

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**PART B SERVICES IN NURSING HOMES  
- An Overview -**



**JUNE GIBBS BROWN  
Inspector General**

**MARCH 1996  
OEI-06-92-00865**

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# EXECUTIVE SUMMARY

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## PURPOSE

To describe the Medicare Part B services provided to nursing home residents and to identify and discuss known or potential program vulnerabilities.

## BACKGROUND

Medicare Part B covers a wide range of medical services and supplies for the program's beneficiaries, including those in nursing homes. These services include physician services and outpatient hospital services, diagnostic laboratory tests, imaging, ambulance services, and a wide range of medical equipment and supplies.

We obtained information about Part B expenditures from a 1992 nationally projectable sample of nursing home residents from 10 States and 150 nursing homes. This includes residents receiving Medicare extended care benefits in a skilled nursing facility (SNF), residents paying for their stay with private insurance or personal funds, residents on Medicaid, or a combination of the above.

This inspection was conducted as a part of Operation Restore Trust. The initiative, focused in five States, involves multi-disciplinary teams of Federal and State personnel seeking to reduce fraud, waste, and abuse in nursing homes and home health agencies, and by durable medical equipment suppliers.

## FINDINGS

***Medicare was charged \$4.1 billion and Medicare payments of \$2.7 billion were made in 1992 for Part B services provided to nursing home residents.***

- The most money was spent on physician evaluation services (\$894 million), followed by medical equipment, supplies, prosthetics, and orthotics (\$772 million).
- More nursing home residents received a physician evaluation service (82 percent of residents) than any other service, followed by laboratory tests (66 percent of residents) and x-rays (47 percent of residents).

***The Part B average daily charge varies significantly among both States and nursing homes.***

- The State average daily charge ranged from an estimated high of \$10.88 in Louisiana to a low of \$4.42 in Maine. (The estimated national average was \$8.75 per day.)
- Differences between nursing home average daily charges ranged from a low of \$1.16 to a high of \$49.67. These are sometimes, but not always, explained by differences in the acuity level of the residents treated in the facility.

***The accessibility and vulnerability of nursing home residents provide a unique opportunity for fraud, waste, and abuse.***

The Medicare Part B program is particularly vulnerable because payment rules and safeguards largely ignore the unique character of the nursing home environment and the varied services and supplies which can be provided. Program vulnerabilities identified include:

- **Duplicate Payments:** Considered the payer of last resort, it is appropriate for Medicaid agencies to require that providers bill Medicare first for Part B covered services provided to dually eligible nursing home residents. Medicaid pays only for services not covered by Medicare. This overlapping responsibility creates a vulnerability whereby both Medicare and Medicaid could mistakenly pay for the same service or supply when each is unaware the other has paid. To determine the consequences of this vulnerability the OIG is currently conducting an evaluation of duplicate payments.

Additionally, the shifting of payment responsibility from one program to another can increase overall costs to the taxpayer when the program paying for the service allows reimbursement at a greater rate than would ordinarily be paid by the other program.

- **Lack of Oversight:** Medicare Part B contractors (carriers and intermediaries) often lack enough information to adequately ensure appropriate payments for residents of nursing homes. For example, carriers generally do not have information that a resident is in a nursing home unless the claim specifically notes the place of service was a nursing home.
- **Questionable Supplier or Physician Practices:** We have previously documented questionable billing and marketing practices in the provision of incontinence supplies, wound care, and orthotic body jackets to patients in nursing homes. In addition to suppliers, physicians and other practitioners warrant further review for such practices as billing for questionably high numbers of residents on the same day.

## **CONCLUSION**

This review of the utilization of Part B services by nursing home residents suggests the need for further work in many areas such as: 1) examining the appropriateness of consolidated billing of Part B nursing home expenses and the daily rate, 2) monitoring trends in Part B payment utilization over time, 3) evaluating issues of poor quality care resulting from such practices as physicians treating too many patients in one day, exposure to excessive or inappropriate medical services, provision of supplies not medically necessary, etc., and 4) developing and applying various fraud detection methods to identify abusive practices and fraud involving residents of nursing homes.

To support the development of fraud detection methods, further information is currently being gathered on the nature and magnitude of abusive provider practices or program

vulnerabilities involving nursing home residents. This information will be used to identify the most efficient fraud detection methods.

## **COMMENTS**

We thank the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) for their comments on the draft report. Changes were made based on their suggestions. In addition to suggestions, the HCFA pointed out several actions it has taken to address vulnerabilities such as: 1) requiring carriers and intermediaries to selectively initiate pre-pay reviews on high dollar payment areas and aberrant trends, and 2) development of enhanced duplicate payment detection methodologies for the Medicare Transaction System. The full text of HCFA and ASPE comments are provided in Appendix B.

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# INTRODUCTION

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## **PURPOSE**

To describe the Medicare Supplementary Medical Insurance program (Part B) services provided to nursing home residents and to identify and discuss known or potential program vulnerabilities.

## **BACKGROUND**

With the aging of the American population, long-term care is becoming an increasingly important component of the U.S. health care system. Since 1966, the proportion of those over age 65 residing in nursing homes has risen from 2.5% to over 5%.<sup>1</sup> Both the Medicare and the Medicaid programs contribute significantly to this population's cost of care.

### ***Medicare Program***

Medicare is a Federal health insurance program, authorized by Title XVIII of the Social Security Act, that covers most people 65 years or older, people with end-stage renal disease, and some disabled people. The program consists of two distinct insurance programs.<sup>2</sup> Hospital Insurance Benefits for the Aged and Disabled (Part A) covers services furnished by hospitals, home health agencies (HHA), hospices, and skilled nursing facilities (SNFs). Supplementary Medical Insurance for the Aged and Disabled (Part B) covers a wide range of medical services and supplies, including physician services, outpatient hospital services, and home health services (not covered under Part A), as well as diagnostic laboratory tests, X-rays, ambulance services, and the purchase and rental of durable medical equipment (DME).

While Medicare does not cover the institutional costs for traditional long-term nursing home care, benefits are provided for extended care to qualified beneficiaries in a Medicare-participating SNF. A certified SNF is a nursing home with the staff and equipment to provide skilled nursing care, skilled rehabilitation services, and other related services, and that meets the conditions of Medicare participation specified by regulations.<sup>3</sup>

### ***Medicaid Program***

The Medicaid program, enacted by Congress under Title XIX of the Social Security Act, provides medical assistance to certain low-income families with dependent children and low-income persons who are aged, blind, or disabled. State Medicaid programs must offer certain basic services, including inpatient and outpatient hospital, physician, nursing home, and home health services.

Historically, the Medicaid program recognized two levels of long-term care: 1) that care provided at an intermediate level in an Intermediate Care Facility (ICF) and 2) that care provided at a skilled level in a Skilled Nursing Facility (SNF). (*Medicare has always recognized*



*only one level - SNF level care.*) However, the administrative distinctions between SNFs and ICFs do not, in practice, indicate marked differences in the residents serviced. Further, in many cases, the regulatory distinction between SNF and ICF simply reflected differences in nursing staff.<sup>4</sup>

In recognition of this, Congress enacted the Omnibus Budget Reconciliation Act of 1987 (OBRA) to eliminate the distinction by combining SNF and ICF levels of service into a single level (called nursing facility services (NF)). States were also required to recognize only the nursing home level of care for purposes of Medicaid certification. Additionally, OBRA 1987 required all facilities to assess residents' needs and to provide those services and activities necessary to attain or maintain the "highest practicable level" of functioning (physical, mental, and psychosocial well-being) for each resident.<sup>5</sup>

Although the Federal government finances between 50 and 83 percent of care provided under the Medicaid program, individual States administer Medicaid within broad Federal requirements and guidelines.<sup>6</sup> Medicaid covers Medicare beneficiaries who meet the limited income and assets standards set by each State's Medicaid program. These beneficiaries are known as dual eligibles. For these persons, State Medicaid programs usually pay the Medicare premiums and cost-sharing (coinsurance) requirements.

Many residents enter the nursing home with assets that are utilized to pay for nursing home care. The process of resource depletion to pay for care is called "asset spend-down" and, once impoverished, the resident typically applies for public assistance through Medicaid. Even after all assets are depleted, a person is likely to pay a portion of nursing home expenses with private monthly income, while Medicaid pays the difference.

### ***Nursing Home Capacity and Resident Characteristics***

The number of licensed nursing homes in the United States totaled 16,751 in 1992. Seven States (California, Illinois, Montana, New York, Ohio, Pennsylvania, and Texas) accounted for nearly 39 percent of the total nursing home bed capacity. By June of 1995, the number of facilities had increased to 17,022, with over 1.8 million licensed nursing home beds. The average number of beds per nursing home grew from 93 beds in 1980 to 102 beds in 1992, while the total number of licensed nursing home beds per 1,000 persons age 65 and over stayed nearly stable at 53.

In 1987, about three-quarters of all nursing home residents were women. Over 90 percent were white and over 65 years of age with a median age of 82. Over half of all nursing home residents in 1987 needed assistance with more than three activities of daily living (ADLs), such as dressing or bathing. Many of these residents are likely to also have suffered some form of cognitive impairment. Only 11 percent had no ADL limitations.

Most nursing home stays are relatively short. Of those residents discharged in 1985, about 52 percent stayed for less than three months, and 63 percent stayed for less than six months. Of the discharged residents, about 50 percent had additional nursing home stays, with the majority of those persons (77 percent) having additional stays in the same nursing home. Of

all persons discharged from a nursing home in 1985, 48 percent were discharged to another health facility, 30 percent were discharged to the community, and the remainder either died in the nursing home or their outcome was unknown.

### ***Program Vulnerabilities***

Medicare is the nation's largest payer of health care services, with 1992 costs of \$128 billion. Additionally, this represents the fourth largest category of Federal expenditures. Despite attempts to constrain costs, Medicare spending and beneficiary out-of-pocket costs have risen at troubling rates according to the Government Accounting Office (GAO).<sup>7</sup> The growth of these payments increases Medicare's potential vulnerability to erroneous and excessive payments, either for claims resulting from program weaknesses or for claims resulting from provider fraud and abuse.

The accessibility and vulnerability of nursing home residents provide a unique opportunity for fraud, waste, and abuse. Unless protected by concerned family or friends, the attending physician, or by the policy and practices of the nursing home, the extended care resident may be subjected to health care practices in which decisions on care can be governed by greed, rather than medical need.

Program vulnerabilities are circumstances which may lead to excessive costs to the Medicare program, the Medicare beneficiary, and, ultimately, the tax payer. Both fraud and abuse are included in our definition of program vulnerabilities.

## **METHODOLOGY**

### **Sources and Limitations of Data**

Two principle sources of data were analyzed and are presented in this report. The primary data source represents data obtained from a two-stage stratified sample in which 150 nursing homes were selected for review from 10 States (15 nursing homes per State). Those States were California, Delaware, Florida, Indiana, Kansas, Louisiana, Maine, Michigan, Montana, and Wyoming. Stratification was based on nursing home size (large, medium, and small).

***Nursing home residents are defined as anyone residing in a Medicare- or Medicaid-certified nursing facility. This includes residents receiving Medicare extended care benefits in a skilled nursing facility, residents paying for their stay with private insurance or personal funds, residents on Medicaid, or a combination of the above.***

Each sample nursing home provided us with a list of all Medicare-eligible residents residing in the facility during 1992, along with their corresponding dates of stay. After verification of each beneficiary's Health Insurance Claim Number (HICN) with the Medicare enrollment database, all Medicare services provided during each nursing home stay were extracted from the Medicare National Claims History File for calendar year 1992. The Part B services processed by both the carrier and the intermediary were identified.

Data from the sample were projected to the total nursing home population (residents in Medicare or Medicaid-certified nursing homes). The estimates provided in this report are *very conservative*. This is because many of the sampled nursing homes did not provide us with a complete and accurate list of all residents in the nursing home during 1992. We estimate under-reporting to be as much as 20 percent. (This percentage was determined by verifying with the Health Care Financing Administration (HCFA) all SNF admissions to the sample nursing homes that were not accurately or completely reported by nursing homes. Because we were unable to determine the degree of under-reporting beyond just the Medicare SNF population, we chose not to make adjustments to the projections. Consequently, data projections should be viewed within this context.

The sample consists of 24,654 nursing home stays. Twenty percent of these stays involved payment by Medicare Part A for SNF level care. The sample projects to nearly one-half billion days of care during 2.6 million stays. The 150 nursing home sample projects to 15,356 nursing homes.

#### TWO TYPES OF PART B DATA USED

1. **Carrier-processed** Part B data reflect the *allowed charges* unless otherwise noted. Allowed charges represent what Medicare considers reasonable for these services. The program pays 80 percent of the allowed charges, with beneficiaries responsible for coinsurance and deductibles.
2. **Intermediary-processed** outpatient Part B data reflect *interim charges* by providers. This is because reimbursement is based on the application of reasonable costs, subject to certain limits which are reported through cost reports. Thus, these charges may not represent the final, settled cost to the Medicare program.

