMMENTS

HHS generally agreed with our recommendation and stated that payment levels must be related to the services provided. HHS stated that it is currently examining this problem and evaluating the best approach to assure that proper program payments are made and that the information we developed will be useful in making that determination.

Monthly capitation payments not correctly reduced for hospitalization periods

Under the ARM and MCP systems, carriers pay physicians a monthly amount to cover the outpatient services provided to ESRD patients. When physicians elect to bill on a fee-for-service basis for inpatient services, Medicare requires carriers to reduce the monthly allowance by 1/30 for each day a dialysis patient is hospitalized. To determine if these adjustments were correctly made, we reviewed the ARM payments made by two carriers in six of the nine states covered by our review.

All three field offices for the carrier (Aetna) that serviced five states and the carrier for Rhode Island did not correctly reduce ARM payments when dialysis patients were hospitalized. We also found instances in which one renal physician billed and was reimbursed for inpatient care, while a second renal physician billed and received a full monthly ARM payment for the same beneficiary during the same period.

In addition, the carrier's field office for Nevada and Arizona was not adjusting ARM payments for the first day of hospitalization or for any hospital stay less than 3 days. This practice is not in accordance with HCFA instructions. The carrier's field office changed its procedures after we informed home office officials of this practice.

The chart below shows the extent of incorrect 1981 ARM payment adjustments found in six states.

not adjust their computations for 31-day months, resulting in payments for these months that exceeded the maximum amount allowable by an amount equal to the daily ARM rate. The overpayments totaled $4,200 during 1981.

--The Massachusetts carrier allowed ARM physicians $201 a month for home patients, even though its established maximum was $182. Total estimated 1981 overpayments were $3,400.

INCORRECT PAYMENTS INVOLVING FEE-FOR-SERVICE PAYMENTS

Our examination of physicians' payment histories disclosed several instances in which the carriers made incorrect payments involving fee-for-service payments to renal physicians. The incorrect payments resulted in overpayments of about $685,000 and consisted of

--$49,000 for outpatient services incorrectly billed and paid for as inpatient hospital care,

--$201,000 in duplicate payments when both a facility and a physician group were paid for the same services,

--$137,000 for inpatient hospital care incorrectly billed and reimbursed as acute inpatient dialysis care,

--$142,000 for unsupported hourly care charges,

--$126,000 for multiple services provided to the same patient on the same day, and

--$30,000 for acute dialysis care provided on the day the patient was discharged from the hospital.

Outpatient services incorrectly paid for as inpatient hospital care

In Massachusetts, renal physicians in a group practice incorrectly claimed reimbursement for some of their outpatient services during the period November 1979 through July 1982. Although the services were provided on an outpatient basis, the group's claims indicated that the services had been provided on an inpatient basis, resulting in higher allowed charges. The carrier paid the physicians for inpatient services. During the period in question, the provider billed for 7,457 inpatient dialysis visits and was allowed $527,370 for these services.

Duplicate payments for physicians' outpatient care under initial method

The same physician group in Massachusetts that inappropriately billed for outpatient care (see p. 28) had also incorrectly claimed reimbursement for some of their other services. From November 1979 through July 1982, Medicare paid twice for supervisory outpatient dialysis care. Massachusetts Blue Cross (the Medicare intermediary in Massachusetts) correctly reimbursed a facility under the initial method for physicians' outpatient care as part of the facility's dialysis treatment rate.[1] However, the physicians incorrectly billed the Medicare carrier separately for their supervisory outpatient care.

In addition, although the physicians had correctly identified their services on the claims under "place of service" as outpatient care, for billing purposes they had used "acute care" inpatient dialysis procedure codes. The physicians were reimbursed on the basis of these codes and were paid about $80 for each service, instead of the $25 which would have been allowable for outpatient care.

