Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES

JUNE GIBBS BROWN
Inspector General

OCTOBER 1994
OEI-06-92-00863

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this study was 1) to describe the Medicare Supplemental Medical Insurance (SMI) services provided to residents in Skilled Nursing Facilities (SNFs) and 2) to identify and discuss known or potential program vulnerabilities, as well as issues involving SNF residents requiring further review.

BACKGROUND

Medicare provides extended care to qualified beneficiaries in a Medicare-participating SNF. The extended care benefit was designed to reduce the length of stay in acute care hospitals and is covered by the Hospital Insurance (HI) program. In addition to receiving services through the HI extended care benefit, residents may receive services covered through the SMI program, such as physician care and outpatient services.

Data presented in this report were obtained from a one-percent sample of all Medicare beneficiaries receiving Medicare extended care benefits during 1991 or 1992. 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 Office of Inspector General (OIG) reviews and fraud alerts for evidence illustrating program vulnerabilities.

DESCRIPTION OF EXTENDED CARE BENEFITS AND SMI SERVICES

Charges in excess of $413 million in 1991 and $517 million in 1992 were made for SMI services provided to Medicare beneficiaries receiving extended care benefits in SNFs.

- These charges represented seven percent of the total charge for medical care for beneficiaries receiving extended care services in a SNF (total charges for extended care (including SMI) were $5.9 billion in 1991 and $7.6 billion in 1992).

- Total charges for extended care (including SMI) were nearly equally divided between accommodations (room and board) and ancillary/SMI charges.

- Of the ancillary/SMI charges, rehabilitation was the largest cost, with SMI providing only a very small part (three percent) of the total charges.

Facilities with less than 50 Medicare certified SNF beds accounted for the majority of covered admissions and covered days of care.

Most SNF stays (82 percent) resulted in the use of SMI services; yet, few categories of services were predominant.

- Evaluation services was the only category of SMI service received by a majority (68 percent in 1991 and 69 percent in 1992) of SNF residents during their covered stay.

- Although evaluation services were present in more residents' stays, the category of medical equipment, supplies, prosthetics, and orthotics accounted for the most charges ($98 million in 1991 and $112 million in 1992).

- Approximately 24 percent of beneficiaries received outpatient services during their SNF stay.

As expected, residents with longer stays were more likely to use more SMI-covered services.

States' utilization of SMI varied considerably. This variation existed in the percentage of SNF stays having SMI services, the average bed day cost, and the types of services and providers.

PROGRAM VULNERABILITIES

Services covered under the HI extended care benefit may be shifted to the SMI program, creating added beneficiary liability.

The SNFs which shift services from the HI program to the SMI program may avoid Medicare limits on SNF payment and, if the shifted services are covered by SMI, increase the costs to residents and, ultimately, the tax payer. Cost shifting may occur for two distinct types of services: 1) routine services (which include the nursing care, bed and board, and certain other labor and supply costs) and 2) certain ancillary services. Examples include:

- As much as $44 million in 1991 and $55 million in 1992 were charged to SMI for rehabilitation therapy. Rather than the SNF providing the ancillary services and charging them to the HI program, third party providers billed the therapy through the SMI program.

- Over $98 million in 1991 and over $112 million in 1992 were charged to SMI for supplies and equipment, which is included as either routine or ancillary costs in the HI program when billed by the SNF. Enteral and parenteral nutrition represent the bulk of shifted costs, at over half of the total ($60 million in both 1991 and 1992).

One reason SNFs are able to shift some types of ancillary costs to the SMI program is because section 1861(h) of the Social Security Act permits <u>each facility</u> 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 HI program or the SMI program.

The different financial costs of an item, depending on whether the item is paid as a cost to the SNF or as a SMI service paid using a fee schedule, result in higher costs to Medicare if the service is not provided under the least expensive method.

The difference between what it costs the SNF to purchase goods or services, which becomes the Medicare cost paid to the SNF, and what is paid by Medicare according to SMI fee schedules may be radically different. Does cost reimbursement to the SNF produce the lowest cost? (The Medicare SNF payment is based upon actual costs of service, irrespective of whether the SNF service is covered by HI or SMI.) Or is the fee-based service of the supplier lower? (For example, the SNF cost for purchasing tape to secure surgical dressings or dietary nutrients may be less than the fee allowed suppliers who provide surgical dressings or nutrients).

SNFs acting as suppliers of drugs, biologicals, appliances, or equipment may contribute to SMI billing motivated by profit.

Medicare's present rules and practices permit the SNF to be both a cost-based provider of HI and SMI services and a charge-based supplier of SMI services. This flexibility allows the SNF to assess the financial impact of cost versus charge payments, and to choose using whichever avenue is most advantageous. Additionally, a SNF acting as a supplier of SMI to its residents can be a lucrative profit-generating business, with questions as to conflicting interests (nursing home's profit versus the cost benefit to residents and tax payers).

Some suppliers provide excessive volumes of supplies to nursing homes or misrepresent the supply to obtain reimbursement for a noncovered item or maximize reimbursement.

A review conducted by Arkansas Blue Cross and Blue Shield found that some suppliers were representing the combination of certain supplies (skin barrier, lubricant, gauze pads, etc.) as oral care kits or ostomy care kits. However, when the supplies were later delivered to the nursing home, they were not kits designated for any specific beneficiary; rather, the supplies were provided in bulk quantities. Some nursing homes stated they are turning away suppliers because their supply rooms are already overstocked with unused supplies from previous shipments.

Considerable State-to-State variation in average SMI costs raises questions about the impact of State Medicaid practices on SMI costs and inequities in beneficiary out-of-pocket costs for care.

The 1992 bed day cost for the SMI ranged from as little as $3 in one State to as high as $35 in another. While we cannot explain this variation with certainty, it is suspected the variances stem, in part, from Medicaid payment policies related to how the

Medicaid nursing facility rate is set. Another factor may be the extent to which the State Medicaid policy forcefully encourages nursing facilities to bill Medicare whenever possible.

An inequity exists in States (or nursing homes) which shift services to the SMI program. This inequity is translated into added beneficiary out-of-pocket costs due to coinsurance and deductibles which might not be required in States (or nursing homes) providing a service under the extended care benefit.

The apparent lack of physician involvement during many beneficiaries' stays raises questions about the adequacy or quality of patient care.

Nearly one-third (32 percent in 1991 and 31 percent in 1992) of residents had no allowed charges for a primary physician encounter (physician visit, evaluation, or consultation) during their stay in the SNF. The primary care physician is critical to the overall management of the resident's health and plays a pivotal role as gatekeeper, determining and/or providing necessary medical care, equipment, and supplies.

Frail extended care residents are particularly susceptible to abusive or unscrupulous providers.

The physical and cognitive limits of some extended care residents provide a unique opportunity for fraud, abuse, and waste. Unless protected by concerned family or friends, or by the policy and practices of the SNF, the extended care resident may be subjected to some of the most egregious practices found in health care, with decisions on care governed by greed, rather than medical need.

CONCLUSION

Significant payments are being made for extended care resident services through the HI and SMI programs. Consequently, monitoring services provided under these benefits and addressing vulnerabilities raised in this report are important, given Medicare's potential exposure to abusive practices.

This review of SNF utilization of SMI services suggests further work is needed in at least the following areas:

1. The apparent wide State-to-State variation in extended care bed day costs for particular SMI services.

2. The appropriateness of SMI payment for the millions of dollars paid each year for services normally included in the extended care benefit, and the resulting inequities in resident cost liability.

3. The adequacy of a resident's knowledge about the cost and frequency of services billed outside of the nursing facility's bill.

4. The policies and practices of various State Medicaid programs, as they contribute to program vulnerabilities in the Medicare extended care benefit.

5. The monitoring of extended care utilization over time, and review of services experiencing rapid growth without any known reason (e.g., coverage change).

6. The lack of physician involvement in some SNF stays.

COMMENTS

The HCFA commented on this report. They agreed with our conclusions and suggested a statutory "rebundling" provision for SNFs (similar to that for hospitals) is needed. We agree that this is the direction to take. To assess the impact of rebundling, our office is presently conducting a more exhaustive analysis of services included in the extended care benefit and also covered by the Supplemental Medical Insurance program.

We thank HCFA for their comments and look forward to working closely to improve services furnished under the extended care benefit. The full text of their comments is provided in Appendix E.

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INTRODUCTION

PURPOSE

The purpose of this study was 1) to describe the Medicare Supplemental Medical Insurance (SMI) services provided to residents in Skilled Nursing Facilities (SNFs) and 2) to identify and discuss known or potential program vulnerabilities, as well as issues involving SNF residents requiring further review.

BACKGROUND

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. Hospital Insurance (HI) Benefits for the Aged and Disabled (Part A) covers services furnished by hospitals, home health agencies (HHA), hospices, and skilled nursing facilities. 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).