**Important Note:** In reviewing this report, the reader should recognize that two types of data are combined - data for claims processed by carriers and data for claims processed by intermediaries (outpatient). The data from carriers refer to those charges which Medicare considers reasonable (allowed charges) and to which coinsurance and deductibles are applied. In contrast, the data for intermediary claims refer to total charges. Total charges (include both covered and noncovered charges) refer to all services for a billing period before reduction for the deductible and coinsurance amounts and before any adjustments for the cost of services provided.

Total charges for intermediary-processed claims were used because they were readily available and could be broken out in sufficient detail (e.g., at least at the revenue center level, and often at the procedure code level) allowing analysis of discrete types of services (supply, lab, etc.).

The second data source presented in this report was obtained from a one percent sample of all Medicare beneficiaries receiving Medicare extended care benefits during 1991, 1992, or 1993. After selecting the sample of beneficiaries, all Part B services received during the covered nursing home stay were extracted, similar to the sample above. Data from the sample were projected to the total SNF population by multiplying by 100. The *1991 to 1992 and 1992 to 1993 percent change calculations* made in this report reflect an inflation adjustment factor (7.4 and 5.9 percent, respectively), which is used to reflect more accurately the true percent change due to charge variation rather than to medical care inflation. Although we are aware

of other adjustment (inflation) factors (e.g., HCFA's Medicare Economic Index (MEI)), the Medical component of the Consumer Price Index for all urban consumers, the U.S. city average (CPI-U), appeared adequate for our use in this report in light of MEI's limitations. While MEI is specific to certain Medicare categories of services (such as physician services, lab tests, etc.), it does not account for all categories of Medicare services.

The reader should recognize that the medical component of the CPI is not always a true representation of the medical care cost changes in Medicare. This is because of various constraints specific to Medicare (e.g., fee schedules, Congressionally-mandated reductions or controls on the pricing of certain types of services, etc.) which do not exist in the general medical community from which the CPI is derived.

### Data Presentation By Categories

To facilitate the presentation of the types of Part B services provided, we classified HCFA Common Procedure Coding System (HCPCS) procedure codes and revenue center codes (*used in outpatient facility cost reporting*) into one of many Part B categories. No procedure or revenue center code is included in more than one category (except in the case of podiatry services which were extracted based on the podiatry specialty code '48'). Where possible, we tried to classify services in terms of the law's reference to coverage of the category. Additionally, we modeled much of the major categorization after a developmental categorization system of HCPCS procedure codes prepared by HCFA's Office of Research and Development in coordination with the Urban Institute. (See Appendix A.)

### Vulnerabilities

Discussions of program vulnerabilities are drawn from our review of applicable law and regulations and analysis of the services depicted in our sample. Additionally, we reviewed findings from prior OIG reviews and fraud alerts for evidence illustrating program vulnerabilities. Finally, we conducted a survey of each Medicare carrier to determine types of abuses involving nursing homes. The survey was completed by the Medicare Fraud and Abuse coordinator or director.

This review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

## **PREFACE**

This report was conducted as a part of Operation Restore Trust. The initiative, focused on five States, involves multi-disciplinary teams of Federal and State personnel seeking to reduce fraud, waste and abuse in nursing homes, home health agencies, and by durable medical equipment suppliers.

This report gives the reader a sense of the utilization of Part B services by residents of nursing homes certified by Medicare and/or Medicaid. Also, we point out areas of vulnerability for consideration as future work by this and other State and Federal offices associated with Operation Restore Trust.

Our discussion begins with a section describing Part B utilization statistics, and concludes with a general discussion of the known or potential vulnerabilities suggested by the nursing home sample, other work conducted by this office, or based on carrier survey responses.

It is important for the reader to note that this report discusses the full range of Part B services provided to residents of nursing homes. Some of these services are billed only by certain providers (e.g. nursing homes can not bill Part B for physician visits). On the other hand, supplies and equipment used by a resident can be billed either by a supplier to Part B or by the nursing home under its cost reporting as a Part A or Medicaid expense. Any discussions in this report of inappropriate Part B payments **apply only** to certain categories of service and should not be construed as applying to the full range of Part B services.

Further, this report discusses generally three types of Medicare eligible nursing home residents: 1) residents receiving Medicare SNF benefits, 2) dual eligible residents with Medicaid coverage, and 3) residents paying for their own stay. Each of these types of residents might be impacted differently due to the application of limitations on Part B payments. Thus, while billing Medicare Part B may be deemed inappropriate for one group, it may be appropriate, and even necessary, for another group.

*For reference in reviewing this and related reports, a glossary of terms has been included in the back of this report.*

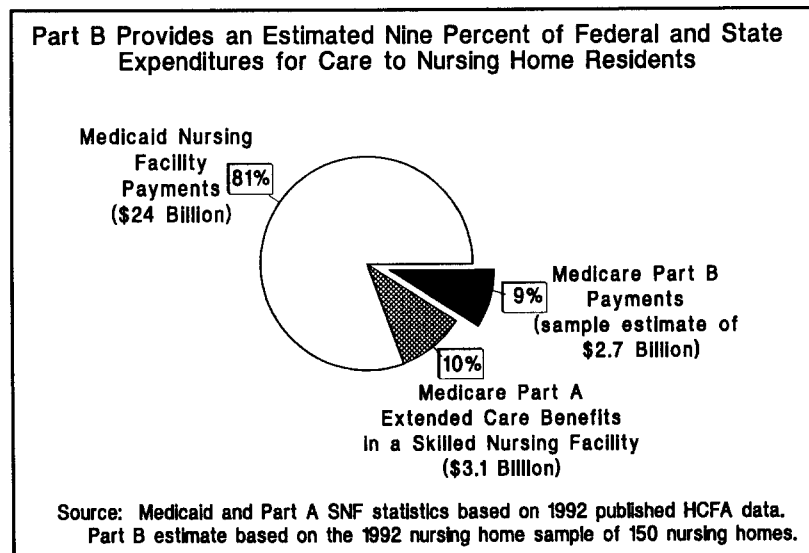
# UTILIZATION OF PART B BY NURSING HOME RESIDENTS

*Medicare was charged \$4.1 billion and Medicare payments of \$2.7 billion were made in 1992 for Part B services provided to nursing home residents.*

At the 95% confidence level, we project Part B charges between \$3.6 and \$4.7 billion were made in 1992 on behalf of residents during nursing home stays. We estimate payment to be \$2.7 billion. As discussed in the methodology, these are very conservative estimates due to suspected under-reporting of the resident population by sampled nursing homes. Coinsurance and deductibles for beneficiaries (Medicaid for dual eligibles) may exceed \$1 billion of the estimated Part B charges.

On a per day basis, Part B daily costs were approximately \$8.75. This charge is composed of \$5.41 in carrier allowed charges and \$3.34 in outpatient total charges. When considering only charges for residents receiving Medicare extended care benefits in a skilled nursing facility, this amount is considerably more at \$20.

Part B represents a substantial (estimated nine percent) cost of the 1992 Federal and State cost of care. (See Figure 1.)

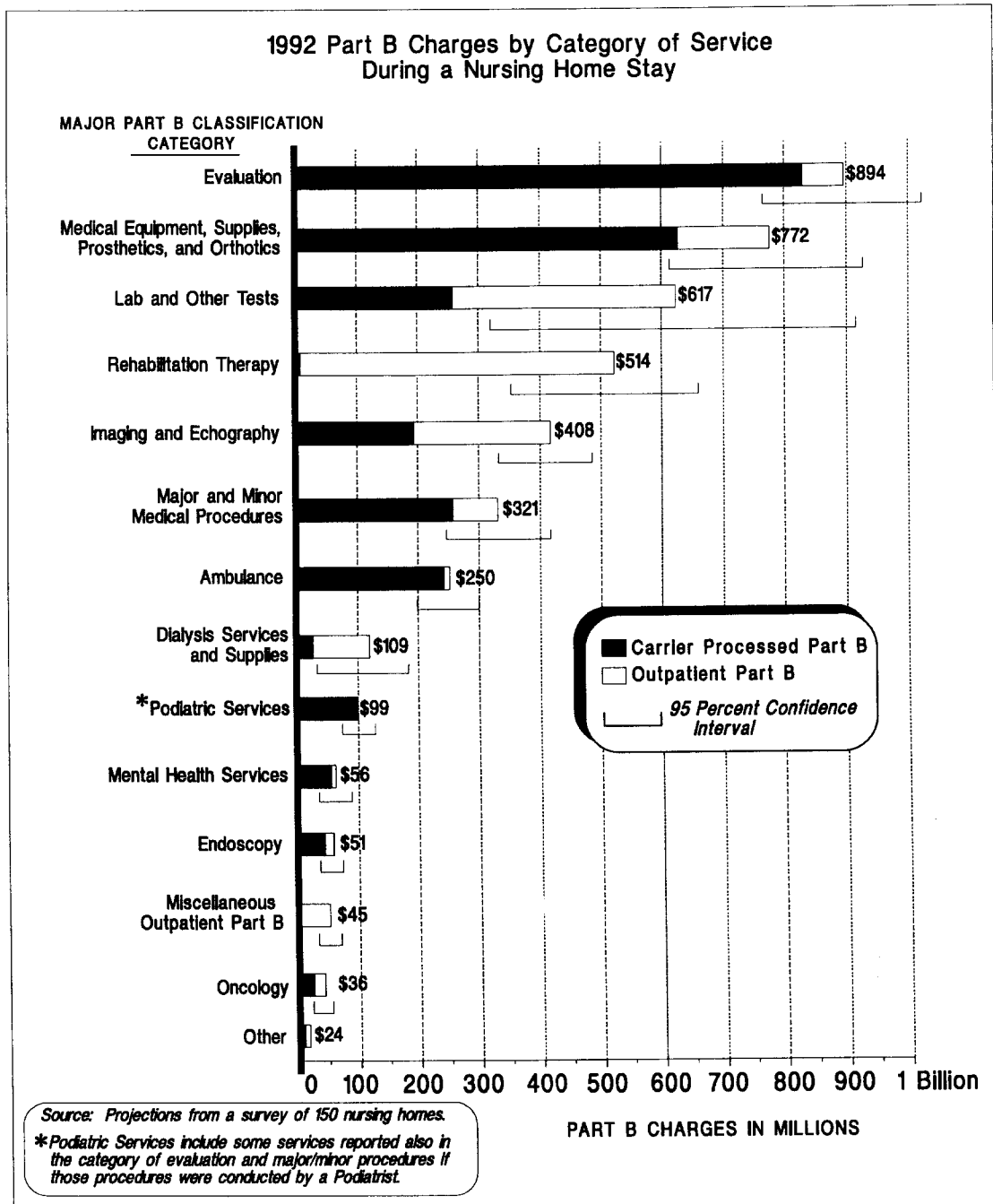


**Figure 1**

Medicaid is the largest payer of nursing home care with payments of \$24 billion in 1992 for over 1.6 million users. Medicare Part A extended care benefits in a skilled nursing facility were \$3.1 billion for 919,115 stays totaling 25.3 million days of care. (NOTE: Part A also paid an estimated \$60 million for hospice and \$29 million for home health for nursing home residents - based on the nursing home sample.). Since the Federal government pays 50 to 80 percent of Medicaid costs, this brings the total Federal institutional cost of nursing home care to between \$12 and \$22 billion.