The physicians started billing separately for their outpatient dialysis services in November 1979. In August 1982, after we discussed this billing practice with carrier officials, the carrier reviewed all billings received from the physicians for the dialysis care provided between November 1979 and July 1982. The carrier concluded that about 10 percent of the services billed represented emergency care and allowed $25 for each service. The remaining charges were disallowed as duplicate billings. As of June 8, 1984, the carrier had identified, based on allowed charges, a total of $201,000 in overpayments.

Carrier officials attributed the duplicate payments to inadequate controls over claims. The place of service was not matched with the type of service billed to determine if the service could be provided in the indicated setting. The carrier has corrected the situation by implementing an appropriate edit procedure in its claims review process.

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[1]Under the initial method, intermediaries reimburse the dialysis facility $12 per session for physician services, and the facility could then reimburse the physicians under any arrangement that was mutually agreeable to the parties.

without verifying the length of time physicians spent with the patient. To determine the appropriateness of the carriers' payments, we judgmentally selected a sample of 41 claims for hourly services and reviewed related beneficiary medical records and dialysis nurses' notes to determine what services were provided and how much time the physicians had spent with the patients. For all 41 claims, we found no indication of the amount of time the physician had spent with the patient or what services were performed during the time period billed. In 19 instances there were no indications that the physician was present during the dialysis treatment.

Following are examples of hourly billings that were not supported by the patients' medical records.

--An Arizona physician billed Medicare $400 for 4 hours of service. The patient's records show that the dialysis treatment started at 7:40 a.m. and ended at 11:40 a.m. The dialysis nurse noted on the medical record that the physician visited the patient at 11:00 a.m., or 40 minutes before the treatment ended. The record does not show how long the visit lasted or what services were provided. The physician was allowed $193 for his services.

--The same physician on another occasion billed $300 for 3 hours of service. The patient's records show that the dialysis treatment lasted 2.5 hours, but does not show that the physician was present at any time during the treatment. The carrier allowed $146 on his claim.

--An Arizona beneficiary was admitted to the hospital for extreme weakness and received six dialysis treatments while hospitalized. His renal physician was allowed a total of $892 for six acute dialysis sessions and 6 hours of acute dialysis care provided in connection with the six treatments. Notations in the patient's dialysis log indicate that the physician was present for a portion of two of the six dialysis treatments. There were no indications that he was present during any of the other treatments. The duration of the visits was not noted in the log.

--A physician group in Hawaii billed $725 for 6 hours of services provided on May 13, 14, and 16, 1981. The patient's dialysis records do not show that a physician was present during either the May 13 or 14 treatments. However, the records indicate that a physician could have been present for 3 hours during the May 16 treatment. A total of $554 was allowed for these visits.

addition to an initial and/or follow-up hospital visit to the same patients on the same day. In other instances, carriers allowed a physician two hospital visits to the same patient on the same day.

The Hawaii carrier, for example, routinely allowed renal physicians to bill for both a follow-up hospital visit and for 1 to 6 hours of acute inpatient dialysis services provided to the same patient on the same day. The carrier also allowed physicians' charges for two hospital visits on days when patients were not dialyzed, without obtaining additional justification.

After discussing the Hawaii carrier's practices with HCFA regional office officials, we were advised that the carrier had been informed of Medicare's restrictions on payments for multiple visits. In addition, HCFA requested that the carrier review its reimbursement procedures to ensure that they conform with Medicare policy. In response, the carrier changed its reimbursement policy and met with Hawaii physicians to explain the revised policy, which will limit reimbursement to one hospital or dialysis visit per patient per day of hospitalization.

The following schedule shows the potential overpayments for multiple visits found in seven of the nine states reviewed.

Summary of Overpayments for Multiple Services

State	Overpayment amounts
Alaska	$ 635
Arizona	7,005[a]
Arkansas	9,735
Hawaii	63,171[a]
Nevada	279
Oregon	3,510[a]
Washington	41,901
Total	$126,236

[a]These amounts are projections based on payment data for a statistical sample of 100 hospitalized ESRD patients in each state. All projections were made at the 95-percent confidence level.

