Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Portable Imaging Services:

Nursing Home Perspectives

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1997
OEI-09-95-00091

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Department of Health and Human Services

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EXECUTIVE SUMMARY

PURPOSE

This inspection determined when, how, and why nursing homes use portable imaging services for their patients.

BACKGROUND

Portable Imaging

Nursing homes* provide directly or arrange for ancillary services--such as x-rays--for patients who require them. In some instances, firms known as ***portable x-ray suppliers*** provide portable x-ray and electrocardiogram (EKG) services in nursing homes.** These services may be billed either by skilled nursing facilities to the Part A fiscal intermediary or by the portable supplier to the Part B carrier. ***"Direct billing"*** occurs when the portable supplier bills the carrier. ***"Billing under arrangement"*** occurs when, based on a contractual agreement, a skilled nursing facility bills the fiscal intermediary and pays the portable supplier for services rendered. Skilled nursing facilities may bill under arrangement even for patients who are not in Part A-covered stays.

When a fiscal intermediary processes the claim, reimbursement is based on a predetermined interim payment which is finalized after a skilled nursing facility submits its annual cost report. When a carrier processes the claim, reimbursement is based on a combination of a reasonable charge determination and the national fee schedule.

In a companion report, entitled "Portable Imaging Services: A Costly Option" (OEI-09-95-00090), we found that portable services cost much more than non-portable services and that Medicare pays too much when services are billed under arrangement. As a result, we conducted interviews with nursing homes that provide portable services to determine (1) why they use portable services and (2) why they bill under arrangement. Another companion report, "Imaging Services for Nursing Home Patients: Medical Necessity" (OEI-09-95-00092), assesses the medical necessity and quality of care.

Methodology

We conducted the interviews with a sample of 93 nursing homes that had provided a portable chest x-ray for the patients sampled in our studies on costs, medical necessity,

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* For purposes of this inspection, *nursing homes* refers to skilled nursing, Medicaid nursing, board and care, assisted living, and retirement facilities collectively. Where appropriate, we distinguish between skilled nursing facilities and these other facilities.

** Other options for nursing homes include transporting patients to hospital outpatient departments, imaging centers, physician offices, or other facilities for x-rays or EKGs.

and quality of care of selected imaging procedures provided in different settings. We asked the nursing homes how they provide services, how they bill for them, and their rationale for these decisions. For skilled nursing facilities that bill under arrangement, we obtained copies of their contracts with portable suppliers.

Operation Restore Trust

In May 1995, President Clinton announced Operation Restore Trust (ORT), a crackdown on Medicare and Medicaid fraud, waste, and abuse in home health agencies, nursing homes, and durable medical equipment suppliers. The ORT focuses on the five States--California, New York, Florida, Texas, and Illinois--that account for 40 percent of the nation's Medicare beneficiaries and program expenditures. This was an ORT inspection, and this report is the second in a series on imaging services for nursing home patients prepared by the Office of Inspector General.

FINDINGS

Portable services have become routine

Although Health Care Financing Administration (HCFA) regulations state that physicians must justify the need for the use of a portable imaging supplier, portable services are routinely provided to patients who reside in the sampled nursing homes. Approximately one-third of the physician orders for chest x-rays that were provided by portable suppliers indicated the reason why the x-ray was medically necessary but did not justify the need for portable services. Furthermore, there was no indication in more than 50 percent of the beneficiaries' medical records that they would be unable to be transported outside of the nursing home for medical services. In response to these findings, sampled nursing homes stated that patients routinely receive portable services because (1) portable services are less costly and more convenient for nursing homes and (2) they believe that portable services are easier and more convenient for the patient.

Reasons for billing under arrangement are questionable

In our report on the costs of imaging services, we found that portable services billed under arrangement cost as much as nine times more than the same services provided in other settings. Respondents were unable to shed much light on the subject of billing under arrangement, however. They stated that they were unable to answer questions about billing under arrangement because they were too new to the skilled nursing facility, were not involved in the decision, or did not occupy a decision-making position when the facility negotiated the arrangement.

Patient records are not secure

Approximately 21 percent of nursing homes in our sample stated that portable x-ray technicians have access to the medical file for the patient who is receiving a portable service.

RECOMMENDATIONS

In the draft of this report, we recommended that HCFA:

- *eliminate the requirement that physicians justify the use of portable services for nursing home patients and*

- *remind nursing homes that suppliers should not have access to patient records.*

The HCFA concurred with our recommendation on patient records but did not concur with our recommendation that it eliminate the requirement that physicians justify the use of portable services. The HCFA believes that the current requirements should be maintained but does not state that it will enforce them.