In 1992, Medicare provided basic health insurance coverage for more than 34 million people at a cost of approximately $129 billion. The SMI payments have recently been growing faster than HI payments and accounted for about $49 billion of the Medicare expenditures for 1992.[1]

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 HI and/or SMI 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.

Extended Care Benefit

While Medicare does not cover expenditures for traditional long-term nursing home care, benefits are provided for extended care to qualified beneficiaries in a Medicare-participating SNF. The extended care benefit was designed to reduce the length of stay in acute care hospitals, and transition beneficiaries to their homes or to custodial care facilities. In comparison to Medicaid nursing home expenditures, Medicare accounts

for only a small percentage of the total nursing home care provided. For example, Medicare services accounted for 4.7 percent ($2.5 billion) of all 1990 nursing home expenditures ($53.1 billion). Medicaid, in contrast, accounted for over 45 percent ($24.2 billion).[2]

The HI program does not pay for a SNF stay if the beneficiary needs skilled nursing or rehabilitation services ***only occasionally***, such as once or twice a week, or if the patient does not need to be in a SNF to get the skilled services.[3] Additionally, Medicare HI does not pay for the stay if the beneficiary is in a SNF for only custodial care. Table 1 describes the conditions which must be met before HI of Medicare will pay for extended care provided a beneficiary in a Medicare-participating SNF.

Conditions for Medicare Extended Care (SNF) Eligibility	
Patient's Condition	The patient's condition requires ***daily*** skilled nursing or skilled rehabilitation services that, as a practical matter, can only be provided in a SNF.
Hospital Stay	The beneficiary was in a hospital at least 3 consecutive days before being admitted to a participating SNF.
SNF Admission Deadline	The beneficiary was admitted to a SNF within 30 days after leaving the hospital.
Care Related to Hospital Stay	The care in the SNF is for a condition that was treated in the hospital or for a condition that arose while the beneficiary was receiving care in the SNF for a condition that was treated in the hospital.
Covered Days	Medicare allows a maximum of 100 days per episode[4] of illness and pays for all covered SNF expenses for the first 20 days. After the 20th day, patients pay part of the SNF care (daily co-insurance).[5]
Medical Professional Certification	A medical professional certifies that the beneficiary needs skilled nursing or skilled rehabilitation services on a daily basis.
Intermediary Approval	The Medicare intermediary does not disapprove the SNF stay.

Table 1

A certified SNF is a facility 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.[6] Skilled nursing care is that care which can only be performed by or under the supervision of licensed nursing personnel. Skilled rehabilitation services include physical therapy, occupational therapy, and speech pathology services performed by or under the supervision of a qualified professional.

The extended care benefit is defined in section 1861(h) of the Social Security Act. In addition to describing services provided by the extended care benefit, this section indicates

the source of the services. Table 2 summarizes the law.

Extended Care Covered Services[7] *(As Described in Section 1861(h))*		
	Section 1861(h)	**Source**
Nursing Care	"(1) Nursing care provided by or under the supervision of a registered professional nurse."	SNF
Room and Board	"(2) Bed and board in connection with the furnishing of nursing care."	SNF
Rehabilitation Therapy	"(3) Physical, occupational, or speech therapy furnished by the SNF or by others under arrangements with them made by the facility."	SNF or Others
Medical Social Services	"(4) Medical social services"	SNF
Drugs and supplies	"(5) Such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the SNF, as are ***ordinarily furnished*** by such facility for the care and treatment of inpatients." *(emphasis added)*	SNF or Others
Medical services of interns	"(6) Medical services of interns and residents-in-training of a hospital with which the facility has in effect a transfer agreement...and other diagnostic or therapeutic services provided by the hospital."	As Specified In Agreement
Other Medical Services	"(7) Such other services necessary to the health of the patients as are generally provided by SNF; excluding, however, any item or service if it would not be included... if furnished to an inpatient of a hospital."	SNF

Table 2

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.

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.

SMI-Covered Services

The SMI program provides coverage for physicians' and certain other practitioners' services and a variety of "medical and other health services" (as defined in section

1861(s)). Physician services are those provided by doctors of medicine and osteopathy, doctors of dental medicine and surgery, doctors of optometry, doctors of podiatric medicine, and chiropractors licensed under State law. The SMI also covers certain services and supplies provided by suppliers (e.g., ambulances, laboratories, medical suppliers, portable X-ray suppliers billing independently, voluntary health and charitable organizations, and pharmacies). In addition, SMI covers services received from certain practitioners who are not physicians, such as certified registered nurse anesthetists, physician assistants, nurse midwives, and clinical psychologists.

Physician and supplier services covered by SMI include diagnosis; surgery; therapy; consultation; home, office, and institutional visits; diagnostic X-ray tests; rental or purchase of durable medical equipment; surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations; and prosthetic devices.

HI and SMI Coverage Overlap

A SMI service is typically provided and billed by practitioners or suppliers. However, the SNF may provide SMI services or supplies. Thus, the service in question may be covered as either an inpatient HI service or as a SMI service. If covered as a HI service, the beneficiary is directly benefited. This is because HI, unlike SMI, does not create an additional dollar liability due to coinsurance and deductibles. As an illustration of program coverage, physical therapy provided to the Medicare SNF inpatient is covered as a HI benefit, if the individual beneficiary is covered under HI. If the therapy is not covered under HI (beneficiary does not qualify for HI or has exhausted the 100 days of SNF coverage), it is covered and paid as a SNF SMI service. Although simplified, figure 1 emphasizes the overlap between the services covered under the extended care benefit and those covered under the SMI program.

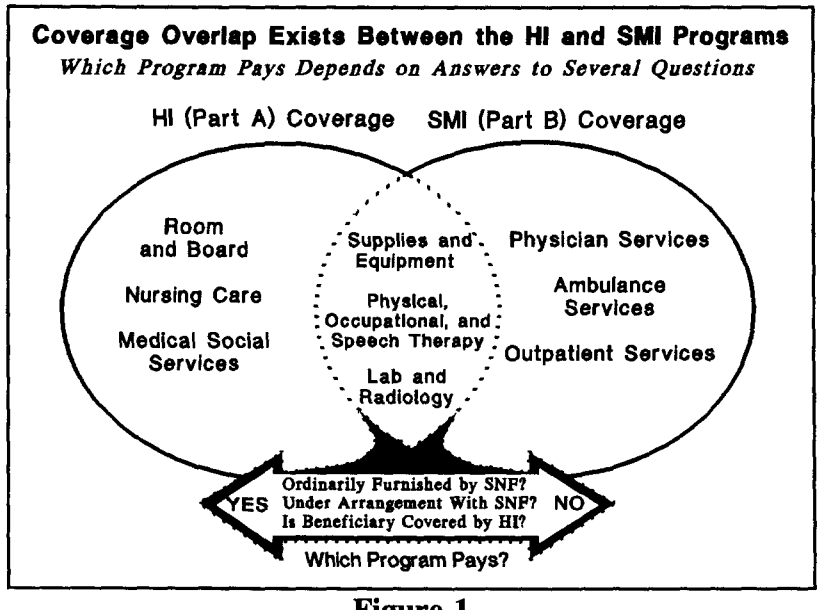


Figure 1

Program Vulnerabilities

Medicare is the nation's largest payer of health care services and, with 1992 costs of $128 billion, 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).[8] The growth of these payments increases Medicare's vulnerability to erroneous and excessive payments for claims resulting from program weaknesses and provider fraud and abuse.

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

Data presented in this report (unless otherwise noted) were obtained from a one percent sample of all Medicare beneficiaries receiving Medicare extended care benefits during 1991 or 1992. After selecting the sample of beneficiaries, all SMI services and HI payments extended during the covered nursing home stay were extracted from the HCFA Common Working File (CWF) database.[9] The SMI services processed by both the carrier and the intermediary were identified.

Data from the sample were projected to the total SNF population.

Carrier-processed SMI data reflect the allowed charges. 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.

Intermediary-processed SMI 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.

Intermediary-processed extended care services (SNF) data are based on unpublished draft data provided by HCFA's Bureau of Data Management and Strategy who extracted the data from the CWF. These data reflect charges (unless otherwise noted).

Important Note: In reviewing the data in this report, the reader should recognize that two types of data are combined. The data combined are for claims processed by carriers and for claims processed by intermediaries. The data from carriers refers to those charges which Medicare considers reasonable (allowed charges) and to which coinsurance and deductibles are applied. In contrast, the data for intermediary claims (SNF and outpatient) refers 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 outpatient and extended care (SNF) claims were used for two reasons. First, total charges 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.). Second, there was little difference between total and covered charges for SNF claims. (In 1991 and 1992, the percent difference between total charges and covered charges was less than three percent).