We believe that many of the incorrect payments discussed above can be attributed to the limited reviews of physicians' claims for inpatient dialysis services. Carrier officials advised us that because of financial constraints, they had not

Calendar Year 1981
Overpayments for Acute Dialysis Visits
Provided on the Day of Discharge

State	Number of cases	Estimated overpayments
Arizona	28	$ 2,410[a]
Hawaii	21	1,700[a]
Massachusetts	253[b]	13,670[b]
Nevada	37	12,121
Total	339	$29,901

[a]The overpayment includes amounts paid by the hour for acute dialysis visits. We could not determine the number of hours billed on the day of discharge in some cases because the physicians billed for multiple acute visits covering several days. In these cases, we assumed the physician had billed 1 hour of dialysis service on the day of discharge.

[b]This amount represents the projected results of a statistically selected sample of 90 hospitalized beneficiaries. The sampling error at the 95-percent confidence level is 253 ± 177 cases and $13,670 ± $9,563.

To determine the prevalence of this practice among the physicians, we analyzed claims histories for the physicians in Arizona, Nevada, and Hawaii. Our analysis showed that 53 percent of the physicians in these three states had been reimbursed at least once for acute dialysis services provided on the day of discharge.

CONCLUSIONS

Although the incorrect payments were due primarily to limited reviews of physicians' claims and/or incorrect billing practices, we believe that the reimbursement system for renal physicians' services also contributed to the overpayment problems noted. We believe also that the present system which pays for outpatient care on a capitation basis and for inpatient care on a fee-for-service basis is inherently difficult to administer.

The overpayments made under the initial payment method should not recur because the system was abandoned in mid-1983. However, because the MCP system allows physicians to bill for their inpatient services on a fee-for-service basis, most of the incorrect payments noted during our review can recur under the new system.

CHAPTER 5

A TOTAL CAPITATION SYSTEM THAT INCLUDES INPATIENT SERVICES--A BETTER ALTERNATIVE

The MCP system will not correct many of the deficiencies discussed in chapter 4 because it is similar to the ARM system. As an alternative to the present system, which like the ARM system pays for routine outpatient care on a capitation basis and for routine inpatient care on a fee-for-service basis, we believe that a total capitation payment system would minimize these problems and eliminate many of the payment errors identified during our review. Under a total capitation system, renal physiciahs would receive a monthly fee to cover all routine inpatient and outpatient care associated with the medical direction and management of ESRD beneficiaries' dialysis treatments. We estimate that a total capitation system could reduce annual ESRD program costs by about $1.6 million in the nine states included in our review.

SOME WEAKNESSES IN ARM WILL STILL OCCUR UNDER MCP

Physicians who billed under the ARM received a substantial amount of their reimbursement from fee-for-service billings for inpatient services provided to their hospitalized renal patients. In the nine states reviewed, about 30 percent of allowed ARM physicians' charges were for such billings. Our review disclosed errors in reimbursement for physicians' inpatient care which can be attributed, at least in part, to weaknesses in carrier payment controls and/or improper physician billing practices. Because the MCP system also allows physicians to bill fee-for-service for inpatient care, most of these errors can continue to occur. Under the new system, carriers still need to

--control charges for inpatient acute and chronic dialysis care when physicians choose to bill fee-for-service,

--control charges for acute inpatient dialysis care provided on the day the patient is discharged from the hospital,

--monitor and control reimbursements for multiple visits provided by the same physician to the same beneficiary on the same day,

--determine the exact dates of patient hospitalization to properly adjust physicians' monthly payments for the periods when their patients are hospitalized and they elect to bill on a fee-for-service basis, and

IMPACT OF MCP AND TOTAL CAPITATION SYSTEM

In 1981, a total capitation system would have reduced physicians' service costs by about $1.6 million in the nine states covered by our review. In one of the states, costs would have gone up slightly because of the lower amounts allowed by the carrier in that state for physicians' inpatient hospital dialysis care. The table below summarizes the potential savings or additional cost for each state included in our review.