After we released our draft report, President Clinton signed into law the Balanced Budget Act of 1997. Among the provisions in this law, it (1) establishes a prospective payment system for beneficiaries in Part A-covered stays in skilled nursing facilities, to be phased in over several years; (2) requires that all Part B items and services furnished to residents of nursing homes (not covered under Part A) be billed by the nursing homes as part of a consolidated billing system; (3) limits reimbursement for services paid under consolidated billing to the Part B fee schedule; and (4) requires HCFA Common Procedure Coding System codes for services provided to skilled nursing facility patients that are billed to fiscal intermediaries.

Based on HCFA's comments as well as the impact of the Balanced Budget Act, we have amended our recommendations. We now recommend that HCFA:

- ***enforce the requirement that physicians justify the need for portable services,***

  We estimate that HCFA could save as much as $63.7 million in 1 year and $371.9 million over 5 years by enforcing current requirements.

- ***take into account the unnecessary payments that have been made for portable imaging services when it implements the prospective payment and Part B provisions of the Balanced Budget Act, seeking legislative authority if necessary, and***

  Because HCFA has not enforced the physician justification requirement, services that were not justified were routinely paid.

- ***remind nursing homes that suppliers should not have access to patient records.***

  Most nursing homes know that portable suppliers do not need access to patient records. Federal law dictates that nursing homes maintain strict control of these records.

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INTRODUCTION

PURPOSE

This inspection determined when, how, and why nursing homes use portable imaging services for their patients.

BACKGROUND

Congress enacted Medicare in 1965 to provide health services to the elderly and disabled. The program consists of two distinct parts. The first part is hospital insurance or **Part A**. Part A covers services furnished by *providers*, i.e., hospitals, home health agencies, and skilled nursing facilities. The second part, supplementary medical insurance or **Part B**, covers a wide range of medical services and supplies. These include physician services, outpatient hospital services, diagnostic laboratory tests, x-rays, ambulance services, and durable medical equipment.

The Health Care Financing Administration (HCFA) administers Medicare and contracts with private insurance companies to process and pay claims. Contractors that process Part A claims are referred to as ***fiscal intermediaries***. Contractors that process Part B claims are called ***carriers***.[1] Some companies operate as both fiscal intermediaries and carriers.

The HCFA provides substantial guidance to fiscal intermediaries and carriers on applicable laws, regulations, national polices, fee schedules, and other requirements. In some areas, Federal law and HCFA allow the fiscal intermediaries and carriers considerable latitude in determining both coverage and reimbursement.

Skilled nursing facilities and other extended care facilities

Medicare beneficiaries recuperating from an acute episode may be eligible for post-acute skilled nursing services. The Medicare program provides coverage under Part A for skilled nursing services but not for custodial care. The skilled nursing benefit includes:

- nursing care,
- bed and board,
- physical, occupational, or speech therapy,
- medical social services, and
- drugs, biologicals, supplies, appliances, and equipment for use in the facility.

Medicare law stipulates that beneficiaries are eligible for skilled nursing benefits if they are transferred to a skilled nursing facility after a minimum 3-day covered stay in an acute

[1] An exception to this general rule is that fiscal intermediaries process Part B claims submitted by hospitals (for inpatient and outpatient services), home health agencies, and nursing facilities.

hospital. The patient must require skilled nursing care, and a physician must order the services. Part A covers skilled nursing services for up to 100 days per "spell of illness."

In addition to skilled nursing facilities, other facilities offer varying levels of care for Medicare beneficiaries. These include Medicaid nursing, board and care, assisted living, and retirement facilities. ***We have included all of these facilities in the scope of this study and refer to them collectively as "nursing homes." We do, however, refer to skilled nursing facilities specifically where findings pertain solely to these entities.***

Portable x-ray and EKG services

Nursing homes provide directly or arrange for ancillary services--such as x-rays--for their patients who require them. In some instances, firms known as ***portable x-ray suppliers*** provide portable x-ray and electrocardiogram (EKG) services in nursing homes.[2] Medicare's portable x-ray benefit covers skeletal films of the arms, legs, pelvis, vertebral column, and skull as well as chest and abdominal films that do not use contrast media. Medicare also covers EKG services under the portable benefit, if they are medically necessary and are performed by certified portable x-ray suppliers. All of these services must be diagnostic rather than therapeutic. Portable x-ray suppliers must meet HCFA's conditions of participation to receive reimbursement for these services. These conditions of participation require, among other things, that suppliers comply with State and local laws, which may provide for the licensing and regulation of portable suppliers.