The ***1991 to 1992 percent change calculations*** made in this report reflect an inflation adjustment factor (7.4 percent), which is used to reflect more accurately the true percent change due to charge variation rather than to medical care inflation. Although we were aware of other adjustment (inflation) factors such as 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 CPI is not always a true representation of the medical care cost changes in Medicare and should be viewed with care. 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 SMI and HI services provided, we classified HCFA Common Procedure Coding System (HCPCS) procedure codes and facility revenue center codes into one of either two HI categories or 20 SMI categories. No procedure or revenue center code is included in more than one category. We were limited in the degree of classification available for HI services because the HCFA data was pre-grouped into the following categories: accommodations, pharmacy, lab, radiology, supply, inhalation therapy, rehabilitation, and other. Where possible, we tried to classify categories 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.

Appendix A summarizes how HI and SMI services were grouped for purposes of this review.

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 carriers to determine what types of abuses are occurring with regard to equipment and miscellaneous supplies.

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

PREFACE

This report is intended to give the reader a sense of the utilization of the SNF extended care benefit ***with special focus on SMI services.*** Also, we hope to point out areas of vulnerability and to set a framework for potential future work by this office, and to present a baseline from which to monitor utilization in subsequent years.

Our discussion begins with a section describing 1991 and 1992 extended care and SMI utilization statistics, and concludes with a general discussion of the known or potential vulnerabilities suggested by the data.

A glossary of terms has been included in the back for reference reviewing this and future reports.

DESCRIPTION OF EXTENDED CARE BENEFITS AND SMI SERVICES

Charges in excess of $413 million in 1991 and $517 million in 1992 were made for SMI services provided to Medicare beneficiaries receiving extended care benefits in SNFs.

The SMI program provides a considerable financial supplement to the services provided under the extended care benefit in the SNF. Although SMI charges represented only seven percent of the total (HI and SMI) cost of care for SNF residents, the costs reflect the important part SMI plays in contributing to resident care. (See Figure 2.)

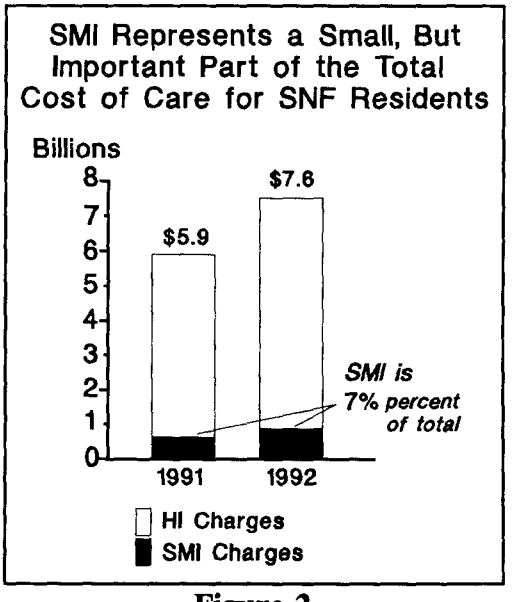


Figure 2

SMI's contribution when compared only with HI ancillary charges (total extended care cost less charges for room and board) represents 13 percent of the charges.

Overall, SMI and HI charges for SNF residents increased approximately 19 percent from 1991 to 1992 (after adjusting for medical inflation using the overall medical care inflation factor from the Consumer Price Index[10]). Individually, SMI and HI charges increased 16 and 19 percent, respectively, from 1991 to 1992.

The SNF bed day cost, rather than total charges, more accurately reflects the cost of extended care.

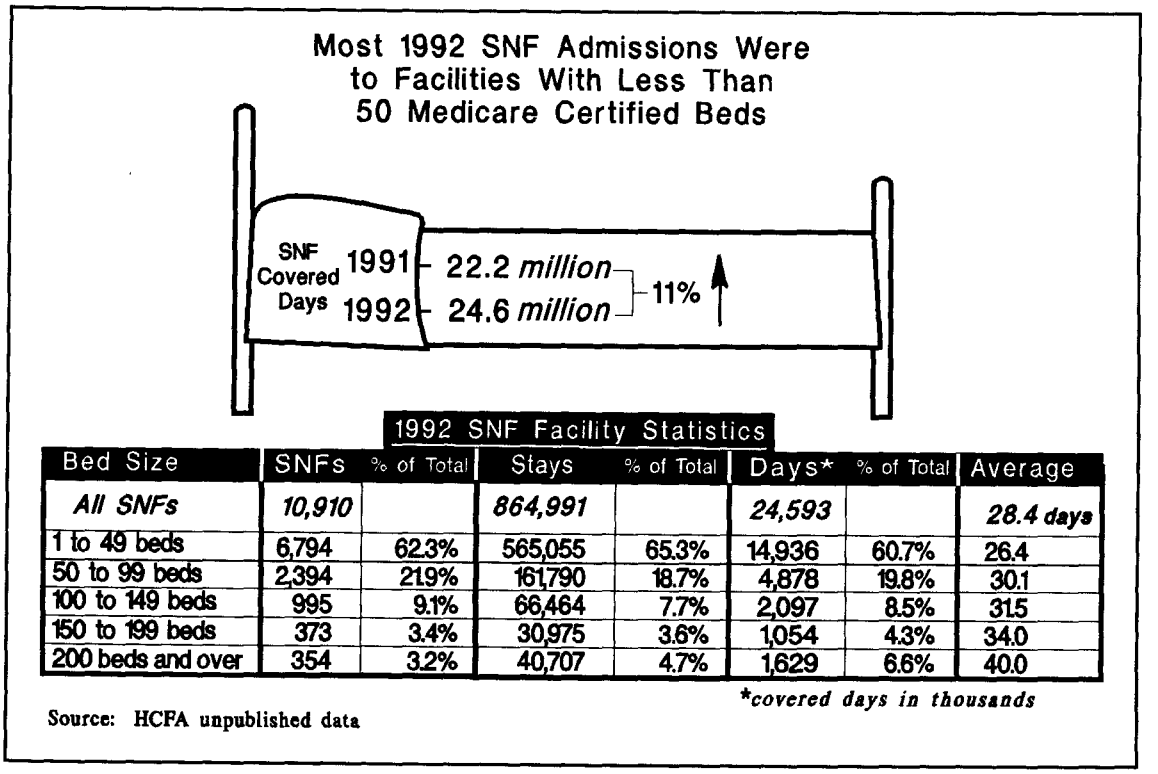
While it is clear that program charges for residents of nursing homes increased significantly from 1991 to 1992, a more accurate representation of the cost of care received by individual SNF residents involves calculating the average Medicare program charges per day in the SNF. We call this the bed day cost. The bed day cost calculations take into account increases in covered days from one year to another.

On average, it cost $267 per bed day in 1991 and $302 in 1992 for care received while a SNF resident. This represents a per bed day cost increase from 1991 to 1992 in *constant* dollars of approximately five percent. The SMI program's part of this daily cost is $20. Additionally, utilization of SMI services was highly variable, with many residents having no SMI charges, while others had high charges. In both 1991 and 1992, 18 percent of SNF stays had no SMI services. At the other extreme, the highest daily average charge was $832 per day for a resident in 1991 and over $1,767 per day for a resident in 1992.

These high daily costs were primarily the result of extensive use of ambulance services and rehabilitation therapy.

Facilities with less than 50 Medicare certified SNF beds accounted for the majority of covered admissions and covered days of care.

As indicated by figure 3, facilities of less than 50 Medicare certified SNF beds accounted for 62.3 percent of all facilities with Medicare certified SNF beds in 1992. Those facilities with 50-99 beds and 100 or more SNF beds represented 21.9 percent and 15.8 percent, respectively.[11]



1992 SNF Facility Statistics

Bed Size	SNFs	% of Total	Stays	% of Total	Days*	% of Total	Average
All SNFs	*10,910*		*864,991*		*24,593*		*28.4 days*
1 to 49 beds	6,794	62.3%	565,055	65.3%	14,936	60.7%	26.4
50 to 99 beds	2,394	21.9%	161,790	18.7%	4,878	19.8%	30.1
100 to 149 beds	995	9.1%	66,464	7.7%	2,097	8.5%	31.5
150 to 199 beds	373	3.4%	30,975	3.6%	1,054	4.3%	34.0
200 beds and over	354	3.2%	40,707	4.7%	1,629	6.6%	40.0

**covered days in thousands*

Source: HCFA unpublished data

Figure 3

Most SNFs (87 percent) were not hospital-based. Although hospital-based SNFs represented only 13 percent of the total number of SNFs, they represented 26 percent of the total covered admissions (222,818) during 1992.

There were 864,991 total covered SNF admissions, with facilities having less than 50 SNF beds accounting for 65.3 percent. These facilities also accounted for the majority of covered days of care (60.7 percent).

On average, resident stays in facilities with a small number of SNF certified beds were for shorter durations than stays in facilities with more SNF beds. Stays in facilities with 200 plus SNF beds were substantially longer than stays in facilities with few SNF beds.

Total charges for extended care and SMI were nearly equally divided between accommodations (room and board) and ancillary charges (including SMI).