**The most money was spent on physician evaluation services (\$894 million), followed by medical equipment, supplies, prosthetics, and orthotics (\$772 million).**

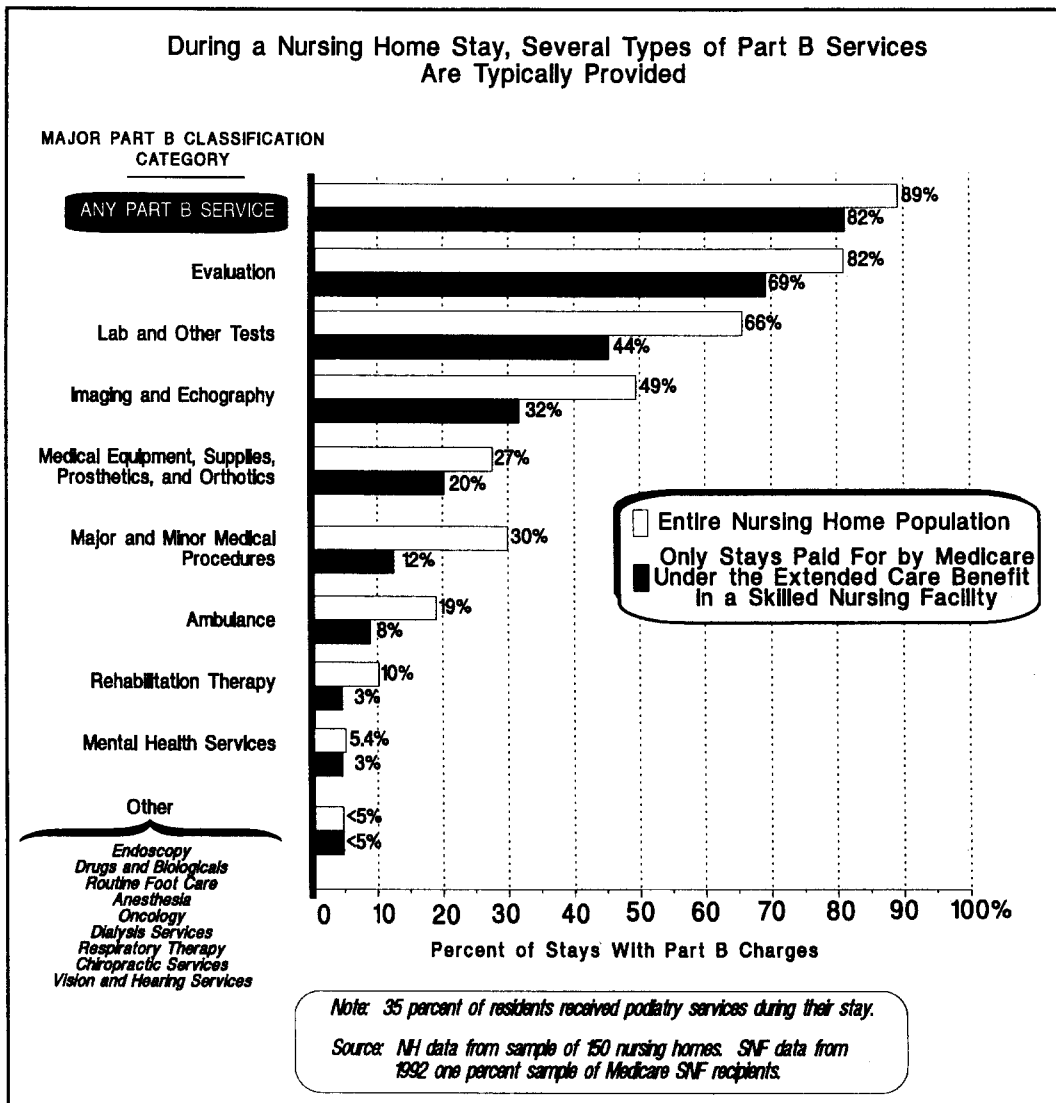
The category of evaluation services (used by 82 percent of residents) accounted for the most charges of any categorical grouping, followed by the category of medical equipment, supplies, prosthetics, and orthotics (used by only 27 percent of residents). (See Figure 2.) The top five categories of service in the nursing home (adding these two categories with lab, rehabilitation, and imaging services) accounted for over 75 percent of the total Part B charges provided to nursing home residents.



**Figure 2**

**More nursing home residents received a physician evaluation service (82 percent of residents) than any other service, followed by laboratory tests (66 percent of residents), and x-rays (47 percent of residents).**

Most residents (89%) had Part B services billed during their nursing home stay. The most likely service provided a nursing home resident was for a physician evaluation service (nursing home or office visit) and laboratory tests. Residents with no Part B billing may be due to a short length of stay (less than one month) or a resident's ineligibility for Medicare Part B. For the residents receiving only Medicare extended care benefits in a skilled nursing facility, approximately 18 percent of resident stays had no Part B services. This is considerably more than the general nursing home population. This is probably because of the short lengths of stay common among Medicare SNF residents (average 28.4 days) and the greater services provided under the Medicare extended care benefit. In contrast to residents with no Part B billing, some beneficiaries had extremely high average daily charges (some in excess of \$1,000 per day). Figure 3 compares the total nursing home population with the Medicare SNF-only population and is based on the percent of residents with one or more services during their nursing home stay.



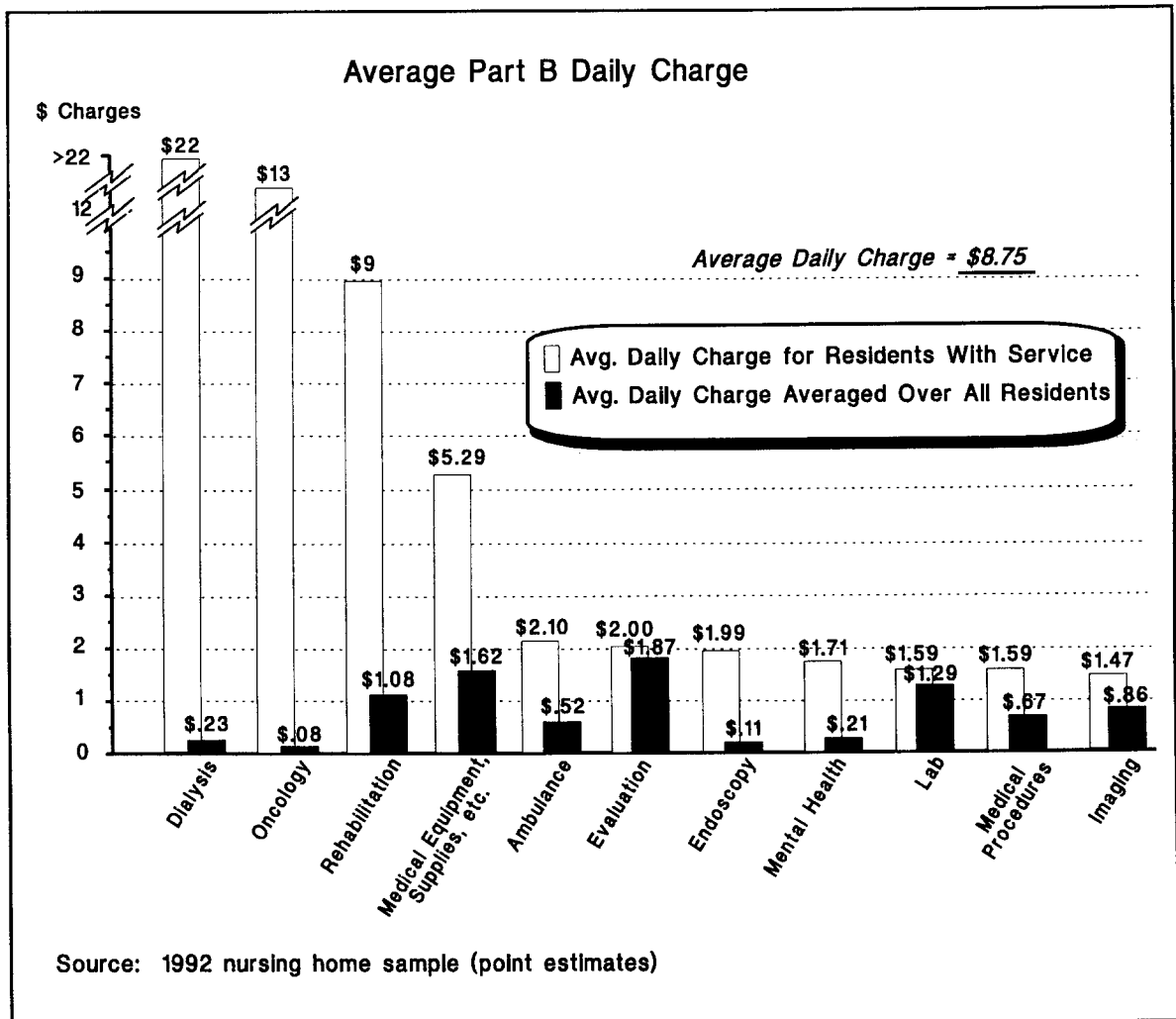
**Figure 3**



*The average daily cost for Part B services differs markedly, depending on the category of service and whether the average is based on all residents or only those who received the particular service.*

On average, the daily charge to Part B for a nursing home resident is estimated to be \$8.75. As discussed previously, evaluation services and medical equipment, supplies, prosthetics, and orthotics have the highest cost. Correspondingly, these categories have the highest average daily charge at \$1.87 and \$1.62, respectively. While few residents receive dialysis services and oncology, they represent the most expensive categories of service when the average cost is computed for only residents actually receiving these services.

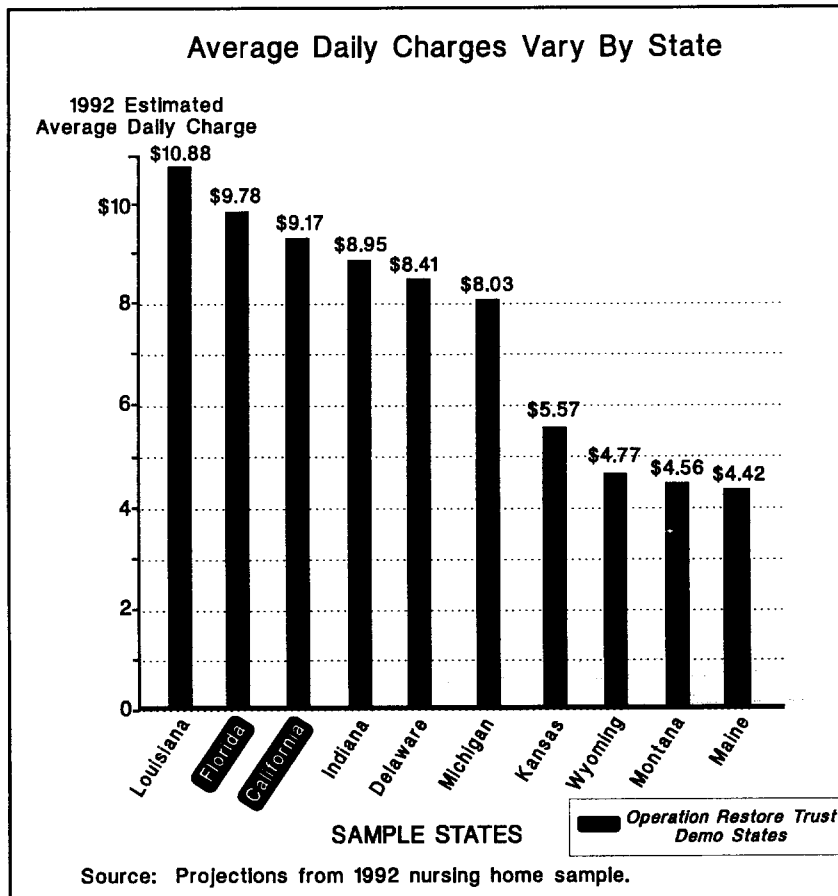
(See Figure 4.)



**Figure 4**

*Average daily costs vary among States and, especially, among nursing homes.*

The average daily Part B cost ranged from an estimated high of \$10.88 in Louisiana to a low of \$4.42 in Maine. (See Figure 5.)



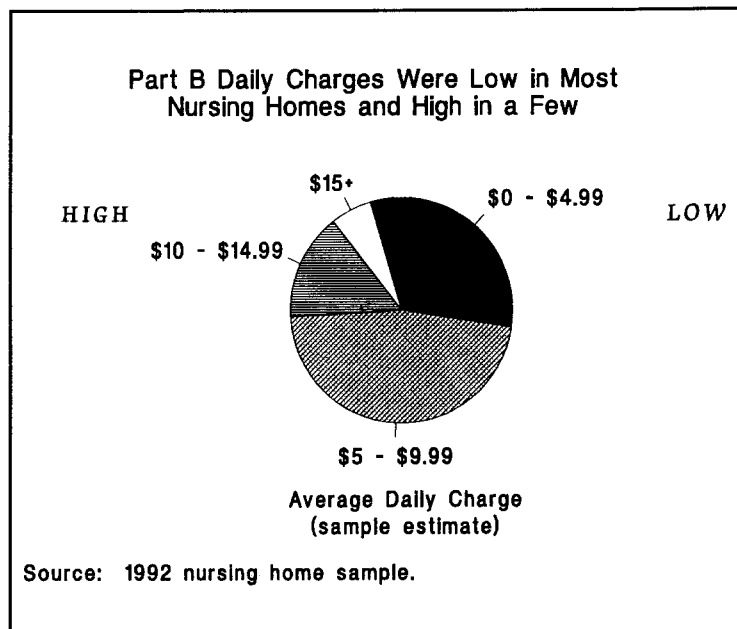
**Figure 5**

While we can not explain these differences, we suspect that Medicaid practices regarding billing of Part B for dual eligibles may explain some or most State differences. State Medicaid daily reimbursement rates often differ in the services included in each State's base rate. For example, in 1992, only 35 States and the District of Columbia included physical therapy, and 32 States and D.C. included occupational therapy. Only two States included prescription drugs, and 11 States and D.C. included physician services in their daily SNF rates.

One would expect higher Part B utilization in those States having less comprehensive base rates (as is likely the case in Louisiana which excludes several types of service routinely included in other States' rates). However, if the State actively encourages nursing homes to bill Medicare, regardless of what is included in the rate, differences should not exist due to coverage.

Significant State differences were noted in other areas not addressed in Medicaid rates. For example, use of ambulance services during a nursing home stay varied from a high of 44 percent in Louisiana to a low of 13 percent in Wyoming. As another example, treatment by podiatrists is estimated to be as high as 46 percent in Florida (average bed day cost equals \$0.28) to a low of 7 percent in Wyoming (average bed day cost equals \$0.01).