According to Medicare regulations, all portable x-ray services must be ordered by a physician. The physician's signed order must specify the reason why the x-ray is being taken, the area of the body to be exposed, the number of x-rays to be taken, and the views needed. The physician also must state why *portable* services are necessary.

Portable x-ray suppliers must maintain records for each patient. These records should include the examination date, a description of the x-rays that were taken, the name of the referring physician, the equipment operator, the physician to whom the x-rays were sent for interpretation, and the date the x-rays were sent to that physician.

Billing for portable x-ray and EKG services

Portable x-ray and EKG services provided to nursing home patients may be billed either by a skilled nursing facility to the Part A fiscal intermediary or by the portable supplier to the Part B carrier. Skilled nursing facilities have the option to do either. When the portable supplier bills the carrier, this is called ***"direct billing."*** When the skilled nursing facility bills the fiscal intermediary and pays the portable supplier for the services provided, this is called ***"billing under arrangement."*** Skilled nursing facilities may bill

[2] Other options for nursing facilities include transporting patients to hospital outpatient departments, imaging centers, physician offices, or other facilities for x-rays or EKGs.

under arrangement even for patients who are not in Part A-covered stays. In these cases, the skilled nursing facility submits an outpatient claim to the fiscal intermediary.

When the claim is processed by the fiscal intermediary, reimbursement is based on a predetermined interim payment which is finalized when the skilled nursing facility submits its annual cost report to its fiscal intermediary. When the claim is processed by the carrier, reimbursement is based on a combination of a reasonable charge determination and the national fee schedule.

These different billing methods can result in vastly different reimbursement rates and costs to the Medicare program and beneficiaries, particularly when one compares reimbursement made by the fiscal intermediary to that made by the carrier. A companion report, entitled "Portable Imaging Services: A Costly Option" (OEI-09-95-00090), contains a full description of these billing methods.

Recent work on ancillary services for nursing home patients

A 1996 General Accounting Office report entitled "Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities" (GAO/HEHS-96-18) warned that

> ...a population with extensive health care needs grouped together at a single location offers unscrupulous providers the opportunity for volume billing, and Medicare often does not look for warning of egregious overutilization or rapid increases in billing.

Operation Restore Trust

In May 1995, President Clinton and Health and Human Services Secretary Donna Shalala announced the kickoff of Operation Restore Trust (ORT), a new health care anti-fraud initiative. The ORT is a crackdown on Medicare and Medicaid fraud, waste, and abuse in home health agencies, nursing homes, and durable medical equipment suppliers. It focuses on the five States--California, New York, Florida, Texas, and Illinois--that account for 40 percent of the nation's Medicare beneficiaries and program expenditures.

The ORT includes Federal and State agencies in collaboration with private sector entities and beneficiaries. The Federal agencies involved in this effort include the Office of Inspector General (OIG), HCFA, and the Administration on Aging. The OIG has undertaken a number of national program inspections aimed at identifying and eliminating systemic weaknesses that allow fraud, waste, and abuse to occur in the areas of home health, nursing homes, and durable medical equipment. This inspection was conducted as part of ORT.

METHODOLOGY

In the companion report, "Portable Imaging Services: A Costly Option," we found that portable services cost much more than non-portable services and that Medicare pays too

much when services are billed under arrangement. As a result, we conducted interviews with nursing homes who provide portable services to determine (1) why they use portable services and (2) if and why they bill under arrangement.

From a 1 percent simple random sample of the Common Working File, we extracted data on all beneficiaries who were in a nursing homes or who received a portable imaging service at any time during calendar year (CY) 1994. We then extracted claims data on all imaging services provided to these beneficiaries during CY 1994.

We identified these nursing home residents through several indicators in the claims data. These indicators included place of service, hospital discharge destination, skilled nursing claims, and HCFA Common Procedure Coding System (HCPCS) codes that are likely to correspond to a nursing home resident (such as transportation of portable x-ray equipment). Based on a pre-test of this approach, we estimate that our database included approximately 93 percent of all imaging services provided to nursing home residents.

From this newly created database, we selected a stratified random sample of 729 imaging services that were provided while the beneficiaries were nursing home residents. The strata are illustrated below:

Stratum			Sample size
Chest x-rays (HCPCS = 71010 through 71035)	Billed as part of Part-A nursing stay	ORT States	53
		Non-ORT States	32
	All other billing arrangements	ORT States	134
		Non-ORT States	60
EKGs (numerous HCPCS codes)		ORT States	143
		Non-ORT States	65
Computerized axial tomography and magnetic resonance imaging (numerous HCPCS codes)		ORT States	167
		Non-ORT States	75

When there was no skilled nursing facility claim overlapping the date of imaging service in our sample, we attempted to verify that the beneficiary was a nursing home resident by contacting providers and nursing homes.