1981 Estimated Savings from a Total Capitation System

State	Total allowed charges for physician services	Estimated allowed charges of total capitation system	Estimated savings	Estimated savings as a percent of total allowed charges
Alaska	$ 80,572	$ 78,118	$ 2,454	3.0
Arizona	1,811,820	1,449,020	362,800	20.0
Arkansas	361,473	289,965	71,508	19.8
Hawaii	1,283,992	1,031,320	252,672	19.7
Massachusetts	3,739,547	3,252,960	486,587	13.0
Nevada	628,557	560,592	67,965	10.8
Oregon	1,307,913	1,062,713	245,200	18.7
Rhode Island	794,666	815,082	(20,416)	(2.6)
Washington	1,221,182	1,104,925	116,257	9.5
Total	$11,229,722	$9,644,695	$1,585,027	14.1[a]

[a]Average for the nine states.

A total capitation system should also correct or minimize most of the payment errors noted during our review. The following table summarizes the deficiencies noted and shows the impact of the MCP system on the deficiencies and the potential impact of a total capitation system.

A total capitation system would also ease the carriers' administrative burden by simplifying claims processing and reducing the number of claims to be processed. It would eliminate most physician charges for inpatient dialysis care and the need to adjust the monthly allowance for hospitalization periods. As shown on page 27, during 1981, between 16 and 45 percent of physicians' monthly payments in six of the nine states had not been properly adjusted for inpatient hospital stays.

PHYSICIANS' OPINIONS OF A TOTAL CAPITATION SYSTEM

In our national survey, we asked 497 physicians to what extent, if at all, they believe a total monthly reimbursement amount (total capitation system) should be developed. Of the 325 physicians who responded, 72 percent did not support a total capitation system.

Most of the reasons given by the physicians for not supporting a total capitation system related to the difficulties involved in establishing a reasonable monthly capitation payment because of the varying levels of care required by different ESRD patients. While some patients require comprehensive physicians' care, others need very little. Some patients are seen by a physician each time they dialyze, as indicated by our survey data, while others are seen only a few times a month.

We believe that a total capitation system recognizes the physicians' concerns. The physicians would receive the same monthly amount per patient regardless of how much time is spent in a month with each patient. Some patients are seen each time they dialyze, and others are seen only two or three times a month. The monthly payment would be based on the average number of times all renal patients are seen by their physicians. Moreover, under a total capitation system, physicians would still be allowed to bill separately for medically necessary nonroutine renal care, provided such care is justified by the beneficiary's hospital or medical records.

We recognize that ESRD patients are frequently hospitalized and have provided for this in our rate computation. The formula includes a factor representing the average amount of routine inpatient care provided. The factor was developed using actual hospitalization statistics for ESRD patients. Any service allowed as nonroutine will reduce the amount of our estimated savings of $1.6 million. However, we cannot estimate the amount of nonroutine services which would be approved.

on health care financing research and demonstration projects and did not find any specifically focusing on reimbursements for physicians' inpatient dialysis care. In addition, HCFA officials told us that they were not aware of any ongoing study focusing on this subject.

In its comments HHS referred to anticipated future data on the level and frequency of physicians' inpatient dialysis services. HCFA told us that these data should be available toward the end of 1985. This also indicates to us that HCFA has no plans to revise the ESRD physician payment system in the near future.

HHS also commented that our recommendation would allow separate payment for other than routine inpatient dialysis care and that this would be virtually impossible for the carriers to administer uniformly throughout the nation. HHS said that physicians will assert that most of the care they furnish dialysis inpatients is not routine due to the patients' renal condition.