At $3.9 billion, SNF ancillary charges combined with SMI charges accounted for slightly over half of the medical care for SNF residents receiving extended care benefits in 1992. The remaining component of medical care was for room and board ($3.7 billion). (See Figure 4.)

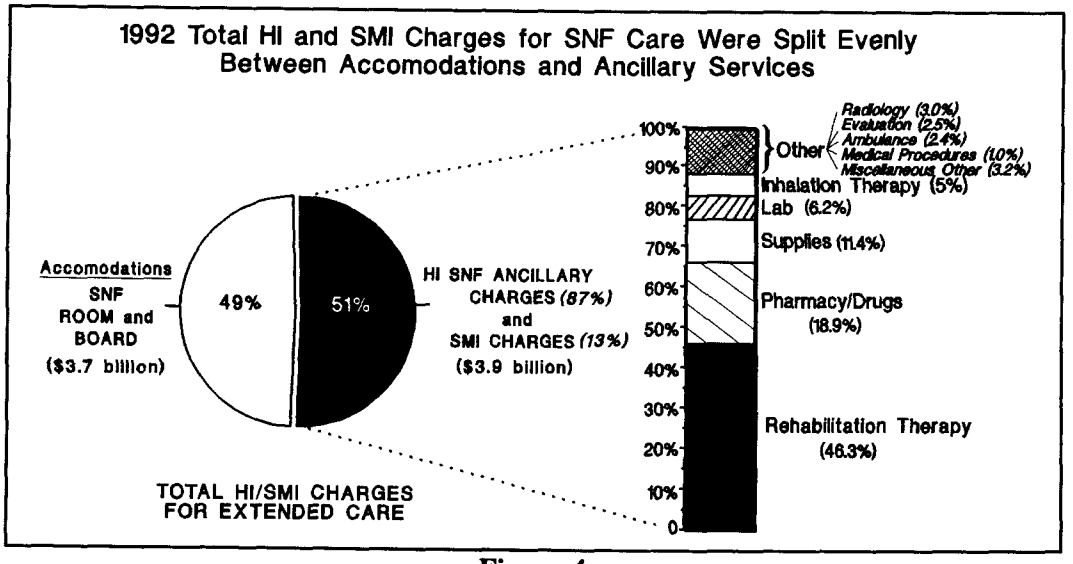


Figure 4

In bed day cost terms, 1992 room and board charges averaged approximately $149 per day. Ancillary and SMI charges accounted for the remaining $153 of the total medical care average bed day charge of $302.

Rehabilitation services was the largest extended care ancillary cost with SMI providing only a very small part of the total charges.

As shown in the previous figure and in the figure below, rehabilitation was the largest single ancillary cost, representing 46 percent of ancillary charges. However, the SMI, in comparison to HI, played a relatively small role in financing rehabilitation services. The SMI charges were only $44 million in 1991 and $55 million in 1992 compared to HI charges of $1.18 billion in 1991 and $1.75 billion in 1992. In bed day cost terms, rehabilitation charges were approximately $72 per day on average in 1992. The HI-covered rehabilitation accounted for most of this daily average, with SMI comprising only $2.16 of this total.

Pharmacy and supply were the next largest components of the total bed day cost at $29 and $18, respectively. The SMI did contribute significantly to the service categories of supplies, lab, and radiology and also the sole source of funding for evaluation, ambulance service, and medical procedures as defined for this report. (See Figure 5 for an overview of SMI and HI charges.)

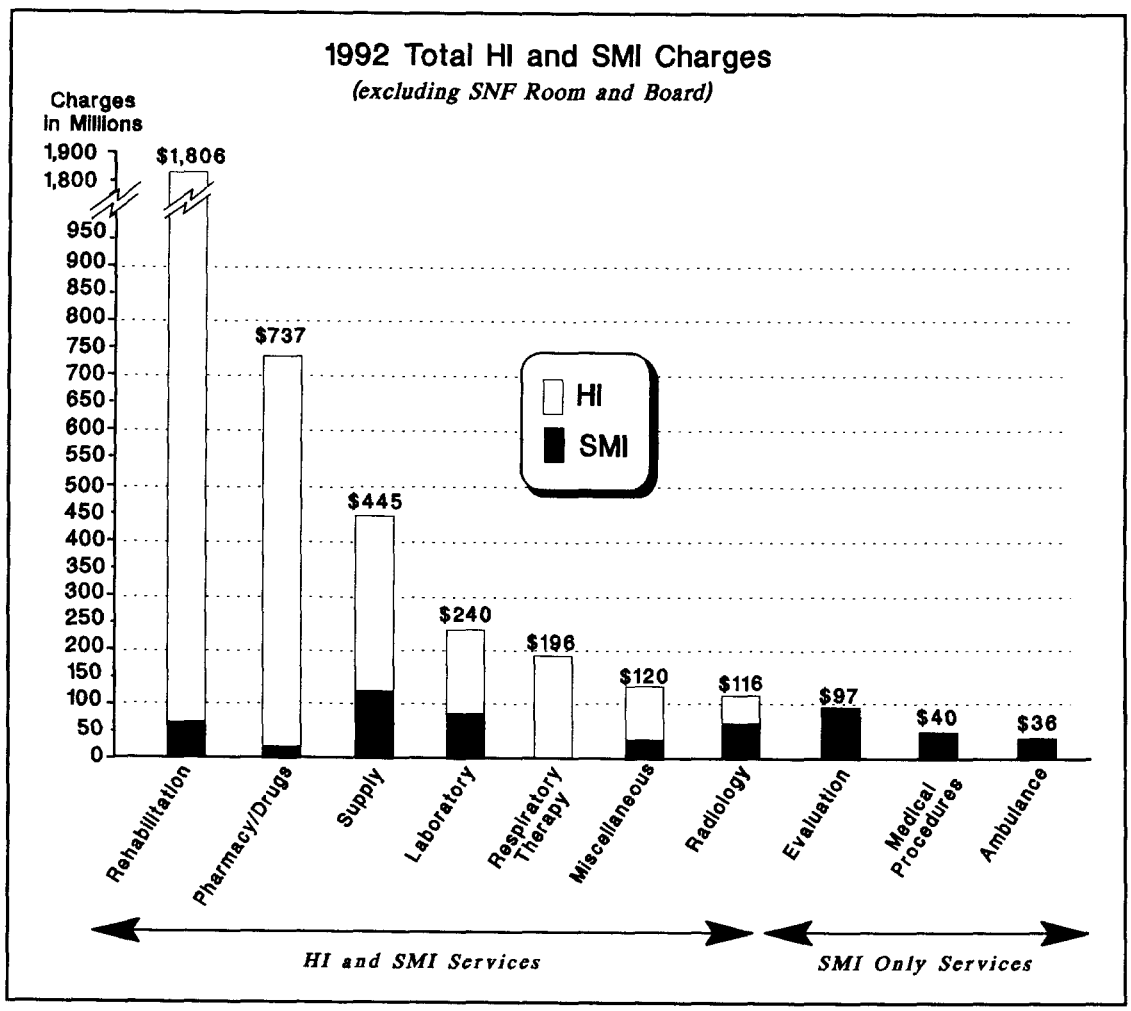


Figure 5

Most SNF stays resulted in the use of SMI services; yet, few categories of services were predominant.

As indicated in figure 6, the percentage of resident stays in a SNF involving SMI services remained unchanged between 1991 and 1992. During this two year period, 82 percent of the SNF stays had some SMI services. However, within specific categories of services, only evaluation services were used in a majority of SNF stays.