We conducted interviews with the 93 nursing homes that we verified had provided a portable chest x-ray for the patients in our sample. We asked the nursing homes how they provide services, how they bill for them, and their rationale for these decisions. For skilled nursing facilities that bill under arrangement, we obtained copies of their contracts with portable suppliers. We also collected medical records for all beneficiaries in our sample for our report "Imaging Services for Nursing Home Patients: Medical Necessity" (OEI-09-95-00092).

FINDINGS

Portable services have become routine

Although HCFA's regulations state that physicians must justify the need for the use of a portable imaging supplier, portable services are routinely provided to patients who reside in the sampled nursing homes. For our review of medical necessity, we collected medical records for all of the patients in our sample. In order to assess compliance with HCFA's regulations on use of portable services, we reviewed each patient's record to determine whether a clear justification for portable services was stated.

Approximately one-third of the physician orders for chest x-rays that were provided by portable suppliers indicated the reason why the x-ray was medically necessary but did not justify the need for portable services. Furthermore, there was no indication in more than 50 percent of the beneficiaries' medical records that they would be unable to be transported outside of the nursing home for medical services.

In response to these findings, we asked sampled nursing homes why their patients routinely receive portable services. They cited two reasons, the first of which has nothing to do with the patient's condition:

- ***Portable services are less costly and more convenient for nursing homes***

  When asked why their nursing homes routinely used portable services, respondents mentioned the increased cost to their nursing home of using non-portable services far more frequently than they mentioned the benefits to their patients. Transporting patients for services that otherwise could be provided by a portable supplier and paid fully by Medicare causes nursing homes to incur additional costs. These include (1) the cost of sending an aide with the patient and (2) the cost of transporting the patient, which is not covered by Medicare if it consists of a wheelchair van or other non-emergency transportation. On the other hand, respondents noted that beneficiaries routinely travel to other medical appointments. More than 88 percent of nursing homes in our sample acknowledged that beneficiaries take wheelchair vans to other appointments, and approximately 38 percent noted that family members sometimes take patients to medical appointments.

  While sampled nursing homes save themselves money by using portable services, they do not consider the cost to beneficiaries, Medicare, and third party payers when selecting a portable supplier. Less than 8 percent of nursing homes solicit bids, negotiate, or otherwise consider the cost-effectiveness when selecting their portable supplier. Those that solicit bids tend to be public facilities that are required to do so in order to meet State or local laws. Nursing homes use other criteria to select portable suppliers. Timeliness and responsiveness are the primary

reasons why nursing homes use their portable suppliers. Nursing homes also consider the supplier's reputation, equipment, and reliability.

Lack of competition among portable x-ray suppliers is a factor. Only 26 percent of the nursing homes in our sample reported considering other portable imaging suppliers when they decided to use their current supplier. In addition, about half of the nursing homes stated that no other portable suppliers solicit their business. For the half that do receive solicitations, almost all of them noted that the suppliers' marketing efforts were ineffective. At the same time, the number of consolidations and buyouts of portable suppliers is significant. We requested medical records from portable suppliers for all beneficiaries in our sample who received portable services. We encountered numerous instances where the supplier who provided the service in 1994 had been bought out by a larger corporation. The market is now dominated by national chains.

- ***Sampled nursing homes believe that portable services are easier and more convenient for the patient***

  Respondents stated that transporting patients for imaging services creates a hardship. Patients may have to endure long waits in hospital outpatient departments where emergency services are given priority over non-emergency imaging procedures.

  A patient's ability to ambulate has no bearing on how the services are provided. In sampled nursing homes, physicians know that if they order a service that can be portable, it will be portable. In fact, no nursing homes in our sample have criteria that would determine when a patient should be transported for a routine or otherwise non-emergency chest x-ray.

Reasons for billing under arrangement are questionable

In our report on the costs of imaging services, we found that portable services billed under arrangement cost as much as nine times more than the same services provided in other settings. Respondents were unable to shed much light on the subject of billing under arrangement, however. They stated that they were unable to answer questions about billing under arrangement because they were too new to their skilled nursing facility, were not involved in the decision, or did not occupy a decision-making position when the skilled nursing facility negotiated the arrangement.