In addition to State variances, there is considerable variation between nursing homes' Part B average daily charges. (See Figure 6.)



**Figure 6**

Based on regression analysis using SUDAAN's Survey Data Analysis Software, we can explain some of the variation (58 percent) in bed day costs between nursing homes.

**Factors increasing bed day cost include:**

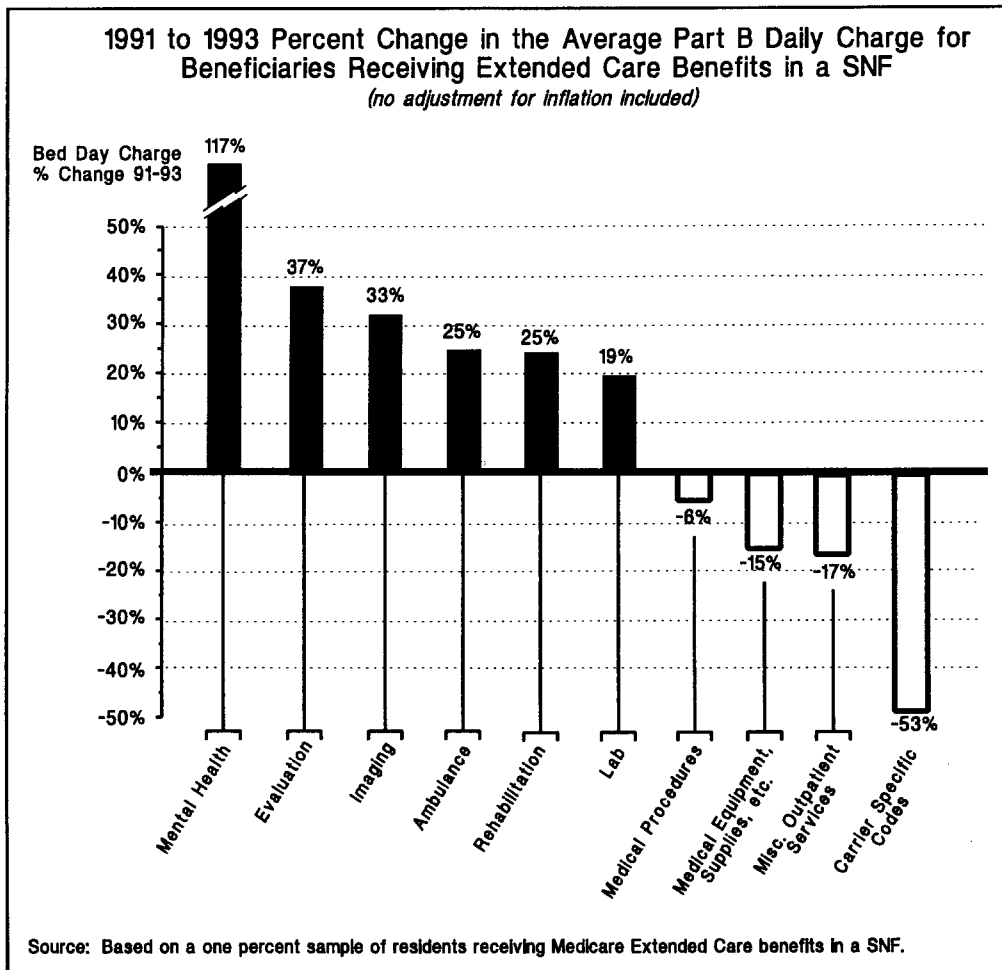
- the extent to which the nursing home treats Medicare SNF residents,
- the degree of illness of the residents as evidenced by the number of hospital admissions during a stay, and
- the overall number of Medicaid residents in the nursing home.

**One factor decreasing bed day cost** is the average length of stay for residents in the nursing home.

Several other factors were tested in the regression analysis and could not be proven to significantly impact bed day cost. These included nursing home certification, profit/nonprofit status, total bed size of nursing home, and percent of private pay residents.

*While we do not have trend data for the general nursing home population, data based solely on residents receiving Medicare extended care benefits in a skilled nursing facility between 1991 and 1993 show that, while the overall cost of Part B has remained nearly constant (\$19-\$20, in 1991 constant dollars), use of some services increased significantly.*

Use of Part B by residents receiving Medicare extended care benefits in a SNF (and possibly all other nursing home residents, Medicaid and private pay, for which we have no data to confirm this trend) has remained relatively constant with little or no average bed day charge change between 1991 and 1993, after adjusting for inflation using the CPI-U. However, this finding does not tell the whole story. Notably, some types of service such as mental health and imaging, have greatly increased, while others have decreased. (See Figure 7.)



**Figure 7**

Within imaging, magnetic resonance imaging (MRI) tests exhibited an exceptionally high increase from 1991 to 1993, with estimated total dollars increasing from one-half million to nearly 10 million dollars in just two years. This may be explained by a shift from use of computerized axial tomography (CAT) scans to MRI testing.

# PROGRAM VULNERABILITIES

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The accessibility and vulnerability of nursing home residents provide a unique opportunity for fraud, waste, and abuse. The Part B program is particularly vulnerable because payment rules and safeguards largely ignore the unique character of the nursing home environment and the varied services and supplies which can be provided. The following discussion presents some of the most blatant program vulnerabilities suggested by the nursing home data, along with abusive supplier and physician billing practices involving nursing home residents.

## PROGRAM PAYMENT OVERLAP

### Medicaid and Medicare Part B

*As the payer of last resort, Medicaid requires providers to bill routine services and supplies to the Part B program. This creates an opportunity for duplicate payments to occur when Medicare and Medicaid mistakenly pay for the same service or supply.*

- Services Covered by Medicaid's Daily Rate

Services covered under Medicaid's nursing home daily rate are routinely billed to the Part B program. In 1992, the cost of Medical Equipment, Supplies, Prosthetics, and Orthotics alone were an estimated \$772 million. *Much of this equipment and supplies would have been paid by the Medicaid program as a part of the nursing home's daily payment rate had the resident not been eligible for Part B.*

A program vulnerability exists because of the overlapping payment responsibilities of Medicare and Medicaid when the Part B service is included in the Medicaid per diem rate, but the established per diem rate is not adjusted to **fully reflect** Medicare reimbursement. If the Medicaid rate-setting mechanism is based on only those costs the nursing home incurs, or will incur, this will not result in duplicate or overlapping payments for the same service or item. However, this is only applicable when billing occurs only to either Part B or Medicaid (as a cost in the facility's cost report with no corresponding credit for Medicare payment), but not both. Billing both programs constitutes fraud and results in duplicate payments, if not detected by either program. Extensive auditing is typically required to detect billing to both Medicare and Medicaid, if the item or service is also included in the rate.

Medicaid is typically considered the payer of last resort. Thus, States consider Medicare Part B as another third-party payer, expecting payment for the service or a letter of denial before Medicaid assumes responsibility (e.g., Ohio's administrative code 5101:3-1-05 states "the department will not pay for any service payable by, but not billed to, Medicare"). However, some confusion and blurring of responsibility exists regarding those items included in the daily rate paid nursing homes. In most States, this includes such items as wheelchairs, beds, bandages, enteral nutrients and infusion pumps, catheters, and sometimes physical therapy.

States reported conflicting views on whether Medicare's contribution to resident care by covering Part B was, in fact, taken into account in their daily rate setting process. As one State worker commented, "in theory, it should be; in reality, who knows?" Interestingly, nearly half of the States responded that their rate setting process did not consider payments by Medicare unless paid directly to the nursing home and included as part of the cost reporting mechanism. Thus, some question exists concerning possible overlap in billing. For example, would the costs of an outside supplier, stocking a nursing home with routine supplies and billing Medicare directly, be adequately addressed in setting the facility's daily payment rate? Additional study is needed to answer this question.

A few States reported that if a service is included in the nursing home per diem, Medicare should not be billed (e.g., Florida and Louisiana (sample states), Hawaii and Minnesota (not in our 10 State sample)). However, we noted no significantly reduced Part B billing in Florida or Louisiana versus other States, which could indicate a failure to enforce their own policy. (Enforcement would be evidenced by the State actively denying payment of the Medicare coinsurance for Part B services provided to dually-eligible nursing home residents.) A Minnesota State official reported that, while the State does consider Medicare billing for items covered under the Medicaid daily rate to be inappropriate, no "oversight is provided to ensure this policy is adhered to."

Even if the per diem adequately reflects Part B billing as a routine practice of the nursing home, the Part B program may be paying considerably more than necessary by not capitalizing on the nursing home's buying power. One example of this involves enteral nutrient products. Our evaluation of enteral nutrients showed that many nursing homes can, or do, purchase enteral nutrient products for their non-Medicare residents, at costs significantly lower than those billed by outside suppliers to the Part B program. Given that several hundred million dollars a year are spent on nutrient products in nursing homes, this represents a substantially inflated cost to the taxpayer. More detail is provided on this subject in our report, *Enteral Nutrient Payments In Nursing Homes*.

- Services Not Covered by Medicaid's Daily Rate

For services or supplies not included in the Medicaid daily rate, it is unlikely that both Medicare and Medicaid would mistakenly pay for the same service or item. This conclusion is based upon States' assurances that a Medicare denial is required before Medicaid would pay for any service or item known to be covered by Medicare. This inspection did not analyze Medicaid data and, consequently, we were unable to determine the extent of any duplicate payments. However, the OIG is beginning an inspection which will combine Medicare and Medicaid data to determine if duplicate billing is occurring for residents in nursing homes.

### **Medicare Part A and Part B**

Cost shifting can also occur between Medicare programs. As discussed in two previously published reports, *Medicare Services Provided to Residents of Skilled Nursing Facilities* and *Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities*, SNFs are not required to provide many types of services or supplies as a facility cost. The impact of this

policy is that nursing homes which shift services to the Part B program (*often called unbundling*) may avoid Medicare's SNF routine cost limits. If routine cost limits are avoided, this increases the cost to Medicare. By shifting costs above the routine cost limit, SNFs increase their profitability, while the taxpayer and SNF resident assume the cost of the amount Medicare allowed for the Part B services billed.

One reason SNFs are able to shift costs to the Part B program is because section 1861(h) of the Social Security Act permits each facility to determine whether certain services are provided as extended care services. Consequently, the extended care facility is able to determine for itself whether those services are covered by either the Part A program or the Part B program.

### **SIZEABLE DIFFERENCES IN PART B UTILIZATION**

*Sizeable variation exists from nursing home to nursing home in the average daily Part B charge and the percentage of residents receiving Part B services.*

Nursing homes vary considerably in Part B use. Figure 8 shows some of the extremes from nursing home to nursing home. Shown is the nursing home with the highest percentage of resident stays with the indicated service compared to the nursing home with the lowest.

**Figure 8**  
**Nursing Homes Can Vary Substantially**  
**In Their Use of Part B**

Selected Categories and States	California		Delaware		Florida		Indiana		Louisiana	
	% of Stays with Service		% of Stays with Service		% of Stays with Service		% of Stays with Service		% of Stays with Service	
	High	Low	High	Low	High	Low	High	Low	High	Low
<b>Evaluation</b>	92%	47%	97%	61%	95%	52%	96%	74%	97%	46%
<b>Imaging &amp; Echography</b>	59	4	90	38	77	32	74	38	78	30
<b>Lab &amp; Other Tests</b>	90	25	95	59	95	2	89	4	94	9
<b>Medical Equipment, etc.</b>	54	<1	67	9	48	11	45	6	46	15
<b>Ambulance</b>	36	<1	66	4	34	9	57	<1	58	<1
<b>Rehabilitation Therapy</b>	20	2	23	3	35	4	34	1	21	1
<b>Mental Health</b>	41	<1	14	<1	49	<1	28	1	11	<1
<b>Podiatry</b>	88	<1	73	13	78	3	64	<1	59	<1

*Source: 1992 Nursing home sample (selected States only)*

***The average daily bed day charge also varies between nursing homes.***

As discussed earlier, we can explain some of the variation (58 percent) in Part B utilization among nursing homes. The primary determinant of Part B utilization is the type of resident treated in the nursing home. The more ill the residents are, the greater their utilization of Part B. Factors not proven to impact bed day cost are nursing home certification, profit/nonprofit status, total bed size of nursing home, and percent of private pay residents.

However, significant variation exists which is unexplained. While more knowledge about the nursing home and residents treated could explain some of this variation, we suspect some variation is the result of abusive or fraudulent billing activity. As an example, the number of residents receiving medical equipment, supplies, orthotics or prosthetics in one Delaware nursing home was 67 percent. In another nursing home, it was only nine percent.

## **LACK OF OVERSIGHT**

***Medicare Part B contractors (carriers and intermediaries) often lack enough information to adequately ensure appropriate payments for residents of nursing homes.***

- Contractors typically do not know if a beneficiary is in a nursing home, unless the place of service on the bill is coded correctly.