First, we did not limit our recommendation to routine inpatient physician dialysis care but extended it to all routine inpatient care furnished by the renal physician. We based this on one initial hospital visit per admission and one follow-up hospital visit per day after the day of admission. Secondly, as discussed in chapter 3, a HCFA study found that the services provided by renal physicians during inpatient dialysis visits were essentially the same as those provided during a hospital visit. Because we included in our computations payments to the physician for each day the patient is, on the average, hospitalized and because data indicated that the services physicians provide during dialysis visits and follow-up hospital visits were essentially the same, almost all physician inpatient services should be covered under our recommendation. Although administering the routine physician inpatient care criteria could present problems, we believe that if HCFA provided renal physicians and the carriers with clear, specific information on what is included under the rate and what additional services would have to be furnished in order to bill for additional payments, administrative difficulties could be minimized.

Although HHS apparently agrees with the concept of a total capitation payment system covering physicians' inpatient and outpatient care, it has problems with using our data as the basis for initiating such a system. For physicians' inpatient care, HHS said that our report does not take into account services that are more complex than an initial or follow-up hospital visit. We recognize that on occasion renal physicians may provide nonroutine services for which they could bill separately, but these situations should be relatively infrequent.

APPENDIX I

ANALYSIS OF SELECTED PHYSICIAN AND BENEFICIARY RESPONSES TO GAO QUESTIONNAIRE

The questionnaire mailed to renal physicians and dialysis patients yielded information on the characteristics of renal physicians' practices and ESRD patients. Although some of this information does not specifically relate to matters discussed in the report, we believe that it may prove useful to those involved with the ESRD program.

PHYSICIAN QUESTIONNAIRE AND RESPONSES

We mailed questionnaires to a statistically selected nationwide sample of 497[1] renal physicians. Usable responses were received from 345 physicians or about 69 percent of the adjusted sample. The physician questionnaire provided information regarding

--physicians' mode of practice,

--the average number of physicians in a group practice,

--the average number of dialysis patients renal physicians have and whether their mode of practice affects this average,

--the average number of contacts a physician has with a dialysis patient during a month,

--the average number of telephone contacts a physician has with a dialysis patient during a month, and

--the extent and nature of outpatient services provided by the physicians.

Physicians' mode of practice

A majority of the physicians in our sample were in group practices. We asked physicians, "Including yourself, how many physicians treat end stage renal disease (ESRD) patients in your practice?" Of the 345 physicians who answered this question, 247 or (72 percent) indicated they were in a group practice.

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[1]A total of 554 questionnaires were mailed, but several physicians had to be omitted because they did not treat ESRD patients.

Physician contacts with home patients

The number of physician contacts with home patients varied by mode of dialysis. Physicians saw patients using continuous ambulatory peritoneal dialysis and continuous cycling peritoneal dialysis the most often, while intermittent peritoneal dialysis patients were seen the least. The following table presents the nationwide projected average number of monthly contacts with home patients by time of contact and mode of dialysis.

Time of contact	Mode of dialysis[a]			
	Hemodialysis	IPD	CAPD	CCPD
During dialysis	1.0	0.6	1.8	1.3
Outside of dialysis	1.4	0.7	1.7	1.2
Total	2.4	1.3	3.4	2.4

[a]The totals do not agree with the individual amounts because of rounding, since each amount was projected separately. The sampling error at the 95-percent confidence level was less than plus or minus 0.3 except for two instances. The sampling error for average contacts during CCPD dialysis was 1.3 plus or minus 0.8, and the total contacts for CCPD was 2.4 plus or minus 0.5.

Physician telephone contacts with beneficiaries

The number of telephone contacts between physicians and dialysis patients varied by dialysis setting. The average number of contacts ranged from 1.6 a month for home patients using IPD to 2.7 per month for home patients using CAPD. The physicians surveyed were asked the following question:

> "During the last 6 months, indicate the average number of telephone contacts each patient in the medical practice had with any dialysis physician each month."

The table below projects nationwide by dialysis setting the average number of monthly telephone contacts the physicians reported.