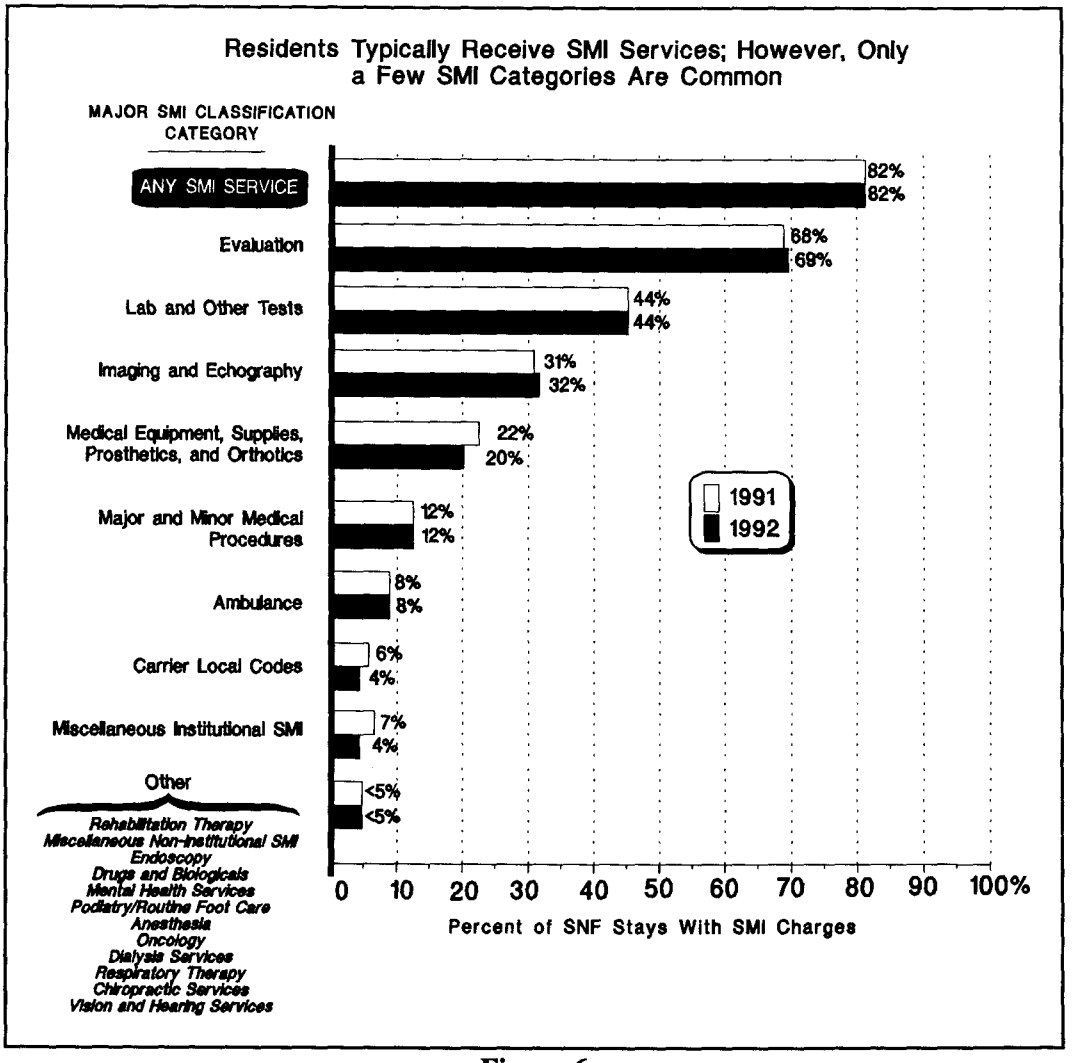


Figure 6

See Appendix B for a complete listing of the 1992 charges, average bed day cost, and the percentage of SNF stays with various SMI services by categorical grouping (as defined in the methodology and projected from our one-percent sample).

During 1991 and 1992, carriers processed approximately two-thirds (62.9 percent) of the charges for SMI services to SNF residents. Conversely, intermediaries processed outpatient claims for the remaining one third of charges. While 80 percent of beneficiaries had SMI processed by a carrier, only 24 percent had outpatient SMI charges processed by the intermediary.

Many types of SMI services were provided to the SNF population during 1992.

In 1992, the category of medical equipment, supplies, prosthetics, and orthotics accounted for the most charges ($112 million) of any categorical grouping. The top three categories of service (adding evaluation and lab services) accounted for over 50 percent of the total SMI charges provided to extended care residents. (See Figure 7.)

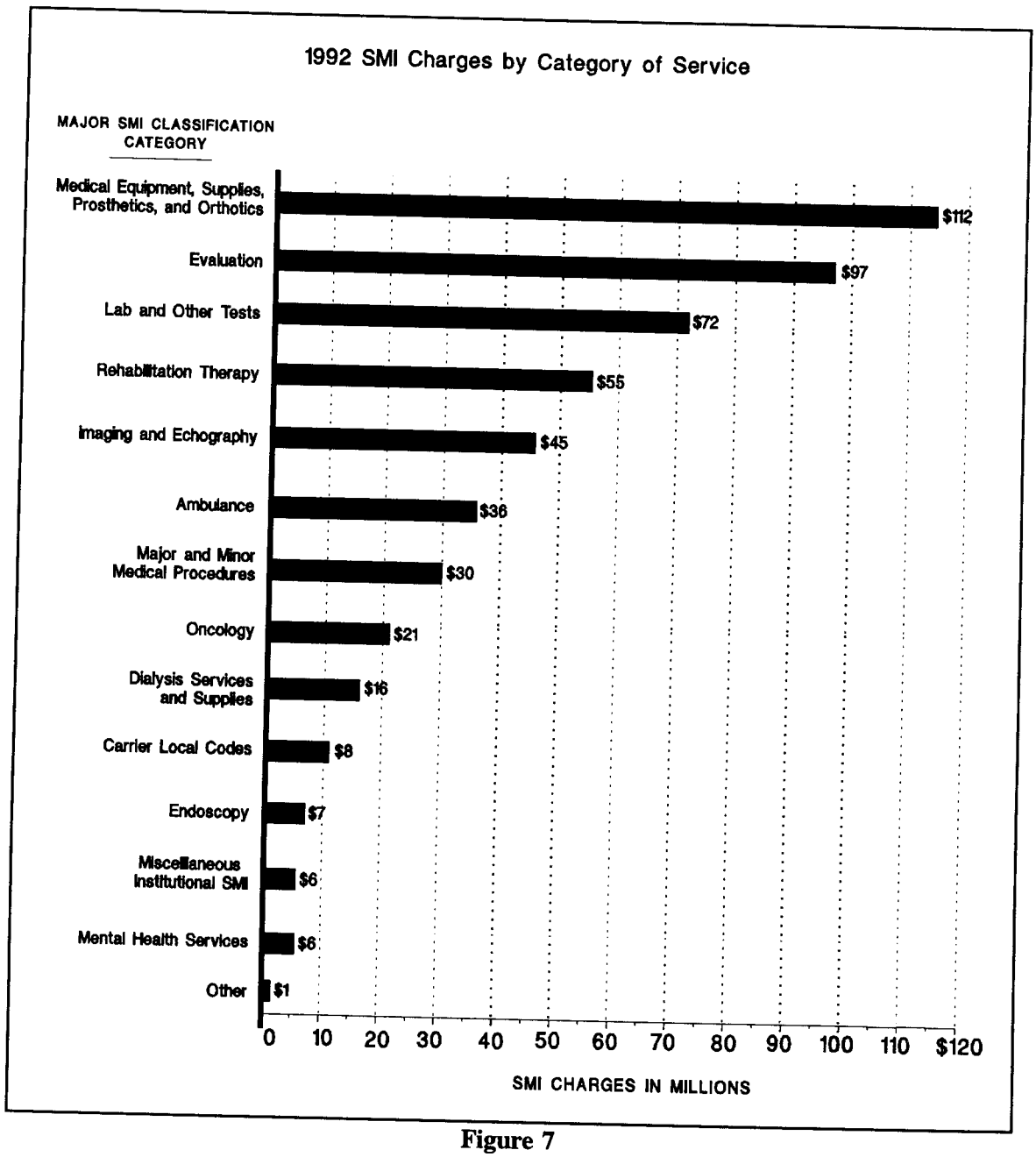


Figure 7

Although not included in our definition of a SMI SNF service, ambulance transport of a beneficiary to a SNF on the day of admission was used by 36 percent of beneficiaries. Allowed charges for this service exceeded $45 million in 1991 and $59 million in 1992.

As expected, residents with longer stays were more likely to use more SMI-covered services.

While 82 percent of residents had SMI charges, the percentage of stays with SMI services differed depending on the length of the SNF stay. As table 3 shows, short stays (1-8 days) were less likely to involve SMI services than stays of a longer duration, regardless of the category of service received.

CATEGORY OF SMI SERVICE	LENGTH OF SNF STAY (days) AND PERCENT OF BENEFICIARIES WITH SMI SERVICES DURING 1992					
	0-8	9-20	21-40	41-60	61-80	81-100
Evaluation	44.6%	66.0%	79.8%	88.0%	90.5%	93.6%
Lab and Other Tests	17.0%	37.5%	56.4%	71.5%	75.1%	84.3%
Imaging and Echography	13.6%	27.0%	40.3%	49.9%	53.8%	55.0%
Medical Equipment, Supplies, and	7.9%	15.3%	25.0%	32.9%	38.8%	49.9%
Major and Minor Medical Procedures	2.3%	7.6%	15.0%	24.3%	28.9%	39.9%
Ambulance Services	3.0%	4.9%	8.8%	13.8%	16.1%	21.7%
Local Codes	1.8%	2.8%	5.6%	5.9%	9.1%	12.7%
Miscellaneous Outpatient Services	0.8%	2.3%	4.7%	7.6%	8.9%	12.4%
Mental Health Services	0.6%	1.3%	3.3%	6.7%	5.2%	10.7%
Routine Foot Care	0.4%	1.0%	2.6%	5.9%	6.5%	8.1%
Drugs and Biologicals	0.7%	1.4%	2.2%	3.4%	3.0%	6.4%
Rehabilitation Therapy	1.0%	3.0%	4.2%	3.9%	5.0%	5.1%
Other	0.8%	1.1%	1.7%	3.3%	5.0%	3.9%
Endoscopy	0.4%	1.0%	2.2%	2.4%	2.2%	3.6%
Anesthesia	0.2%	0.8%	1.1%	2.2%	2.2%	1.5%
Oncology	0.5%	1.3%	1.8%	2.0%	0.9%	1.0%
Dialysis Services	1.0%	1.1%	1.7%	1.5%	1.3%	0.8%
Respiratory Therapy	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
OVERALL *(any service)*	**58.9%**	**84.4%**	**93.1%**	**97.4%**	**98.1%**	**98.0%**

Table 3

In 1992, 45 percent of all SNF clients residing for eight or less days had an evaluation. Utilization of an evaluation service continued to increase until most clients (93.6 percent) residing for periods of 81-100 days had an evaluation. The relationship of days of care to the potential for a SMI evaluation service was relatively constant between 1991 and 1992.