Accurate payment for some types of services are dependent upon knowing the place where the beneficiary received the service. This knowledge is especially important for residents of nursing homes. For example, if the person resides in a nursing home (generally, DME is not covered in a nursing home) but a claim for a wheelchair is received with the place of service incorrectly coded as “home,” it is likely the claim will be paid in error. This is because contractors rely on the place of service coding by the supplier to alert them where the beneficiary resided when the service was provided. Only in the case of the beneficiary receiving Medicare extended care benefits in a skilled nursing facility does the Medicare contractor receive notification of a SNF stay if the claim involves DME. However, with heavy workloads, it is possible that carriers would overlook an alert (only rejects must be reviewed by carriers prior to payment).

The impact of this vulnerability is to expose Medicare to millions of dollars in overpayments. Our report, *Durable Medical Equipment Payments in Nursing Homes*, discusses our finding that as much as \$27 million may have been paid by Medicare to suppliers, even though the beneficiary was residing in a nursing home on the date the durable medical equipment was provided.



- Some States may restrict nursing homes from billing Part B for services or supplies included in the Medicaid per diem rate; however, Medicare contractors are often unaware of State policies.

While most States encourage or require providers to bill Medicare for any service covered by Medicare (including services or supplies covered in the Medicaid per diem), at least five States (Florida, Hawaii, Louisiana, Minnesota, and Nevada) reported to us that services and supplies already included in the Medicaid rate, might not be billable to Medicare. In Florida, alone, Part B charges for medical equipment, supplies, prosthetics and orthotics (much of which is included in the rate and must be provided to Medicaid residents) may be as high as \$25 million.

- Medicare contractors are unable to monitor trends and instances of duplicate payments between Medicare and Medicaid, because Medicaid data is not available to carriers.

Medicare Part B contractors currently lack nursing home stay information (admission and discharge dates) for the long term care nursing home resident. Thus, no analysis can be done on a routine basis to look for trends in payments by service which might indicate abusive practices, either within facilities or across the nation. Additionally, Medicaid data is unavailable to contractors to determine if duplicate payments are being made. Only Medicaid is able to monitor duplicate payments based on information from the Part B coinsurance payments it made for dually-eligible residents.

## **QUESTIONABLE SUPPLIER AND PHYSICIAN PRACTICES**

### ***Suppliers***

- Some suppliers may provide excessive volumes of supplies to nursing homes.

An area of potential abuse involves excessive volumes of supplies. As reported previously, more money is paid by Medicare for the category of Medical Equipment, Supplies, Prosthetics, and Orthotics than any other major category of Part B services except Evaluation Services. One example of excess involves incontinence supplies. Our recently published reports on incontinence supplies (*Questionable Medicare Payments for Incontinence Supplies and Marketing of Incontinence Supplies*) discuss how suppliers have overutilized and misrepresented these supplies. For example, 30 percent of beneficiaries surveyed reported that they do not utilize all of the incontinence supplies that are reimbursed by Medicare. Additionally, many nursing homes do not track Medicare-reimbursed supplies to the specific beneficiary for which they were billed. Thus, “Medicare and individual beneficiaries may be paying month after month for unnecessary supplies which may be used for other patients.” In some cases, supplies were delivered in bulk quantities (thus, not designated for any particular resident). Some nursing homes stated they are turning away suppliers because their supply rooms are already overstocked with unused supplies from previous shipments.

Another example of Medicare paying for supplies that are excessive involves routine billing by suppliers each month. Routine billing becomes a problem when the resident no longer

needs the supply; however, the supplies keep coming. The most blatant example of this found in our nursing home sample involves billing for ostomy supplies even though the person no longer was in the nursing home. Weeks before the billing, the resident had entered the hospital and remained there for nearly a month. The billing was \$1,000. This case has been referred to the carrier for recovery.

- Some suppliers bill for medically unnecessary supplies.

The area of wound care presents an example of not only excessive supplies, but of medically unnecessary supplies. Our investigation of wound care products (e.g., tape, gauze, dressings, etc.) used in nursing homes found that a substantial amount of these products provided to nursing home residents are not used. In addition to being delivered in excessive quantities, products were found to be medically unnecessary for some residents.

Another area of abuse involves air-fluidized beds which are not medically necessary when used for preventive purposes only.

- Still other suppliers bill for supplies or services never provided.

In addition to excessive and medically unnecessary supplies or services, some suppliers bill for services or supplies never provided. One gross example found in our sample involved a portable x-ray supplier. The patient purportedly received x-rays at a SNF during two consecutive weeks, although the person was in the hospital during this time. Allowed charges were over \$500 for x-ray transport, setup, and service. This case has been referred for investigation.

After researching the payment vulnerability resulting in this overpayment, it was found that the system of edits in Medicare's payment system (CWF) did not include any edits to suspend payment of similar types of services and supplies (except for DME) while the person is known to be in the hospital or any other inpatient setting.

### ***Physicians***

- The nursing home presents an opportunity to provide services to many different residents during a visit (sometimes called "Gang Visits"). With this opportunity comes the potential for abuse and poor quality care.

While seeing many residents in one day is not inherently bad, the volume of residents seen can suggest a physician or supplier may be billing for a level of care not provided. According to HCFA officials, 15 minutes per person is the suggested minimum time to spend reviewing a resident's condition and performing the appropriate visual inspection of the resident (we note that HCFA has not defined fully what a visit should entail - length of time actually with the resident, time reviewing chart, etc.). The average physician sees 20 or less patients per day. Yet, some physicians billed for large numbers of residents for single day visits in several nursing homes.

To illustrate an extreme, one physician billed for more than 80 nursing home visits on the same day. While this is possible, such an extreme suggests the physician did little more than a paper review (at most). If the physician afforded each resident the desired 15 minutes, it would have taken this physician over 20 hours to complete the billed visits (with no breaks). Spending even half the time (7 ½ minutes), would require 10 hours, still an unlikely scenario. Even under optimistic assumptions (the nursing home is in a remote area where a physician must travel a long distance, medical charts are well-documented and assessments are completed by the nursing staff prior to the physician's visit, etc.), it is easily arguable that this physician was not providing the expected level of care billed for each patient during his visit.

Podiatry services present another example of physician services that appear excessive in some nursing homes. As previously shown in Figure 8, there is wide variation between nursing homes regarding involvement of podiatrists. While nursing homes with little involvement of a podiatrist may reflect a medical physician providing foot care, high podiatrist involvement could indicate an abusive pattern of practice (non-covered routine foot care billed as a covered service). It appears unreasonable that a podiatrist could see over 80 percent of a nursing home's resident population during a year (as occurred in 3 of 150 sampled nursing homes). Further, it appears excessive for a podiatrist to treat high numbers of residents on the same day (6 of 150 nursing homes had podiatrists treating 50 or more residents on the same day; one podiatrist exceeded 65). Finally, we question the medical necessity of seeing the same residents as frequently as every month.

- A few primary care physicians provide the majority of routine care visits.

It appears, from the sampled nursing homes, that either many doctors are caring for very few nursing home patients or a few doctors may be caring for too many patients. This raises concerns about the quality and appropriateness of patient care. (Physicians caring for too few nursing home residents may be ill-equipped to deal with the nursing home geriatric population. Physicians seeing too many nursing home residents may not be giving enough time to the care of a special needs population.)

Nursing home care is predicated on a medical model requiring direct physician leadership in the overall management of a patient's plan of care. Thus, the physician plays a pivotal role as gatekeeper, determining and/or providing necessary medical care, equipment, and supplies necessary for the patient's well-being. However, since the beginning of Medicare and Medicaid, physicians have been criticized for their perceived lack of involvement in the care of nursing home residents.<sup>8</sup>

The OBRA 1987 strengthened the role of the medical director in the nursing home, and the Resource-Based Relative Value Scale (RBRVS) abolished the rule that lowered reimbursements for physicians who see multiple patients during nursing home visits. It also raised reimbursement for the two most common types of nursing home visits. The intent was to put nursing home visit rates on par with office visit rates (addressing a common complaint of nursing home physicians). Our 1992 nursing home data was not recent enough to determine if these events, coupled with more emphasis on geriatric training by some medical schools, may be improving physician participation in the nursing home.

**A FEW EXAMPLES OF PART B ABUSE NOTED BY CARRIERS**  
*BASED ON SURVEY OF FRAUD STAFF*

**Physician and Practitioners**

- Eye Exams - Physicians solicit services at nursing homes with eye exams billed as non-routine or problem focused exams while also using office visit service codes.
- Copayments - Waiving beneficiary copayments.
- Nurses - Physician billed services provided by nursing staff with the physician not present.
- Foot Care - Podiatrists performing routine foot care (a noncovered item).
- Psychiatric - Excessive billing for evaluation testing under preadmission assessment and annual resident review (PASARR) regulations when not reasonable and necessary for diagnosis or treatment (e.g., annual screening required by for Medicaid residents as part of certification process and compensated by Medicaid as part of the daily rate).
  - Individual or group therapies not medically necessary or being performed by inappropriate types of providers, not psychiatrists or community mental health clinics.

**Outpatient Rehabilitation Therapy**

- Excessive charges.
- Therapist billing for services that the nursing home staff performs.
- Using one provider number for services to many different nursing homes giving the impression all residents are in the same facility.
- Providing medically unnecessary services.

**Supplies and Equipment**

- Excessive and medically unnecessary billings for incontinence supplies, ostomy, and surgical dressings. Also, noted were billing for air-fluidized beds used for preventive services (not covered by Medicare) and nebulizers (including nebulizer drugs).
- Providing medically unnecessary orthotics and prosthetics (e.g., body jackets).
- Misrepresenting supplies and equipment ( e.g., lymphedema pumps have been offered to nursing home residents free of charge on a trial basis; however, the supplier bills Medicare).
- Billing for items not covered in a nursing home (e.g., wheelchair).

**Laboratory Services**

- Billing for placement of glucose monitors, collection of specimens from and mileage to the nursing home when not medically necessary or technicians providing services for equipment designed for home use by nonprofessionals.

# CONCLUSIONS

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Significant payments are being made for Part B services, in addition to institutional payments to the nursing homes directly paid by Medicaid and the Medicare SNF benefit. Consequently, more closely monitoring services provided under these benefits and addressing vulnerabilities are important, particularly given Medicare's potential exposure to abusive practices.

This review of utilization of Part B services by nursing home residents suggests the need for further work in, at least, the following areas:

## ***Bundling Payments***

This includes examining the appropriateness of consolidated billing of Part B nursing home expenses and the daily rate paid by Medicare Part A or Medicaid. The Office of Inspector General (OIG) will be doing additional work on both the concept of bundling (consolidated billing) and the vulnerability posed by potential duplicate billings.

## ***Monitoring Trends***

This includes monitoring Part B utilization over time, with focused review of services experiencing rapid growth (e.g., mental health, magnetic resonance imaging) without any known reason (e.g., coverage change). We plan additional work on a number of such areas.

## ***Quality of Care***

This includes detecting poor quality care resulting from such practices as physicians treating too many patients in one day (e.g., podiatrists), exposure to excessive or inappropriate medical services, provision of supplies not medically necessary, etc. Under Operation Restore Trust, the HCFA is now experimenting with methods to involve State surveyors in such efforts, which might prove fruitful; the involvement of nursing home volunteer ombudsmen in such efforts will also be tested as part of ORT.

## ***Fraud Detection Measures***

This includes developing and applying various fraud detection methods to identify abusive practices and fraud involving nursing homes. We plan to employ such methods in future work under ORT.

For example, the nursing home bed day cost could be a valuable tool in identifying nursing homes or providers with aberrant and, possibly, abusive practices. Although use of bed day cost is a post review process, it requires a minimum of effort to identify and flag potentially abusive providers or nursing homes. Depending on the likelihood of abuse underlying the high average daily charge, the information could be provided to survey and certification staff to be used during their next scheduled visit, to contractor fraud and abuse staff for

investigation, or to others (long term care ombudsmen, OIG, State Health Departments, Medicaid Fraud Control Units, etc.) for consideration and action.

Linking resident assessment data to billing history on services provided to residents may be used, both to identify medically unnecessary services and to identify quality of care issues (e.g., patient care needed but not provided). Facilities must conduct, initially and periodically, a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. The assessment must include the resident's medical history, current medical status, functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. The assessment must be performed within 14 days of admission. It must be repeated yearly, as well as promptly after any significant change in the resident's condition.

In order to meet the requirement for a comprehensive assessment, the Minimum Data Set (MDS) must be used. The information captured by MDS is available, or will be available in the future, as an automated database. Thus, this information could be linked to billing history data maintained in the National Claims History File or Common Working File (CWF). By linking this data, one could test the appropriateness of service billing patterns against factual assessment data about individual resident needs. For example, an analysis could be completed of residents billed for enteral nutrients, despite the fact that current resident assessment data shows no indication of any eating disorder, difficulty swallowing, etc. that would warrant tube feedings. The reverse situation may also be reviewed (e.g., the assessment data indicates a need for services that were not rendered).

Resident assessment data could be used to summarize a nursing home's population based on various medical indicators, allowing one to account for case mix differences between nursing homes when assessing the significance of differences in bed day costs from one nursing home to another.