Approximately 14 percent of respondents from skilled nursing facilities that bill under arrangement acknowledged that they do so to increase Medicare revenue. Other reasons for billing under arrangement included that (1) it was the policy of the skilled nursing facility or its corporate entity to provide all ancillary services under arrangement or (2) the facility thought that Medicare required it to bill under arrangement.

Most respondents (72 percent) do not know whether they would continue billing under arrangement if the fee schedule were applied. This is primarily because they are not acquainted with the fee schedule.

Patient records are not secure

Approximately 21 percent of nursing homes in our sample stated that portable x-ray technicians have access to the medical file for the patient who is receiving a portable service. In all other nursing homes, respondents stated that they provide the technician with a specific order and that the patient's file is kept under strict control of the facility's personnel.

RECOMMENDATIONS

Legislative Update

After we released our draft report, President Clinton signed into law the Balanced Budget Act of 1997. Among the provisions in this law, it:

- *establishes a prospective payment system for beneficiaries in Part A-covered stays in skilled nursing facilities, to be phased in over several years;*
- *requires that all Part B items and services furnished to residents of nursing homes (not covered under Part A) be billed by the nursing homes as part of a consolidated billing system;*
- *limits reimbursement for services paid under consolidated billing to the Part B fee schedule; and*
- *requires HCPCS codes for services provided to skilled nursing facility patients that are billed to fiscal intermediaries.*

In the draft of this report, we recommended that HCFA:

- *eliminate the requirement that physicians justify the use of portable services for nursing home patients and*
- *remind nursing homes that suppliers should not have access to patient records.*

AGENCY COMMENTS AND REVISED RECOMMENDATIONS

The HCFA concurred with our recommendation on patient records but did not concur with our recommendation that it eliminate the requirement that physicians justify the use of portable services. The HCFA believes that the current requirements should be maintained but does not state that it will enforce them. The full text of HCFA's comments appears in appendix A.

Based on HCFA's comments as well as the impact of the Balanced Budget Act, we have amended our recommendations. We now recommend that HCFA:

- ***enforce the requirement that physicians justify the need for portable services,***

  We estimate that HCFA could save as much as $63.7 million in 1 year and $371.9 million over 5 years by enforcing current requirements. Appendix C describes how we estimated the cost savings.

- ***take into account the unnecessary payments that have been made for portable imaging services when it implements the prospective payment and Part B provisions of the Balanced Budget Act, seeking legislative authority if necessary, and***

  Because HCFA has not enforced the physician justification requirement, services that were not justified were routinely paid. In implementing the Balanced Budget Act, HCFA needs to take these unnecessary payments into account and reduce prospective payment and Part B ancillary rates accordingly. This recommendation should be considered in tandem with a recommendation in our report "Portable Imaging Services: A Costly Option." That report recommends that, in implementing the Balanced Budget Act, HCFA should take into account the inflated charges for (1) services billed under arrangement (including payments for services that were non-covered) and (2) transportation charges that were excessive or prorated incorrectly.

- ***remind nursing homes that suppliers should not have access to patient records.***

  Most nursing homes know that portable suppliers do not need access to patient records. Federal law dictates that nursing homes maintain strict control of these records.

APPENDIX A

AGENCY COMMENTS

Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

AUG 4

DATE: JUL 24 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Portable Imaging Services: A Costly Option" (OEI-09-95-00090), and "Portable Imaging Services: Nursing Facility Perspectives," (OEI-09-95-00091)

We reviewed the above-referenced reports identifying a number of problems with how nursing facilities provide and bill for imaging services for their patients.

Our detailed comments on the recommendations are attached for your consideration. Thank you for the opportunity to review and comment on these reports.

Attachment

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Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Reports:
"Portable Imaging Services: A Costly Option" (OEI-09-95-00090), and
"Portable Imaging Services: Nursing Facility Perspectives," (OEI-09-95-00091)

General Comments

The Inspector General should be aware of legislation proposed by the President in his fiscal year (FY) 1998 budget that would mitigate problems with ancillary billing that are experienced under current law.

First, the President proposed to implement a prospective payment system (PPS) for skilled nursing facilities (SNFs) effective July 1, 1998. Prospective payments would cover all SNF service costs, including routine service costs, ancillary costs (whether provided under Part A or Part B of Medicare), and capital-related costs. A PPS would eliminate cost-based discrepancies between "direct" billing and "under arrangement" billing.

Second, the President's consolidated billing proposal is designed to address the current law's lack of restraints on ancillary billing. Under the proposal, SNFs would be required to bill Medicare for all services (except the services of physicians, certified nurse midwives, psychologists, hospice care, and nurse anesthetists). This proposal would prohibit payment to any entity other than the SNF for services or supplies furnished to Medicare-covered SNF patients.