Services performed	Ranking by amount of time spent: Facility patients	Ranking by amount of time spent: Home patients
Consulting with nurses about ESRD patients	1	4
Consulting with ESRD patients about their care, progress, laboratory test results, etc.	2	1
Providing psychological support to patients	3	3
Examining ESRD patient	4	5
Reviewing laboratory test results	5	2
Prescribing medication	6	6
Consulting with other physicians about ESRD dialysis patient care	7	7

BENEFICIARY QUESTIONNAIRE AND RESPONSES

We also mailed questionnaires to a statistically selected sample of 676 beneficiaries in eight states--Alaska, Arizona, Arkansas, Hawaii, Massachusetts, Nevada, Oregon, and Rhode Island. Usable responses were received from 583 beneficiaries or about 86 percent of the total. We surveyed these patients to obtain their views on certain aspects of their relationship with their physicians. Specifically, we asked beneficiaries about the frequency of renal physician contacts each month and the amount of direct time these physicians spend with them.

Characteristics of beneficiaries responding to questionnaire

The beneficiaries included in our sample reported being on dialysis for an average of about 4 years and had an average age of 54.6 years. Most beneficiaries were receiving dialysis at a free-standing facility. The 577 beneficiaries who responded to the questionnaire reported receiving dialysis in the following settings:

APPENDIX I

--Almost 63 percent of the responding physicians reported spending 2 or more hours each month with their facility-based patients. However, we project that about 14 percent[3] of the facility patients would have reported physicians spending this much time with them.

--About 84 percent of the responding physicians reported spending 2 or more hours each month with their hospital-based patients. However, we project that about 13 percent[3] of the hospital-based patients would have reported physicians spending this much time with them.

--Almost 54 percent of the responding physicians reported spending 1 or more hours each month with their home patients. However, we project that about 19 percent[4] of the home patients would have reported physicians spending this much time with them.

The following three tables compare the amount of direct physician time reported by physicians and beneficiaries and show the differences in the responses received from the two groups. The tables are broken down for patients treated in dialysis facilities, hospital-based facilities, and at home.

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[3]Projections with sampling errors are presented in the tables on page 53.

[4]At the 95-percent confidence level, the estimated percent of home patients who would see their physicians more than 1 hour per month was 18.5 plus or minus 9.1.

Comparison of Time Reported for Home Patients

Length of time	Reported by physicians		Reported by beneficiaries		
	Number of responses	Percent	Number of responses	Projected percent	Sampling error[a]
Less than 15 minutes	1	1.0	37	30.8	10.6
15 to 30 minutes	9	8.8	39	28.1	10.7
30 to 60 minutes	37	36.3	32	22.6	9.7
1 to 2 hours	34	33.3	17	15.2	8.2
2 or more hours	21	20.6	3	b	b
Total	102	100.0	128	96.7	

[a]See footnote on page 53.

[b]The results are not projected because the sampling error exceeds 100 percent.

The number of contacts reported by physicians and beneficiaries also differed. Facility patients reported that physicians see them an average of 10.2 times per month.[5] The physicians reported seeing patients an average of 10.7 times a month. Home patients likewise reported fewer direct contacts than did physicians. Home patients reported seeing their physicians an average of 1.3 times per month.[6] Physicians reported seeing home patients an average of 1.7 times a month. The number of contacts shown here differ from those used in chapter 2 because they are limited to the eight states covered by our beneficiary survey. Those used in chapter 2 are for the nationwide physician survey.

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[5]This projection had a sampling error of ± 3.5 at the 95-percent confidence level.

[6]This projection had a sampling error of ± 0.8 at the 95-percent confidence level.