The HCFA could also monitor the number of beneficiaries treated by particular providers on the same day. As discussed previously, the potential exists for a provider to bill for an unrealistically high number of residents on the same day. Determining the total number of beneficiaries seen by a provider and comparing it to an average or specified standard can alert the carrier to providers requiring closer scrutiny.

To support the development of fraud detection methods, further information is currently being gathered on the nature and magnitude of abusive provider practices or program vulnerabilities involving nursing home residents. This information will be used to identify the most efficient fraud detections methods.

## **AGENCY COMMENTS**

We thank the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) for their comments to the draft report. Changes were made based on their suggestions. In addition to suggestions, the HCFA points out several actions it has taken to address vulnerabilities such as: 1) requiring carriers and intermediaries to selectively initiate pre-pay reviews on high dollar payment areas and aberrant trends, and 2) development of enhanced duplicate payment detection methodologies for the Medicare Transaction System. The full text of HCFA and ASPE comments are provided in Appendix B.

# ENDNOTES

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1. Girwitz, J., Sanchez-Cross, M, and Eckler, M. *The Epidemiology of Adverse and Unexpected Events in the Long-Term Care Setting*. Journal of the American Geriatrics Society, 1994, (42) pages 33-38.
2. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (DHHS), administers Medicare and contracts with private insurance companies (e.g., Blue Cross or Blue Shield plans) to process and pay Hospital Insurance (Part A) and/or Part B claims. Contractors, called intermediaries, process claims from institutions such as hospitals and nursing homes; other contractors, called carriers, process claims from noninstitutional providers, such as physicians and suppliers. The HCFA provides direction to contractors on payment matters and is, ultimately, responsible for assuring a contractor's adherence to applicable program policies and procedures.
3. Section 1819(a) of the Social Security Act defines a SNF as "an institution (or distinct part of an institution) which is primarily engaged in providing to residents 1) skilled nursing care and related services for residents who require medical or nursing care, or 2) rehabilitative services for the rehabilitation of injured, disabled, or sick persons." Also, a SNF is not providing care primarily for the care and treatment of mental diseases. This definition was formerly found in section 1861(j)(1) and is often referred to as the "j1" provision.

Medicare-participating SNFs are paid their costs and receive interim amounts to pay estimated costs. Actual costs are settled later, with adjustments made if interim payments were too high or too low. Any costs determined to be in excess of those necessary for the efficient delivery of needed health services are excluded. The SNF services are divided between routine and ancillary services. Routine services include room, dietary, nursing services, medical social services, items which are reusable and expected to be available in a SNF (e.g., wheelchairs), and items which are furnished routinely to all patients. In contrast, ancillary services include laboratory, radiology, drugs, therapy, and other items and services for which charges are customarily made in addition to a routine per diem charge.

4. Institute of Medicine. *Improving the Quality in Nursing Homes*. Washington, DC. National Academy Press, 1986.
5. This assessment is completed using a comprehensive resident assessment instrument developed by HCFA called the Minimum Data Set (MDS). The MDS was implemented nationally in October of 1990 and serves as a basis for the development of major, uniform data collection systems for resident characteristics. A slightly modified version of the MDS, the Minimum Data Set Plus or MDX+, is seen as the cornerstone for the development and implementation of a Medicare Part A case mix system for setting reimbursement to nursing homes.



6. Federal guidelines allow States discretion in establishing income and resource criteria for program eligibility; determining the amount, duration, and scope of covered services; and determining provider reimbursement methodologies. As a consequence, characteristics of State Medicaid programs vary considerably from State to State.
7. General Accounting Office. *Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse*. GAO/HRD-92-1, released October 1991.
8. Mitchell, JB. *Physician Visits to Nursing Homes*. *Gerontologist*, 1982, (22) pgs. 45-8.

# APPENDIX A

## PROJECTED PART B CHARGES FOR NURSING HOME RESIDENTS

<i>Type of Service</i>	<i>Estimated 1992 Charges</i>	<i>Stays With Service</i>	<i>Stays Also With Medicare SNF</i>	<i>Bed day Charge ----- With Service</i>	<i>Based on All Stays</i>
<b>ALL SERVICES</b>	<b>\$4,173,584,532</b>	<b>89%</b>	<b>25%</b>	<b>\$9.13</b>	<b>\$8.75</b>
<b>EVALUATION</b>	<b>\$893,831,089</b>	<b>82%</b>	<b>23%</b>	<b>\$2.00</b>	<b>\$1.87</b>
<i>Office Visits</i>	\$72,074,385	22%	21%	\$0.50	\$0.15
<i>Hospital Visits</i>	\$161,848,927	15%	30%	\$1.98	\$0.34
<i>Emergency Room Visits</i>	\$55,554,187	16%	23%	\$0.54	\$0.12
<i>Home Visits</i>	\$2,098,658	1%	14%	\$0.22	\$0.00
<i>Specialist Evaluation</i>	\$41,359,353	15%	17%	\$0.38	\$0.09
• <i>Pathology</i>	\$15,471,756	6%	20%	\$0.37	\$0.03
• <i>Ophthalmology</i>	\$18,302,744	10%	14%	\$0.25	\$0.04
• <i>Other</i>	\$7,584,853	1%	49%	\$2.48	\$0.02
<i>Consultations</i>	\$99,912,011	22%	24%	\$0.73	\$0.21
<i>Nursing Home Visits</i>	\$460,983,284	75%	23%	\$1.10	\$0.97
<b>ANESTHESIA</b>	<b>\$33,584,865</b>	<b>5%</b>	<b>26%</b>	<b>\$1.01</b>	<b>\$0.07</b>
<b>MAJOR AND MINOR MEDICAL PROCEDURES</b>	<b>\$320,949,774</b>	<b>30%</b>	<b>21%</b>	<b>\$1.59</b>	<b>\$0.67</b>
<i>Major Procedures</i>	\$92,050,701	4%	34%	\$3.85	\$0.19
<i>Eye Procedures</i>	\$81,313,693	2%	11%	\$6.37	\$0.17
• <i>Corneal Transplant</i>	\$2,174,759	0%	15%	\$8.75	\$0.00
• <i>Cataract Removal/Lens Insertion</i>	\$56,565,162	1%	13%	\$7.72	\$0.12
• <i>Retinal Detachment</i>	\$496,023	0%	0%	\$3.95	\$0.00
• <i>Treatment of Retinal Lesions</i>	\$1,824,844	0%	13%	\$2.48	\$0.00
<i>Ambulatory Procedures</i>	\$70,622,822	5%	28%	\$1.97	\$0.15
<i>Minor Procedures</i>	\$76,962,558	25%	19%	\$0.45	\$0.16
<b>ONCOLOGY</b>	<b>\$35,899,068</b>	<b>1%</b>	<b>45%</b>	<b>\$13.15</b>	<b>\$0.08</b>
<b>ENDOSCOPY</b>	<b>\$51,065,945</b>	<b>4%</b>	<b>25%</b>	<b>\$1.99</b>	<b>\$0.11</b>
<b>DIALYSIS SERVICES</b>	<b>\$108,757,165</b>	<b>1%</b>	<b>40%</b>	<b>\$21.82</b>	<b>\$0.23</b>

<i>Type of Service</i>	<i>Estimated 1992 Charges</i>	<i>Stays With Service</i>	<i>Stays Also With Medicare SNF</i>	<i>Bed day Charge</i>	
				<i>With Service</i>	<i>Based on All Stays</i>
<b>IMAGING AND ECHOGRAPHY</b>	<b>\$408,111,812</b>	<b>49%</b>	<b>25%</b>	<b>\$1.47</b>	<b>\$0.86</b>
<i>Standard Imaging</i>	\$302,404,985	47%	25%	\$1.12	\$0.63
• <i>Chest</i>	\$48,543,654	32%	24%	\$0.27	\$0.10
• <i>Musculoskeletal</i>	\$51,972,672	19%	26%	\$0.44	\$0.11
• <i>Breast</i>	\$2,442,160	1%	8%	\$0.32	\$0.01
• <i>Contrast Gastrointestinal (G.I.)</i>	\$94,095,987	9%	26%	\$1.55	\$0.20
• <i>Nuclear Medicine</i>	\$9,737,123	2%	25%	\$0.91	\$0.02
• <i>Other</i>	\$12,229,717	7%	27%	\$0.28	\$0.03
• <i>Transport and Setup of X-ray Equipment</i>	\$83,383,672	20%	21%	\$0.69	\$0.17
<i>Advanced Imaging (Cat Scan or MRI)</i>	\$71,223,773	6%	27%	\$1.91	\$0.15
<i>Echography</i>	\$27,389,120	6%	22%	\$0.69	\$0.06
• <i>Abdomen/Pelvis</i>	\$7,206,888	2%	20%	\$0.44	\$0.02
• <i>Heart</i>	\$11,545,122	2%	21%	\$0.93	\$0.02
• <i>Carotid Arteries</i>	\$2,504,886	1%	20%	\$0.52	\$0.01
• <i>Prostate, Transrectal</i>	\$97,668	0%	0%	\$0.50	\$0.00
• <i>Other</i>	\$4,163,416	1%	36%	\$0.73	\$0.01
<i>Imaging Procedures</i>	\$7,093,934	1%	29%	\$1.83	\$0.01
• <i>Heart (cardiac catheterization)</i>	\$1,597,956	0%	34%	\$8.35	\$0.00
• <i>Other</i>	\$5,495,977	1%	28%	\$1.48	\$0.01
<b>LAB AND OTHER TESTS</b>	<b>\$617,138,509</b>	<b>66%</b>	<b>22%</b>	<b>\$1.59</b>	<b>\$1.29</b>
<i>Lab Tests</i>	\$561,483,308	65%	22%	\$1.46	\$1.18
• <i>Routine Venipuncture</i>	\$224,122,353	44%	19%	\$0.81	\$0.47
• <i>Automated General Profiles</i>	\$69,550,382	44%	22%	\$0.26	\$0.15
• <i>Urinalysis</i>	\$11,457,955	29%	21%	\$0.06	\$0.02
• <i>Blood Counts</i>	\$50,714,881	44%	22%	\$0.19	\$0.11
• <i>Glucose</i>	\$7,038,917	6%	16%	\$0.17	\$0.01
• <i>Bacterial Cultures</i>	\$37,912,428	27%	24%	\$0.23	\$0.08
• <i>Other</i>	\$160,686,392	51%	23%	\$0.53	\$0.34
<i>Other Tests</i>	\$39,190,232	14%	23%	\$0.43	\$0.08
• <i>Electrocardiogram</i>	\$14,201,057	9%	21%	\$0.23	\$0.03
• <i>Cardiovascular Stress Test</i>	\$386,827	0%	11%	\$0.46	\$0.00
• <i>EKG Monitoring</i>	\$3,528,040	1%	16%	\$0.72	\$0.01
• <i>Other</i>	\$21,074,307	7%	25%	\$0.51	\$0.04
<i>Specimen Collection</i>	\$16,464,970	29%	18%	\$0.09	\$0.03

Type of Service	Estimated 1992 Charges	Stays With Service	Stays Also With Medicare SNF	Bed day Charge	
				With Service	Based on All Stays
<b>MEDICAL EQUIPMENT, SUPPLIES, PROSTHETICS, AND ORTHOTICS</b>	<b>\$772,228,643</b>	<b>27%</b>	<b>29%</b>	<b>\$5.29</b>	<b>\$1.62</b>
<b>Durable Medical Equipment</b>	<b>\$35,428,504</b>	<b>6%</b>	<b>41%</b>	<b>\$2.08</b>	<b>\$0.07</b>
• Hospital Beds and Accessories	\$5,134,812	1%	47%	\$2.08	\$0.01
• Oxygen Equipment and Supplies	\$14,249,157	1%	37%	\$6.72	\$0.03
• Wheelchairs and Accessories	\$9,353,138	3%	38%	\$0.92	\$0.02
• Other DME	\$3,194,710	1%	45%	\$1.18	\$0.01
• Walkers	\$1,357,581	1%	57%	\$0.85	\$0.00
• Canes and Crutches	\$63,412	0%	70%	\$0.43	\$0.00
• Commodes	\$1,092,060	1%	57%	\$0.74	\$0.00
• Seat/Patient Lifts	\$348,261	0%	26%	\$1.26	\$0.00
• Pressure Pads, Cushions, and Mattresses	\$2,635,374	0%	28%	\$0.68	\$0.01
<b>Braces, Trusses, Artificial Limbs</b>	<b>\$62,389,553</b>	<b>3%</b>	<b>20%</b>	<b>\$2.73</b>	<b>\$0.13</b>
• Braces and Trusses	\$44,900,809	3%	18%	\$2.13	\$0.09
• Artificial Limbs	\$17,488,744	0%	37%	\$8.46	\$0.04
<b>Casts, Splints, and Fracture Reduction Devices</b>	<b>\$8,774,695</b>	<b>1%</b>	<b>33%</b>	<b>\$1.79</b>	<b>\$0.02</b>
<b>Surgical Dressings</b>	<b>\$22,268,560</b>	<b>1%</b>	<b>18%</b>	<b>\$3.28</b>	<b>\$0.05</b>
• Primary Surgical Dressings	\$129,032	0%	2.2%	\$0.95	\$0.00
• Gauze, Bandages, and Tape	\$8,104,184	1%	24%	\$1.73	\$0.02
• Adhesive and Remover	\$14,035,343	1%	18%	\$2.27	\$0.03
<b>Prosthetic Devices and Related Supplies</b>	<b>\$643,367,331</b>	<b>20%</b>	<b>27%</b>	<b>\$5.41</b>	<b>\$1.35</b>
• Enteral Nutrition Equipment and Supplies	\$367,573,163	5%	34%	\$15.57	\$0.77
• Parenteral Nutrition Equipment and Supplies	\$8,451,450	0%	37%	\$63.30	\$0.02
• Medical and Surgical Supplies	\$198,465,794	14%	26%	\$2.25	\$0.42
• Catheters and Related Items	\$55,626,395	7%	27%	\$1.28	\$0.12
• Tracheostomy Devices and Items	\$350,453	0%	37%	\$0.26	\$0.00
• Ostomy and Related Items	\$7,888,119	1%	18%	\$1.65	\$0.02