Finally, as recommended by OIG, the President's FY 1998 budget legislation would require SNFs to include HCFA common procedure coding system (HCPCS) codes on their bills.

OIG Draft Report - OEI-09-95-00090 - Portable Imaging Services: A Costly Option

OIG Recommendation

HCFA should instruct fiscal intermediaries (FIs) to never pay more than the fee schedule amount for portable imaging services billed under arrangement.

HCFA Response

We concur. However, we note it will take a considerable amount of administrative work to implement this policy. (For example, it is currently impossible to impose this requirement because SNFs use revenue codes rather than HCPCS codes when billing for these services. It is impossible to compare services using these codes. It will take time to make the changes necessary to require SNFs to use HCPCS codes.) HCFA already instructed the FIs, that in applying the prudent buyer principle, they should compare the price paid by SNFs for portable x-ray services with the amount paid when portable x-ray services are billed by the supplier to the carrier.

OIG Recommendation

HCFA should require FI edits and HCPCS codes on all claims to discontinue payments for non-covered services.

HCFA Response

We concur with the intent of the recommendation. HCFA is currently pursuing legislation that will change SNF payment methodology and make this action unnecessary. We believe implementation of consolidated billing and an amendment to the current statute is a broader approach to resolving issues surrounding non-covered services and excessive costs associated with SNFs billing for portable imaging services. In the interim, HCFA explored use of HCPCS codes. However, this would require a major change to the Medicare Uniform Institutional Provider Billing Form (UB-92) and costly claims processing systems changes. Therefore, it is not cost effective over the longer term.

OIG Recommendation

HCFA should require FIs to disallow any nursing facility overhead associated with portable imaging services.

HCFA Response

We do not concur. Portable x-ray costs incurred by the SNF under arrangement are subject to the test of reasonableness as required by regulations at 42 CFR 413.9, Costs Related to Patient Care, and Chapter 21, Costs Related to Patient Care, of the Provider Reimbursement Manual (PRM). As pointed out in PRM section 2103B, Prudent Buyer-Application of Prudent Buyer Principle, intermediaries may employ various means for

detecting and investigating situations where costs appear to be excessive. Included may be such techniques as comparing the prices paid by providers to the price paid by others. HCFA instructed the FIs, that in applying the prudent buyer principle, they should compare the price paid by SNFs for portable x-ray services with the amount paid when portable x-ray services are billed by the supplier to the carrier. After allowing any reasonable amount of actual overhead that may be applied to the cost incurred by the SNF for the technical component and transportation component of the portable x-ray charge made by the carrier to the SNF, that amount should be compared with the amount paid when portable x-ray services are billed by the supplier to the carrier (excluding the professional fee portion).

OIG Recommendation

HCFA should immediately convert transportation reimbursement rates to a national fee schedule, rebundle equipment setup with transportation, and remind carriers that they must prorate transportation charges when multiple patients are seen at the same facility.

HCFA Response

We partially concur. We will soon publish a proposed rule for the 1998 Medicare physician fee schedule. Among the proposals will be one addressing an adjustment of practice expense relative values assigned to codes payable under the physician fee schedule. As a part of that proposal, we plan to include a national payment rate for the portable x-ray transportation codes R0070 - one patient and R0075 - multiple patients, effective with the 1998 physician fee schedule.

We made a policy decision that it was appropriate to pay a setup fee with every portable x-ray procedure furnished because there was no question that Medicare had historically paid higher amounts for the technical component of x-ray services furnished by portable suppliers vis-a-vis procedures performed by stationary entities. The setup fee reflects the historic national average difference between carrier payments for x-rays furnished by portable suppliers vis-a-vis payments made for the procedures furnished by other facilities. We continue to believe these payments are appropriate. Further, it would be inappropriate to bundle setup fees with transportation payments since carriers pay a single transportation payment per trip, but would pay multiple setup fees when an individual beneficiary receives several x-ray procedures during a session.

Separate codes, describing situations in which one patient is seen and those in which multiple patients are seen, clearly indicate that carriers should have different payment amounts. Further, a discussion of the required proration when multiple patients are seen was included in a Medicare Carriers Manual revision published in June 1996, transmittal number 1546, citation section 15022.G.3.

OIG Draft Report OEI-09-95-00091 - Portable Imaging Services: Nursing Facility Perspectives

OIG Recommendation

HCFA should eliminate the requirement that physicians justify the use of portable x-ray services for nursing facility patients.