Compared to 1991, residents in 1992 with SNF stays beyond 40 days had an increased likelihood for mental health services. In 1991, clients had only a .2 percent chance of receiving mental health services during SNF stays of less than eight days. However, this increased to a four percent likelihood of such services during stays of more than 81 days. Interestingly, mental health services, in contrast to evaluation services,

increased disproportionately between 1991 and 1992. As indicated in figure 8, 1992 residents residing for 1-8 days had less than a one percent opportunity of having such services. However, clients residing for longer than 81 days had a ten percent chance of receiving mental health services.

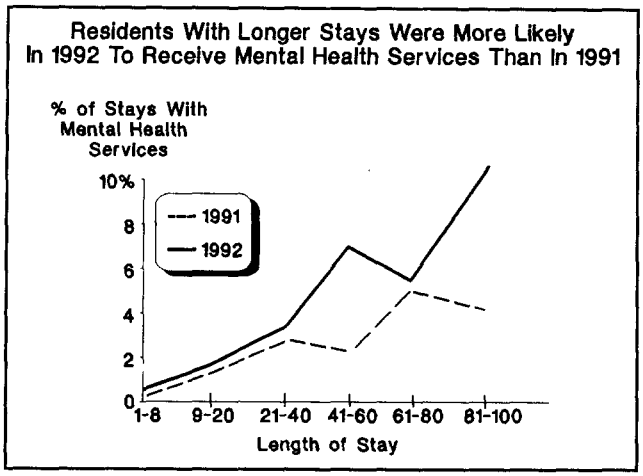


Figure 8

Our office has already begun an evaluation of mental health services which will help to explain this rise in utilization from 1991 to 1992.

States' utilization of SMI varied considerably.

- There was variation from State-to-State in the percentage of SNF stays involving SMI services.

As shown in figure 9, among the 15 largest States (as defined by the number of SNF covered days), the percentage of stays with SMI varied from a high of 94 percent in Connecticut to a low of 71 percent in Minnesota. Little variation existed from 1991 to 1992 except for Wisconsin, which decreased considerably.

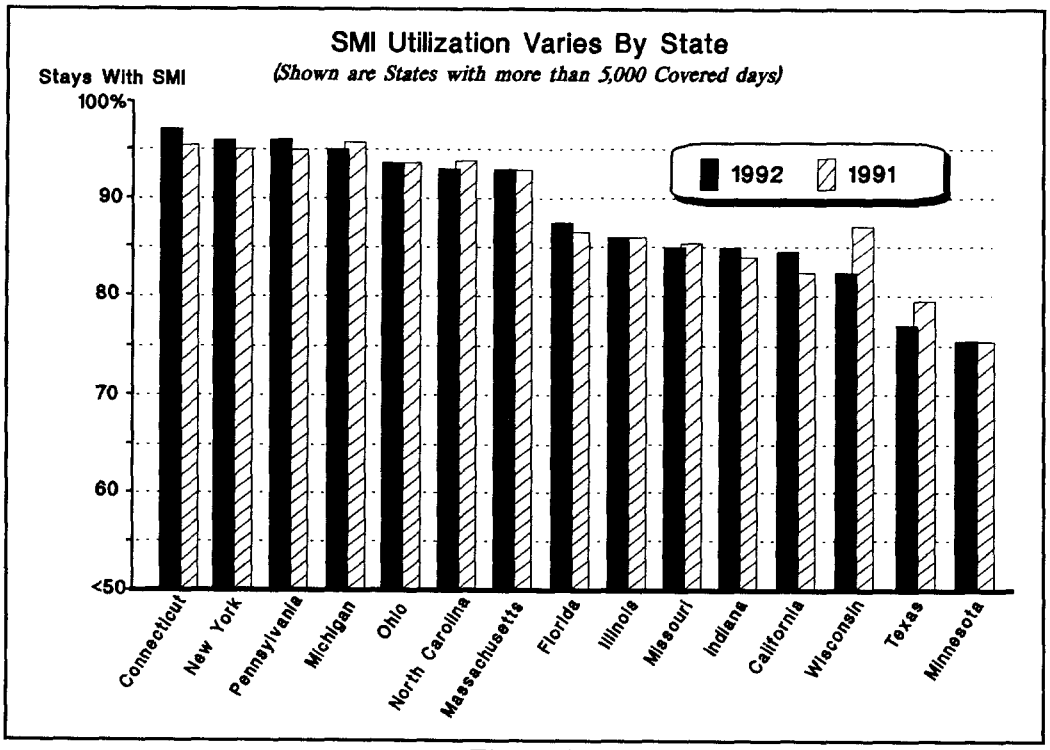


Figure 9

While we are unable to explain the utilization differences between States, it seems likely that Medicaid practices within the State may help explain these differences. However, further study is needed to validate any causal conclusions.

- Average SMI bed day costs varied significantly between States.

In 1992, bed day costs for the 15 largest States varied substantially from a low of $10 per bed day in Minnesota to a high of $33 in Pennsylvania. (See Figure 10 and Appendix C).

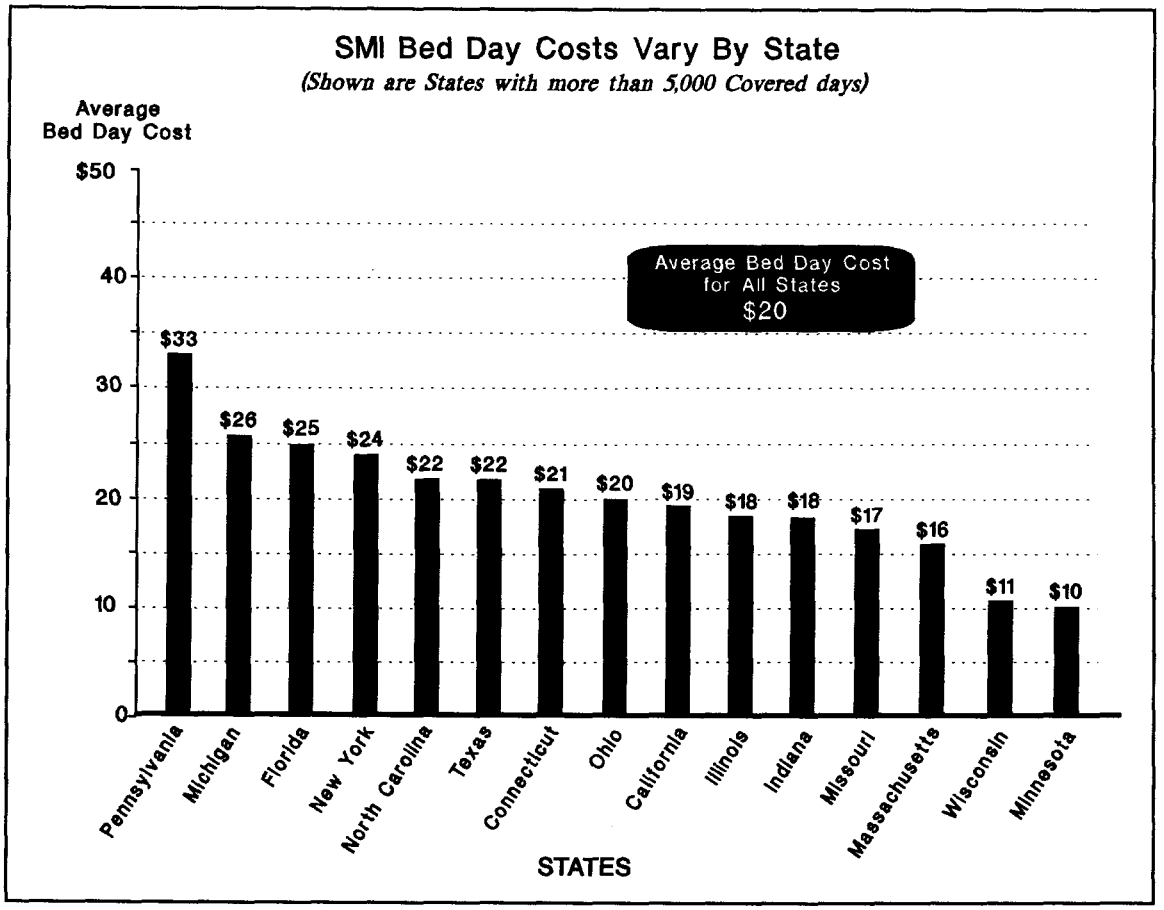


Figure 10

Again, we are unable to explain the variance between States. It is likely that Medicaid practices within the State will explain some of these utilization differences; however, further study is needed to validate this conclusion.