<i>Type of Service</i>	<i>Estimated 1992 Charges</i>	<i>Stays With Service</i>	<i>Stays Also With Medicare SNF</i>	<i>Bed day Charge ----- With Service Based on All Stays</i>	
<b>AMBULANCE</b>	<b>\$250,046,021</b>	<b>19%</b>	<b>24%</b>	<b>\$2.10</b>	<b>\$0.52</b>
<i>Basic Life Support Transport</i>	\$105,045,057	15%	25%	\$1.11	\$0.22
<i>Advanced Life Support</i>	\$97,274,119	10%	23%	\$1.60	\$0.20
<i>Non-emergency Transport</i>	\$40,065,844	6%	32%	\$0.99	\$0.08
<i>Oxygen and Medical Supplies</i>	\$7,661,001	6%	22%	\$0.19	\$0.02
<b>CHIROPRACTIC SERVICES</b>	<b>\$155,033</b>	<b>0%</b>	<b>15%</b>	<b>\$0.35</b>	<b>\$0.00</b>
<b>DRUGS AND BIOLOGICALS</b>	<b>\$17,879,871</b>	<b>5%</b>	<b>30%</b>	<b>\$0.60</b>	<b>\$0.04</b>
<b>VISION &amp; HEARING SERVICES AND SUPPLY</b>	<b>\$4,449,496</b>	<b>1%</b>	<b>15%</b>	<b>\$0.44</b>	<b>\$0.01</b>
<b>REHABILITATION THERAPY</b>	<b>\$513,823,746</b>	<b>10%</b>	<b>29%</b>	<b>\$8.99</b>	<b>\$1.08</b>
<i>Physical</i>	\$225,980,972	7%	30%	\$6.51	\$0.47
<i>Occupational</i>	\$163,025,951	4%	27%	\$7.39	\$0.34
<i>Speech Therapy</i>	\$124,816,823	3%	35%	\$7.98	\$0.26
<b>RESPIRATORY THERAPY</b>	<b>\$535,266</b>	<b>0%</b>	<b>21%</b>	<b>\$1.28</b>	<b>\$0.00</b>
<b>MENTAL HEALTH SERVICES</b>	<b>\$55,919,308</b>	<b>5%</b>	<b>22%</b>	<b>\$1.71</b>	<b>\$0.12</b>
<b>PODIATRIC SERVICES</b>	<b>\$99,051,759</b>	<b>35%</b>	<b>18%</b>	<b>\$0.42</b>	<b>\$0.21</b>
<i>Routine Foot Care</i>	\$15,622,802	9%	17%	\$0.23	\$0.03
<b>DENTAL SERVICES</b>	<b>\$19,968</b>	<b>0%</b>	<b>0%</b>	<b>\$2.34</b>	<b>\$0.00</b>
<b>MISCELLANEOUS (OUTPATIENT)</b>	<b>\$45,077,461</b>	<b>8%</b>	<b>28%</b>	<b>\$0.92</b>	<b>\$0.09</b>
<b>CARRIER SPECIFIC CODES</b>	<b>\$24,290,380</b>	<b>4%</b>	<b>28%</b>	<b>\$1.01</b>	<b>\$0.05</b>
<b>OTHER</b>	<b>\$4,198,310</b>	<b>3%</b>	<b>20%</b>	<b>\$0.25</b>	<b>\$0.01</b>

# APPENDIX B

## ASSISTANT SECRETARY FOR PLANNING AND EVALUATION COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JAN 16 1996

TO: Claudia Cooley  
Executive Secretary

FROM: Acting Assistant Secretary for  
Planning and Evaluation

SUBJECT: Formal Comments Regarding OIG Draft Reports On Medicare Payments for  
Services Provided to Nursing Home Residents

In our earlier response to the three OIG reports on Medicare payments for nursing home residents, we expressed concern that the reports could inadvertently lead to the conclusion that Medicare Part B payments should not be made on behalf of nursing home residents and that we would discuss this concern and other issues during a meeting with OIG staff on December 12, 1995. As a result of this discussion between ASPE and OIG staff the following formal ASPE comments are offered regarding the three OIG reports entitled "Part B Services in Nursing Homes - An Overview," "Durable Medical Equipment Payments in Nursing Homes," and "Enteral Nutrients Payments in Nursing Homes".

### **Enteral Nutrients Payments in Nursing Homes**

We agree with the OIG conclusion that food should be considered a basic nursing home service that is included in a nursing home payment rate. In addition, we agree that enteral nutrition is a way for certain persons to meet daily nutritional requirements. Further, we agree, to the extent that the costs of enteral nutrition are comparable to the costs of meals for the general nursing home population, that the costs of enteral nutrition should be included in the basic nursing home payment rate. Based on the preceding, we agree that Medicare Part B payments for enteral nutrition should not be made on behalf of persons residing in nursing homes.

However, we recommend the report note that the extent to which other payers (e.g., Medicaid) take into account the costs of enteral nutrition or meals for the general nursing home population is unknown, and, as a result, the impact on nursing home residents of a policy prohibiting Medicare Part B payments for enteral nutrition is unknown.

### **Durable Medical Equipment (DME) Payment in Nursing Homes**

We are opposed to the OIG recommendation to expand the current prohibition on Part B DME payments on behalf of persons in a Part A covered SNF stay to also include persons in non-Part A covered stays. At this time, there is no agreement on the core services that should be included

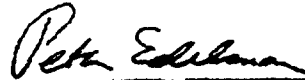
in a nursing home payment rate. As a result, we are unable to identify which Medicare Part B DME payments are made for routine nursing home services (i.e., services that should be included in a nursing home payment rate) and which are not. Further, while we understand current law limits Part B DME to persons who are residing in their "home," it is not clear when a nursing home resident (i.e., in non-Part A covered stay) is permanently residing in such a facility, and, thus, is at home in the facility, versus a resident that is receiving short-term care and intends to return home. To ensure that beneficiaries are not inappropriately denied needed coverage, a policy prohibiting Part B DME payments to all nursing home residents would have to assume that Part B DME payments are for routine or core nursing home services and that there are no long-term, permanent nursing home residents for whom the nursing home has, in fact, become their home. We do not believe that these are accurate assumptions. Further, we are concerned that denying Medicare Part B DME payments to nursing home residents could have a negative effect on their quality of care. Therefore, we believe, at least in the interim, the Department should presume that nursing home residents in a non-Part A covered SNF stay are residing in their "home" and permit Part B DME payments on behalf of such residents in need of these supplies. We recommend the OIG study this issue and recommend a categorization of equipment routinely covered in nursing home payment rates and DME not routinely included in such rates. A review of State Medicaid nursing facility payment methods may provide some insight into this issue.

Finally, we recommend that the conclusion of this report clearly indicate that Part B DME payments made within a week of discharge for any nursing home resident (regardless of payer) who is eligible for Part B are appropriate to facilitate discharge planning.

#### **Part B Services in Nursing Homes**

We recommend including in the Background section a discussion of the circumstances under which Medicare Part B payments on behalf of nursing home residents are appropriate, the difficulties in identifying when such payments are inappropriate, and the variable impact that proposals to limit Medicare Part B payments will have on different nursing home residents (i.e., those in a Part A covered SNF stay, those who are not, and those who are also eligible for Medicaid) and on State and Federal governments.

We understand that the OIG intends to undertake a study of State Medicaid nursing facility payment rates and methods. We agree that such a study is needed in order to understand when duplicate payments have been made (i.e., Medicare and Medicaid both have paid) and when Medicaid cost sharing is inappropriate.



**Peter Edelman**

HEALTH CARE FINANCING ADMINISTRATION  
COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

DATE DEC 15 1995

TO June Gibbs Brown  
Inspector General

FROM Bruce C. Vladeck *Bruce Vladeck*  
Administrator

SUBJECT Office of Inspector General Draft Report: "Part B Services in Nursing Homes, An Overview," (OEI-06-92-00865)

We reviewed the above-referenced report that describes the Medicare Part B services provided to nursing home residents and identifies known or potential program vulnerabilities. The report contains no recommendations.

Various Health Care Financing Administration (HCFA) work groups have identified these same vulnerabilities and are working to correct them. HCFA is currently investigating payment alternatives, such as bundling nursing home payments, to prevent program fraud and abuse. Since the inception of the Durable Medical Equipment Regional Carriers in 1993, our efforts to monitor trends and take fraud detection measures have increased and become more efficient. We are also building enhanced duplicate payment detection methodologies into the Medicare Transaction System.

HCFA is requiring that carriers and intermediaries selectively initiate pre-pay reviews on high dollar payment areas and aberrant trends such as respiratory therapy and surgical dressings. This should identify abuses before claims are paid.

There is one technical issue that should be noted. On page 5, paragraph 2, the last sentence implies that the Consumer Price Index (CPI) is derived solely from the general medical community. In fact the CPI is based on many factors, of which the medical community is but one.

Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments further.



# GLOSSARY

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**Artificial Limb** - Replacement for a natural limb (prosthesis).

**Bundling** - This term refers to the payment policy of requiring institutions to bill for services provided residents, rather than some services provided by the institution and some provided by outside suppliers and other providers (who bill Medicare separately).

**Brace** - An orthopedic appliance or apparatus (*orthosis*), usually made of metal or leather, applied to the body, particularly the trunk and lower extremities, to support the weight of the body, to correct deformities, to prevent deformities, or to control involuntary movements, such as occur in spastic conditions. In some cases bracing is needed after remedial surgery.

**Cardiac Catheterization** - The insertion of a catheter into a vein or artery and guiding it into the interior of the heart for purposes of measuring cardiac output, determining the oxygen content of blood in the heart chambers, and evaluating the structural components of the heart.

**Carriers** - Part B contractors that provide administrative services, for given geographic territory, to all beneficiaries, physicians, and various suppliers of service, e.g., lab, ambulance, and durable medical equipment in that area that are not connected with an institutional provider; process only claims which are paid from Medicare Part B trust funds.

**Casts** - A stiff dressing or casing, usually made of plaster of Paris, used to immobilize body parts.

**CAT Scan** - A revolutionary radiologic imaging modality that uses computer processing to generate an image of the tissue density in a "slice" about 1 centimeter thick through the patient's body.

**Catheter** - A tubular, flexible instrument passed through body channels for withdrawal of fluids from (or introduction of fluids into) a body cavity.

**Cholecystectomy** - Excision of the gallbladder.

**Coinsurance** - The percentage of the balance of covered medical expenses that a beneficiary must pay after payment of the deductible. Under Medicare Part B, the beneficiary pays coinsurance of 20 percent of allowed charges. See Copayment, Deductible.

**Colonoscopy** - Endoscopic examination of the colon, either transabdominally through laparotomy, or transanally by means of a colonoscope.

**Common Working File (CWF)** - A pre-payment claims validation and Medicare Part A/Part B benefit coordination system which uses localized data bases maintained by a host contractor; the host contractor provides Medicare contractors within a geographic area (referred to as sector) with beneficiary entitlement and eligibility data.

**Contractor** - Private health insurers, State, and public or private organizations which process Medicare claims and make payments to providers of services and to beneficiaries.

**Copayment** - The sum of coinsurance and deductibles. Alternatively, a fixed dollar amount per service that is the responsibility of the beneficiary. See Coinsurance, Deductible.

**Current Procedural Terminology (CPT)** - The coding system for physicians' services developed by the American Medical Association; basis of the HCPCS coding system for physicians' services. See Coding, HCFA Common Procedures Coding System.

**Customary Charge** - The amount physicians or suppliers usually bill patients for furnishing particular services or supplies.

**Customary, Prevailing, and Reasonable (CPR)** - One method used for reimbursement of services which typically limit reimbursements for services to the lowest of the provider's actual charge, the provider's customary charge for comparable services, or the prevailing charge in the area.