HCFA Response

We do not concur. We believe the current requirement in 42 CFR 486.106(a) should be maintained, even though it may not be enforced effectively at this time. We recently proposed and adopted a new rule requiring that the physician who orders a diagnostic test must be a physician who is responsible for some aspect of the beneficiary's care. One of the primary reasons we took this action was to give the carriers an additional tool to use in determining whether diagnostic tests performed in nursing facilities are medically necessary. We believe any action taken the following year to relax the ordering requirements for a category of diagnostic tests that is usually done in nursing facilities would be poorly timed. Further, we believe, since x-ray procedures furnished on a portable basis are more expensive, more extensive justification of the necessity for the procedure is reasonable. Finally, since relaxing the ordering criteria could not possibly save the program any money, we can not see any benefit arising from making such a change.

Furthermore, section 483.75(k) of The Requirements for Long-Term Care Facilities requires a SNF to provide or obtain radiology and other diagnostic services to meet the needs of its residents. In so doing, the facility must assist the resident in making transportation arrangements to and from the source of services, if the resident needs assistance. As stated in your report, 88 percent of the facilities in your sample note that beneficiaries routinely travel to medical appointments outside the facility by taking wheelchair vans, and 38 percent of the facilities note that family members sometimes

take patients to medical appointments outside the facility. This would indicate the use of more costly portable x-ray services performed in the SNF may not always be reasonable and necessary in those instances where the use of available outside resources is feasible.

There is no requirement that an aide be sent with a resident when obtaining services outside the facility. We recognize in some instances an aide may be necessary to ensure the safety of the resident. In those cases, the SNF may charge the resident for this service. Furthermore, under Title 3, Part B, section 321(a) of the Older Americans Act, grants are provided to state units on aging to provide supportive services, including transportation (i.e., wheelchair vans), that are utilized by all long-term care (LTC) facility residents in order to attend medical appointments outside the facility. These services are provided at no cost to the facility. Also, under the Medicaid program, nursing facilities (NFs) are reimbursed for transportation charges as part of the daily rate.

OIG Recommendation

HCFA should remind NFs that suppliers should not have access to patient records.

HCFA Response

We concur. HCFA is preparing to release a program memorandum that addresses medical necessity and confidentiality of medical records for all services provided in LTC facilities.

Technical Comments

The term nursing facility utilized throughout this report is misleading. Current Federal regulations distinguish between two types of LTC facilities: an NF under the Medicaid program, and a SNF under the Medicare program. We suggest that the term "long-term care facility" replace the words "nursing facility" throughout this report when referring to a generic nursing home. If a policy or concern specifically relates to Medicare SNFs or Medicaid NFs, it should be so noted.

The definition of SNF coverage under Part A that appears in the "Background" is too general. We suggest it be more specific. Section 1861(h) of the Social Security Act provides for coverage of extended care services furnished to an inpatient of a SNF. Such coverage includes: (1) nursing care provided by, or under the supervision of a registered professional nurse; (2) bed and board in connection with the furnishing of such nursing

care; (3) physical or occupational therapy or speech-language pathology services furnished by the SNF or others under arrangements with them made by the facility; (4) medical social services; (5) such drugs, biologicals, supplies, appliances, and equipment furnished for use in the SNF, as are ordinarily furnished by such facility for care and treatment of inpatients; (6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement, under an approved teaching program of such hospital, and other diagnostic, or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and (7) such other services necessary to the health of the patients as are generally provided by SNFs. Additionally, the definition of the SNF benefit that appears in the "Background" is too general. We suggest it be more specific. The SNF benefit is referred to as post-hospital extended care services. It is designed to assist persons who have had a 3-day qualifying hospital stay, and require skilled services on a daily basis to recuperate from an acute episode. Coverage, if approved, is limited to a total of 100 days per benefit period. On the 21st day the beneficiary becomes responsible for a daily coinsurance amount equal to one-eighth of the inpatient hospital deductible, as prescribed by law.

A statement is made on page 3 of the "Introduction" that "Nursing facilities may bill under arrangement even for patients who are not in Part A-covered stays. In these cases, the nursing facility submits an outpatient claim to the fiscal intermediary." Although the first sentence is technically correct, the second sentence is incorrect and needs clarification. We suggest the following language: "Payment may be made for a limited range of services under Part B when furnished by a participating SNF to an inpatient of the SNF, if payment cannot be made under Part A, e.g., the beneficiary exhausted his allowed days of inpatient SNF coverage under Part A in his current spell of illness. In these cases, the SNF submits a claim to the FIs for those inpatient services rendered."