APPENDIX II

State	Carrier	Type of dialysis procedure	Average amount allowed per service
Arkansas	Arkansas Blue Shield	Class I - acute renal failure complicated by illness or failure of other organ system. Patient generally confined to critical care area.	$ 74
		Class II - acute renal failure without failure of other organ systems but with dysfunction in other areas.	103
		Class III - acute renal failure with minor or no other complicating problems.	45
		Acute peritoneal dialysis.	115
		Chronic dialysis.	74
Hawaii	Aetna Life & Casualty Co.	Acute dialysis visit with patient in critical condition per hour.	82
Massachusetts	Mass. Blue Shield	Maintenance dialysis covered in hospital only when there is clear evidence of medical necessity for physician personal services in connection with maintenance dialysis.	50
		Initial dialysis.	71
		Second and third dialysis.	87
		Fourth and each subsequent dialysis.	55

APPENDIX II

State	Carrier	Type of dialysis procedure	Average amount allowed per service
Oregon		Class IV - critically ill patient, unstable and physician in attendance during the entire dialysis session.	$321
Rhode Island	Rhode Island Blue Shield	Chronic inpatient dialysis.	25
		Acute dialysis - conditions necessitating acute dialysis can vary, i.e., patient goes into acute renal failure postoperatively, etc.	65
Washington	Washington Physician Service	Chronic stable.	40
		Chronic unstable.	68
		Acute stable.	70
		Acute unstable.	133
		Acute peritoneal.	52
		Chronic peritoneal.	60

APPENDIX III

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Changes Needed in Medicare Payments to Physicians Under the End Stage Renal Disease Program"

Overview

In this report on Medicare Payments to physicians under the End Stage Renal Disease (ESRD) program, GAO evaluated the Health Care Financing Administration's (HCFA's) methodology for deriving the monthly capitation payment (MCP) amount (a fixed monthly amount per patient) to determine whether it actually reflects the services provided by physicians to ESRD beneficiaries. In addition, GAO evaluated whether physician payments were properly determined.

GAO basically concludes that Medicare costs for physicians' services under the ESRD program could be reduced if HCFA changed its reimbursement system. More specifically, GAO believes that more current data are available than the 1974 data used in part to compute the monthly capitation payment and that such current data should be used. GAO also believes that renal physicians should be reimbursed for their dialysis care on the basis of services provided rather than the patients' condition as is done under the special dialysis procedure codes (codes used by physicians to bill for services provided to hospitalized dialysis patients which generate Medicare allowances based on the patients' condition rather than the service provided as is normally the case).

GAO notes that physicians should be allowed essentially the same amounts for the same or similar services and that a system which reimburses for physicians' outpatient care on the basis of a fixed monthly payment and for inpatient care on a fee-for-service basis is cumbersome to administer.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to modify the MCP rate taking into consideration our survey data on the relative physician involvement with home and facility patients.

Department Comment

We believe the data collected in GAO's study will generally be helpful in examining the appropriateness of the level of physician reimbursement under the MCP rate. However, we do not believe the data in this study is sufficient to authorize a reduction in the MCP at this time. We anticipate that further information will become available which will be more current and include national experience in the data base. The GAO information will be a useful supplement to these data.

GAO Recommendation

We believe that establishing a total capitation system for all routine inpatient and outpatient care would be a better solution for paying for routine inpatient care than the present fee-for-service system. However, if the following recommendation for a total capitation system is not accepted, we recommend that the special dialysis visit procedure codes be either:

APPENDIX III

Technical Comments

1. The report mentions that the initial method of physician reimbursement has been eliminated. This is accurate; however, a September 7, 1984 district court decision orders the Secretary to reinstate the initial method in a modified form that takes into account congressional requirements such as promoting the use of home dialysis.

2. The report mentions overpayments that resulted from a failure to reduce the monthly payment by the number of days a patient was hospitalized. In July 1983, we published an instruction to carriers that clarified this point. Furthermore, this will be incorporated as a specific criterion upon which carriers' performance will be evaluated each year by HCFA.

3. There is a basic misunderstanding in the finding for adding a factor of 1.5 to the MCP for inpatient care; even if it is assumed that the value of physicians' inpatient services could be approximated by one hospital visit per inpatient day. The present MCP is based on followup brief and intermediate office visits, not hospital visits. Therefore, the factor of 1.5 would need to be weighted to account for the difference between these two types of physicians' services.

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