**Cystoscopy** - Examination of the bladder by means of a cystoscope, a hollow metal tube that is introduced into the urinary meatus and passed through the urethra and into the bladder. At the end of the cystoscope is an electric bulb that illuminates the bladder interior. By means of special lens and mirrors the bladder mucosa is examined for inflammation, calculi, or tumors.

**Deductible** - A specified amount of covered medical expenses that a beneficiary must pay before receiving benefits. In 1992, Medicare Part B had an annual deductible of \$100.

**DMERCs (Durable Medical Equipment Regional Carriers)** - In June 1992, HCFA issued a final rule designating four DMERCs to process all claims for DME, prosthetics, orthotics, and supplies. Effective October 1993, DMERCs replaced nearly 40 area carriers which had previously processed DME claims.

**Diagnosis-Related Group (DRG)** - The prospective payment system established using one price for each DRG based on diagnosis and other characteristics. System used to classify patients into clinically coherent and homogeneous groups that use similar resources. Prices are established in advance for the coming year, and hospitals are paid these prices regardless of the costs they actually incur.

**Discharge** - The termination of a period of inpatient SNF or the formal release of the inpatient by the hospital.

**Dressing** - Any of various materials used for covering and protecting a wound. A pressure dressing is used for maintaining constant pressure, as in the control of bleeding. A protective dressing is applied to shield a part from injury or from septic infection.

**Durable Medical Equipment (DME)** - Medicare-covered items such as oxygen equipment, wheelchairs, and other medically necessary equipment prescribed by a doctor for a patient's in-home use.

**Electrocardiogram** - The record produced by Electrocardiography, a tracing representing the heart's electrical action derived by amplification of the minutely small electrical impulses normally generated by the heart.

**End Stage Renal Disease (ESRD)** - Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have end stage renal disease. To qualify for Medicare coverage, such individuals must be fully or currently insured under social security or the railroad retirement system or be the dependent of an insured person. Eligibility for Medicare coverage begins the third month after the month in which a course of renal dialysis begins.

**Echography** - Ultrasonography, the use of ultrasound as a diagnostic aid. Ultrasound waves are directed at the tissues and a record is made, as on an oscilloscope, of the waves reflected back through the tissues, which indicate interfaces of different acoustic densities and thus, differentiate between solid and cystic structures.

**Endoscopy** - Visual examination of interior structures of the body with an endoscope.

**Enteral** - Within, by way of, or pertaining to the small intestine.

**Evaluation and Management Service** - A nontechnical service provided by most physicians for the purpose of diagnosing and treating diseases and counseling and evaluating patients.

**Fee for Service** - A system of paying physicians for individual medical services rendered, as opposed to paying them salaries or capitation payments. The CPR payment system and the Medicare Fee Schedule are examples of fee for service payment methods. See Customary, Prevailing, and Reasonable; Fee Schedules.

**Fee Schedules** - A predetermined flat maximum payment amount for individual procedure codes within a type of service. States may develop Medicaid fee schedules or adopt Medicare fee schedules.

**Global Service** - A package of clinically related services treated as a unit for purposes of billing, coding, or payment.

**HCFA Common Procedure Coding System (HCPCS)** - A coding system based on CPT, but supplemented with additional codes; required for coding by Medicare carriers. See Current Procedural Terminology.

**HCFA Data Center (HDC)** - A large, centralized, and complex data processing environment where state-of-the-art technology is being used, including computer hardware, operating systems, and data communications networks; maintains databases on the various contractor report items and uses that information to generate subsequent reports for HCFA and DHHS managers' use.

**Home Health Agency (HHA)** - A public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in your home; Medicare will pay for such services provided certain conditions are met.

**Home Health Services** - Home health services are services and items furnished in patients' homes under the care of physicians. These services are furnished by home health agencies or by others under arrangements made by home health agencies. Services are furnished under a plan established and periodically reviewed by a physician. The services include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biologicals); home health aid services; and services of interns and residents.

**Hospice** - A program operated by a public agency or private organization which engages primarily in providing pain relief, symptom management, and supportive services for terminally ill people and their families.

**ICD-9-CM** - International Classification of Diseases, 9th Revision, Clinical Modification. A statistical coding classification system used to measure the incidence of disease, injury, and illness.

**Imaging** - The production of diagnostic images.

**Intermediaries** - Contractors that perform Medicare administrative services for institutional providers, i.e., hospitals, SNFs, HHAs, and hospices. See Home Health Agency, Hospice, Skilled Nursing Facility.

**Laryngoscopy** - The direct visual examination of the larynx with a laryngoscope.

**Limiting Charge** - The maximum amount that a nonparticipating physician is permitted to charge for a service; a limit on balance billing. Starting in 1993, the limiting charge will be a flat percentage of the Medicare Fee Schedule amount paid to nonparticipating physicians.

**Major Diagnostic Categories (MDCs)** - A classification system which groups the 467 DRGs into 23 categories based on body systems (e.g., nervous system, respiratory system, etc.) and disease origin. See Diagnostic-Related Group.

**Medicaid** - A health care program cooperatively administered by Federal and State governments to provide medical assistance to eligible needy individuals.

**Medical Review (MR)** - A contractor activity performed as part of the claims processing function to determine the medical necessity of services provided to beneficiaries.

**Medicare Economic Index (MEI)** - An index that tracks changes over time in physician practice costs and general earnings levels. From 1975 through 1991, increases in prevailing charge screens were limited to increases in the MEI.

**Medicare Fee Schedule** - The resource-based fee schedule currently used by Medicare to pay for physicians' services.

**Occupational Therapy** - Services designed to restore self-care, work, and leisure skills to patients/clients who have specific performance incapacities or deficits that reduce their abilities to cope with the tasks of everyday living.

**Oncology** - The sum of knowledge regarding tumors; the study of tumors and cancer.

**Ostomy** - General term for an operation in which an artificial opening is formed, as in colostomy, ureterostomy, etc.

**Other Practitioners' Services** - Health care services of licensed practitioners other than physicians and dentists.

**Orthopedic** - Pertaining to the correction of deformities of the musculoskeletal system; pertaining to orthopedics.

**Outpatient Hospital Services** - Outpatient hospital services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients under the direction of a physician or dentist by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting and meets the requirements for participation in Medicare as a hospital.

**Paid Amount** - The portion of a submitted charge that is actually paid by both third-party payers and the insured, including copayments and balance bills. See Submitted Charge.

**Parenteral** - Not through the alimentary canal, e.g., by subcutaneous, intramuscular, intrasternal, or intravenous injection.

**Part A of Medicare** - The hospital insurance portion of Medicare; established by section 1811 of title XVIII of the Social Security Act of 1965, as amended; covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.

**Part B of Medicare** - The supplementary or "doctors" insurance portion of Medicare; established by section 1831 of title XVIII of the Social Security Act of 1965, as amended; covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.

**Periodic Interim Payment (PIP) System** - A system used by intermediaries to pay providers, in which estimated Medicare reimbursement for the year is divided into equal, regularly spaced payment amounts; enables a provider to manage its cash flow more easily.

**Physical Therapy** - The examination, treatment, and instruction of persons in order to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction, and pain from injury, disease, and any other bodily and mental conditions.

**Physician Services** - Services furnished by, or under the direction of a licensed doctor of medicine or osteopathy in the State where the services are performed. Physician services may be provided in the physician's office, the recipient's home, a hospital, or a nursing facility.

**Podiatry** - The specialized field dealing with the study and care of the foot, including its anatomy, pathology, medical and surgical treatment, etc.

**Premium** - An amount paid periodically to purchase medical insurance benefits; for Medicare Part B services in 1992, beneficiaries paid a premium of \$31.80 per month.

**Principal Diagnosis** - The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

**Professional Component** - The part of a relative value or fee that presents the cost of a physician's interpretation of a diagnostic test or treatment planning for a therapeutic procedure. See Technical Component.

**Qualified Medicare Beneficiaries (QMBs)** - QMBs are elderly or disabled persons whose incomes are at or below specified percentages of the Federal poverty level.

**Radiation Therapy** - The treatment of disease by ionizing radiation. The purpose of radiation therapy is to deliver an optimal dose of either particulate or electromagnetic radiation to a particular area of the body with minimal damage to normal tissues.

**Recipient** - An individual who has been determined to be eligible for Medicaid and who has used medical services covered under Medicaid.

**Relative Value Scale (RVS)** - An index that assigns weights to each medical service; the weights represent the relative amount to be paid for each service. The RVS used in the development of the Medicare Fee Schedule consists of three cost components: Malpractice Expense, Medicare Fee Schedule, and Physician Work/Practice Expense.

**Relative Work Value (RWV)** - An assigned value that reflects the average work of a physician of average efficiency relative to an arbitrary standard. See Relative Value Scale.

**Retrospective Cost-Based Reimbursement** - A method of payment for hospitals/SNFs based on the "reasonable costs" incurred for providing covered services to beneficiaries in the preceding year(s).

**Severity of Illness Index** - A measure to reflect the relative level of loss of function and mortality normally caused by a particular illness.

**Sigmoidoscopy** - Direct examination of the interior of the sigmoid colon.

**Speech Therapy** - Therapy by a professional trained to identify, assess, and rehabilitate persons with speech or language disorders such as articulation, language, voice, or stuttering problems.

**Splints** - A rigid or flexible appliance for fixation of displaced or movable parts.

**State Buy-In** - This is the term given to the process by which a State provides supplementary medical insurance and/or hospital insurance coverage for its needy, eligible persons by paying their Medicare premiums through an agreement with the Federal Government.

**Stress Test** - A technique for evaluating circulatory response to physical stress produced by exercise. The procedure involves continuous electrocardiographic monitoring during physical exercise, the objective being to increase the intensity of physical exertion until a target heart rate is reached or signs and symptoms of cardiac ischemia appear.

**Submitted Charge** - The actual charge submitted to the patient or a payer. See Paid Amount.

**Supplementary Medical Insurance Program (SMI)** - See Part B (of Medicare).

**Supplier** - A provider of health care services, other than a practitioner, that is permitted to bill under Medicare Part B. Suppliers include independent laboratories, durable medical equipment providers, ambulance services, orthotists, prosthetists, and portable x-ray providers.

**Technical Component** - The part of a relative value or fee for a diagnostic test or therapeutic procedure that represents the costs of performing the service, excluding the physician's interpretation or treatment planning. See Professional Component.

**Title XVIII of Social Security Act** - Passed by Congress in 1965, and subsequently amended; provides statutory authority for the Medicare program. Both section 1816 (Part A) and section 1842 (Part B), provide for the "use" of "public agencies or private organizations" for the administration of benefits on behalf of the Secretary.

**Title XIX** - The Medicaid program.

**Tracheostomy** - Creation of an opening into the trachea through the neck, with insertion of an indwelling tube to facilitate passage of air or evacuation of secretions.

**Transcutaneous/Neuromuscular Electrical Nerve Stimulation (TENS)** - A procedure in which mild electrical stimulation is applied by electrodes in contact with the skin over a painful area. The stimulation interferes with the transmission of pain signals and helps to suppress the sensation of pain in the area.

**Transurethral Resection (TURP)** - Resection of the prostate by means of an instrument passed through the urethra.

**Truss** - An elastic, canvas, or metallic device for retaining a reduced hernia within the abdominal cavity.

**Upcode** - To bill for a service that is paid more than the service actually provided.

**Urinalysis** - Analysis of the urine as an aid in the diagnosis. Many types of tests are used in analyzing the urine in order to determine whether it contains abnormal substances indicative of disease.

## OPERATION RESTORE TRUST AND NURSING HOMES

On May 3, 1995, President Clinton announced a new anti-fraud initiative undertaken by the Department of Health and Human Services. Led by the Office of Inspector General in partnership with the Health Care Financing Administration and the Administration on Aging, this project utilizes the expertise of many Federal, State, and private sector personnel. They will direct their combined energies to crack down on Medicare and Medicaid fraud, waste, and abuse initially associated with home health agencies, nursing homes, hospices, and durable medical equipment suppliers. They will work closely with the Department of Justice and an intergovernmental team comprised of other Federal and State personnel.

In addition to identifying and penalizing those who defraud the government, the project is designed to alert the public and industry to the fraud schemes or vulnerable areas in policy. To aid in this endeavor, the Office of Evaluation and Inspections will work within the Office of the Inspector General to perform its primary mission of conducting evaluations that provide timely, useful, and reliable information and advice to the pertinent decision makers involved in the demonstration. To this end, the following reports on nursing homes have been completed:

*Medicare Services Provided to Residents of Skilled Nursing Facilities (OEI-06-02-00863)*

*Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities (OEI-06-92-00864)*

*Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays (OEI-06-92-00860)*

*Part B Services in Nursing Homes - An Overview (OEI-06-92-00865)*

*Enteral Nutrient Payments in Nursing Homes (OEI-06-92-00861)*

*Durable Medical Equipment Payments in Nursing Homes (OEI-06-92-00862)*

Ongoing evaluations are being conducted related to Medicare payments for residents of nursing homes for such services as mental health therapy, wound care, imaging, hospice, ambulance transportation, and nail debridement. Also under review are duplicate payments between Medicare and Medicaid for nursing home services.