APPENDIX B

CONFIDENCE INTERVALS FOR SELECTED STATISTICS

The following table shows the point estimates and 95 percent confidence intervals for (1) two statistics that appear on page 6 of the report and (2) one statistic that appears in appendix C (bottom of page C-1).

Statistic		
	Point estimate	**95 percent confidence interval**
Of 1994 portable chest x-rays for nursing home residents, percent in which the medical record did not contain a physician order for the portable service		
	31.8 percent	19.9 percent - 43.6 percent
Of 1994 portable chest x-rays for nursing home residents, percent in which the medical record did not indicate that the patient was not ambulatory		
	53.7 percent	41.1 percent - 66.3 percent
Amount Medicare paid during 1994 for transportation and setup for nursing home residents' portable chest x-rays, in which the medical records did not indicate that the patient was not ambulatory		
	$31.4 million	$19.9 million to $42.9 million

APPENDIX C

CALCULATION OF ESTIMATED SAVINGS TO THE MEDICARE PROGRAM

The calculation of estimated savings involved (1) estimating the amount that Medicare would have saved during 1994 if HCFA had disallowed the transportation and setup charges for portable x-ray services when the patient could have been transported and (2) projecting these savings to a 5-year period from 1997 through 2001.

1994 portable x-rays for patients who could have been transported

We calculated this estimate through a four-step process, as described below. We cannot calculate a confidence interval for this estimate, because only chest x-rays were part of our sample.

1. Using a 1 percent sample of 1994 part B claims, we calculated the amounts that Medicare paid to suppliers for portable x-ray transportation and setup claims that were billed directly to the Medicare carrier, as shown in the table below.

Service (billed directly to carrier)	1994 amount paid for transport and setup
Portable x-ray service that included a chest x-ray	$50,504,123
Portable x-ray service that did not include a chest x-ray	$31,367,549
Cannot determine (no x-ray technical component billed)	$1,777,298
TOTAL	$83,648,970

As illustrated below, the ratio of (1) payments for services that did not include chest x-rays to (2) payments for services that included chest x-rays is 0.621.

Calculation: Ratio of services that did not include chest x-rays to services that included chest x-rays	$31,367,549 ÷ $50,504,123 = 0.621

2. From our review of medical necessity, we estimated that Medicare paid $31.43 million during 1994 for portable chest x-ray transportation and setup, in which the medical records did not indicate that the patient was not ambulatory.

3. As illustrated below, we multiplied the estimate from step 2 by the ratio from step 1.

$31,431,239 * 0.621 = $19.52 million

4. By adding the amounts from steps 2 and 3, we estimated that, during 1994, Medicare paid $50.95 million for portable x-ray transportation and setup, in which the medical records did not indicate that the patient was not ambulatory.

Estimated savings for 1997 through 2001

We used a three-step process to estimate how much Medicare will save from 1997 through 2001 if HCFA disallows transportation and setup charges when a patient could have been transported.

1. Using 1 percent sample data for each year from 1992 through 1995, we calculated the total amount that Medicare paid for portable x-ray transportation and the associated setup charges. Next, we calculated the annual percent changes for each year. We selected the smallest of these annual percent changes (a 7.74 percent increase) to use in the step 3 calculations.

2. As calculated in step 4 above, Medicare would have saved $50.95 million during 1994 by disallowing transportation and setup charges when a patient could have been transported.

3. Starting with the 1994 estimated savings from step 2, we calculated the savings in each subsequent year by increasing the previous year's savings by 7.74 percent. The results of these calculations are displayed on the following page.

For example, the table below illustrates how we calculated the 1997 savings.

Starting point: 1994 savings	$50,952,832
Smallest percent increase in payments for x-ray transportation and setup, 1992 - 1995	7.74 percent
1995 savings calculation	$50,952,832 * 1.0774 = $54,896,399
1996 savings calculation	$54,896,399 * 1.0774 = $59,145,184
1997 savings calculation	$59,145,184 * 1.0774 = $63,722,810

The precise number used for these calculations was 1.07739642383

STATISTICS FROM 1 PERCENT SAMPLE DATA

Year	Amount paid for directly billed portable x-ray transportation and associated setup	Percent change from previous year
1992	$66,100,078	Not applicable
1993	$77,639,918	17.46%
1994	$83,648,970	7.74%
1995	$90,378,681	8.05%
1996	Data for 1996 were not available at the time of this report.	

5-YEAR SAVINGS ESTIMATES

Year	Estimated savings if HCFA disallows transportation and setup charges when a patient could have been transported
1997	$63,722,810
1998	$68,654,727
1999	$73,968,357
2000	$79,693,244
2001	$85,861,216
TOTAL	$371,900,354