- State-to-State variation in the types of SMI service providers was even greater.

As shown in figure 11, most 1992 SMI charges were from outpatient departments, physicians, and suppliers. The same overall ratios existed in 1991. However, based on the specialty coded on the claim form, our data suggest wide variations in the types of SMI providers between States.

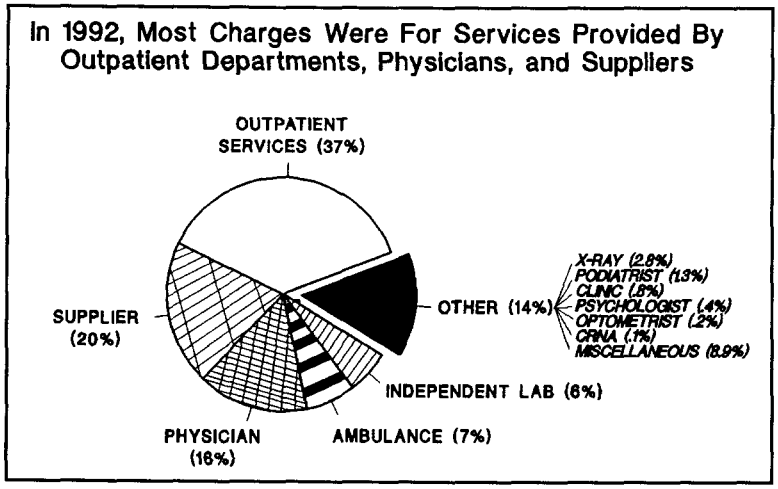


Figure 11

Charges often differ markedly from the overall ratio depicted in figure 11. For example, the percentage of 1992 SNF charges for services provided by suppliers was over 45 percent in Kentucky and Arkansas, while the percentage was less than five percent in Colorado and Mississippi. There were similar wide State variations for all provider types including outpatient services. For example, the percentage of charges provided by ambulance companies ranged from over 15 percent in Connecticut and South Carolina to less than 5 percent in Michigan and Mississippi. (Appendix D provides a listing of State variations in provider types.)

By far, the most extreme variation in charges occurred in outpatient services. In Mississippi, over 70 percent of the charges were from outpatient claims, while in Maine there were no outpatient charges represented in our sample.

As discussed previously, we cannot explain these variations with certainty without further review, but we suspect Medicaid practices and other factors (income, availability of health services, practice patterns, etc.) influence nursing home use of SMI by residents.

PROGRAM VULNERABILITIES

Services covered under the HI extended care benefit may be shifted to the SMI program, creating added beneficiary liability.

The SNFs which shift services from the HI program to the SMI program may avoid Medicare limits on SNF payment and, if the shifted services are covered by SMI, increase the costs to residents and, ultimately, the tax payer. Cost shifting may occur for two distinct types of services: 1) routine services (which include the nursing care, bed and board, and certain other labor and supply costs) and 2) certain ancillary services.

Each year HCFA publishes regulations which limit the Medicare payment for routine services. (For example, the Medicare daily limit for a free standing SNF's care of a beneficiary in Dallas is $96.97 per day for the cost reporting year beginning January 1993.) The SNF incurs a loss for costs over the limit, as neither the Medicare program nor the Medicare beneficiary pay for the excess amounts. Thus, SNFs will directly benefit, dollar for dollar, to the extent amounts over the limit are reduced by shifting these costs for routine services elsewhere.

By shifting costs above the routine cost limit, SNFs increase their profitability, while the tax payer and SNF resident assume the cost of the amount Medicare allowed for the SMI services billed.

Therapy Services

As much as $44 million in 1991 and $55 million in 1992 were charged to SMI for rehabilitation therapy. Rather than the SNF providing the ancillary services and charging them to the HI program, third party providers billed the therapy as SMI services.

Supplies and Equipment

Over $98 million in 1991 and over $112 million in 1992 were allowed by SMI for supplies and equipment (this represents the SMI category we defined as medical equipment, supplies, prosthetics, and orthotics), which is included as either routine or ancillary costs in the HI program when billed by the SNF.

Enteral and parenteral nutrition, which totaled $60 million in both 1991 and 1992, represented over half the shifted costs. Other components of the cost shifted items (in millions) were:

	1991	1992
Durable medical equipment	$8	$11
Braces, trusses, and artificial limbs	$7	$12
Casts, splints, and fracture reduction devices	$2	$3
Surgical dressings	$7	$6
Miscellaneous prosthetics and supplies	$14	$20

Vulnerability in the definition of extended care services

One reason SNFs are able to shift costs to the SMI 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 HI program or the SMI program. The law states that a facility must provide:

> "(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ***ordinarily furnished by such facility***..." *(emphasis added)*

An example of the impact of this citation is that each SNF, as often as it wishes, is allowed to decide to provide catheters as a SNF service one day and on the next to provide catheters through outside suppliers, who then bill Medicare and the resident for the services.

Beneficiary Liability

Charges to Medicare for the routine and ancillary services noted above (therapy, nutrition, and medical supplies and equipment) illustrate the impact of services provided outside of the SNF payment. Since beneficiaries are liable for coinsurance and deductibles for SMI services, the cost to the beneficiary during 1991 and 1992 was between $62 million and $99 million (the upper bound would be if all residents incurred the $100 deductible for these services).[12] Had each SNF provided these services (itself or under arrangement), none of the residents would have been liable for coinsurance or deductibles.

The different financial costs of an item, depending on whether the item is paid as a cost to the SNF or as a SMI service paid using a fee schedule, result in higher costs to Medicare if the service is not provided under the least expensive method.

The difference between what it costs the SNF to purchase goods or services, which becomes the Medicare cost paid to the SNF, and what is paid by Medicare according to SMI fee schedules may be radically different. Does cost reimbursement to the SNF produce the lowest cost? (The Medicare SNF payment is based upon actual costs of service, irrespective of whether the SNF service is covered by HI or SMI.) Or is the fee-based service of the supplier lower? (For example, the SNF cost for purchasing tape to secure surgical dressings or dietary nutrients may be less than the fee allowed suppliers who provide surgical dressings or nutrients.)

SNFs acting as suppliers of drugs, biologicals, appliances, or equipment may contribute to SMI billing motivated by profit.

Medicare's present rules and practices permit the SNF to be both a cost-based provider of HI and SMI services and a charge-based supplier of SMI services. This flexibility allows the SNF to assess the financial impact of cost versus charge payments and to choose

whichever avenue is most advantageous. Additionally, a SNF acting as a supplier of SMI to its residents can be a lucrative profit-generating business, raising questions about potential conflicts of interest (nursing home's profit versus the cost benefit to residents and tax payers).

An Illustration of Possible Excessive Payments for Nutrients In a Nursing Home Setting

To illustrate the possible excessive cost incurred by the Medicare program for nutrients, we provide the following case which involved a complaint received by a carrier alleging gross abuse of the Medicare program for a nursing home resident. The complainant had a family member in a nursing home requiring enteral feeding. Prior to the family member's admission to the nursing home, the complainant had been purchasing the required nutrients (Ensure) at a local pharmacy for $50 per case. Upon admission, the nursing home suggested that a supplier be used to provide the nutrients at no cost to the resident. To the complainant's surprise and dismay, the supplier was able to bill Medicare over $200 for the same amount of nutrients she was able to buy at the local pharmacy for $50. The supplier even offered to submit claims to Medicare for any purchases the complainant had made prior to the relative's admission to the SNF.

Considerable State-to-State variation in average SMI charges raises questions about the impact of State Medicaid practices on SMI costs and inequities in beneficiary out-of-pocket costs for care.

The 1992 bed day cost for the SMI ranges from as little as $3 in one State to as high as $35 in another. (See Appendix C).

Figure 12 emphasizes the wide variation of State bed day costs for SMI, with about a third of the States averaging a bed day cost above $20 and the rest below.

While we cannot explain this variation with certainty, we suspect the variances stem, in part, from Medicaid payment policies related to how the Medicaid nursing facility rate is set. Another factor may be the extent to which the State Medicaid policy forcefully encourages nursing facilities to bill Medicare whenever possible.

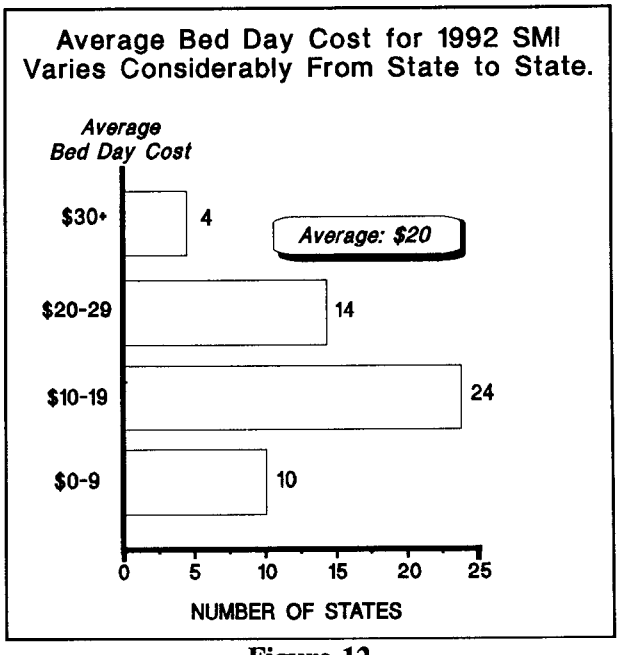


Figure 12

The bed day cost variance could also come from the different medical care needs of the State's population, limitations on our data because of small sample sizes in some States,

and other factors (e.g., personal income, the supply of health care resources, and the concentration of hospital services in urban areas).

An inequity exists in States (or nursing homes) which shift services to the SMI program. This inequity is translated into added beneficiary costs due to coinsurance and deductibles which might not be required in States (or nursing homes) providing the services under the extended care benefit.

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

Another area of potential abuse involves excessive volumes of supplies. An example found in the nursing home population is the oversupply of convenience/hygiene supplies. A review conducted by Arkansas Blue Cross and Blue Shield found that some suppliers were representing the combination of certain supplies (skin barrier, lubricant, gauze pads, etc.) as oral care kits or ostomy care kits. However, when the supplies were later delivered to the nursing home, they were not kits designated for any specific beneficiary; rather, the supplies were provided in bulk quantities. Some nursing homes stated they are turning away suppliers because their supply rooms are already overstocked with unused supplies from previous shipments. Although the prevalence of the oversupply of routine medical supplies by suppliers has not yet been studied, this anecdotal example and the following statistics suggest the need to do so.

The cost of routine medical supplies charged to the SMI program for SNF residents exceeded $10 million in 1991 and $15 million in 1992. This represents a significant increase (over 42 percent after adjusting for medical cost inflation) from 1991 to 1992.

Some suppliers misrepresent supplies in order to gain reimbursement from Medicare.

Two areas where suppliers have been inappropriately reimbursed involve misrepresentation of a noncovered item as a covered item and misrepresentation of the place where the service is provided.

- Misrepresenting items of supply.

Claims for orthotic body jackets represent one example of suppliers misrepresenting an item to gain Medicare reimbursement for noncovered items. Specifically, approximately 95 percent of the claims for orthotic body jackets in 1991 were for non-legitimate devices and were inappropriately allowed.

This finding resulted from our study of HCPCS code L0430 and is presented in a report entitled "Medicare Payments for Orthotic Body Jackets."[13] Code L0430 represents an orthotic device (called a body jacket) commonly used to treat injuries to the spine (e.g., vertebra fractures and compressions) and to facilitate healing following a surgical procedure on the spine or related tissue. The study was initiated in response to an allegation received by the OIG from a company which provides Medicare billing services to nursing homes. The allegation stated that DME suppliers were billing Medicare

approximately $1,200 per device for devices consisting of "nothing more than a $50 piece of foam rubber."

After reviewing a sample of claims for body jackets, it was determined that 95 percent of the devices claimed under code L0430 did not meet either the construction requirements or the medical purpose of a Medicare-covered body jacket. In many cases, the devices billed were provided primarily for the purpose of keeping patients upright in a wheelchair. The significance of the finding suggests that more than $7 million in 1991 and, perhaps, as much as $13.7 million in 1992 were inappropriately paid for non-legitimate devices billed as L0430.

Although the study did not focus solely on body jackets received by SNF residents, the findings are equally pertinent to the SNF population. The billing of L0430 for SNF residents amounted to $129,668 in 1991 and $384,795 in 1992. Assuming 95 percent were for non-legitimate devices, approximately half a million dollars were incorrectly paid for SNF residents ($123,185 in 1991 and $365,555 in 1992). Significantly, claims for the non-legitimate devices are increasing dramatically by triple digit rates (190 percent from 1991 to 1992 after adjusting for medical cost inflation).

- Misrepresenting the place of service.

Durable medical equipment (DME) is a noncovered item for beneficiaries, unless the DME is provided in the beneficiary's residence. A SNF, like a hospital, is not considered a residence. Based on data from this database and presented in a separate report, "Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays," the combined Medicare and resident cost for DME was approximately $10 million in 1992 and over $8 million in 1991.[14] Significantly, 99 percent of the 1991 DME claims incorrectly showed (intentionally or unintentionally) the resident's location when the item was provided. Suppliers stated the place of service was the 'home' or 'other'; however, at the time of the service, the beneficiary was actually residing in a SNF. Had the supplier indicated that the beneficiary resided in a SNF, the carrier would have known to disallow the claim.

In a 1993 survey, we asked carriers to list their concerns about possible abuses in utilization and payment for durable medical equipment and supplies in nursing homes. Some of these concerns reflect suspected or known abuse in areas discussed previously in this report. Others reflect concerns about false billing, improper handling of certificates of medical necessity, and financial arrangements.

Examples of Possible Problems Cited By Carriers Regarding Medical Equipment and Supplies

- *Billing for items not provided or billing different carriers for the same service.*
- *CMN Abuse:*
  - *Falsification of Certificates of Medical Necessity (physician signature, altering effective dates of medical need)*
  - *Coercion by suppliers to obtain physicians' signatures*
  - *CMNs completed by the supplier*
  - *Physicians signing prescriptions without seeing the patient (e.g., renewals requested by supplier in the mail)*
  - *Falsification of diagnosis information (e.g., lymphedema pumps)*
- *Lumbar Sacral Supports used primarily as restraints and offering no therapeutic benefit to the client.*
- *Suppliers billing for equipment either after the equipment has been returned or following the beneficiary's death.*
- *Overutilization of incontinence supplies.*
- *Joint ownership management arrangements between suppliers, physicians, and nursing homes.*
- *Misrepresentation of service.*
- *Misrepresenting the beneficiary's address to receive or increase reimbursement (the beneficiary was in a SNF making the service uncovered).*
- *Suppliers provided more supplies than specified in the CMN or upgraded the equipment prescribed. Additionally, carriers note instances of billing for large volumes of supplies never used (e.g., dressings - quantity 90 when a quantity of 30 is needed).*

We note that some of the problems listed are being, or have been addressed by the new Durable Medical Equipment Regional Carriers (DMERCs)[15]. Carriers were not asked to provide details on the source or extent of their reports of possible fraud and abuse or whether they had referred any cases to the Office of Inspector General.

The apparent lack of physician involvement during many beneficiaries' stays raises questions about the adequacy or quality of patient care.

Nearly one-third (32 percent in 1991 and 31 percent in 1992) of residents had no allowed charges for a primary physician encounter (physician visit, evaluation, or consultation) during their stay in the SNF. The primary care physician is critical to the overall management of the resident's health and plays a pivotal role as gatekeeper, determining and/or providing necessary medical care, equipment and supplies. The absence of these physician services for many beneficiaries raises quality of care concerns. Additionally, the absence of physician involvement may expose the resident to unscrupulous schemes providing non-covered and unneeded services. An example of this exposure is illustrated by a recent investigation where electrocardiogram (EKG) readings were performed directly by the SNF's staff with the results transmitted over phone lines for an interpretation. However, there was no evidence of a physician examination of the resident to initiate the testing and no indication of cardiac problems requiring testing.

Frail extended care residents are particularly susceptible to abusive or unscrupulous providers.

The physical and cognitive limits of some extended care residents provide a unique opportunity for fraud, abuse, and waste. Unless protected by concerned family or friends, or by the policy and practices of the SNF, the extended care resident may be subjected to some of the most egregious practices found in health care, with decisions on care governed by greed, rather than medical need.

CONCLUSIONS

Significant payments are being made for extended care resident services through the HI and SMI programs. Consequently, monitoring services provided under these benefits and addressing vulnerabilities are important, given Medicare's potential exposure to abusive practices.

This report and a companion report on durable medical equipment billed for SNF residents receiving Medicare extended care benefits are the first in a series of reports addressing nursing facility resident issues. Each report will focus on a known or potential vulnerability related to either prudent use of tax dollars for resident care or quality of care issues. The methodology used to gather information on each issue will vary; however, as with this report, we plan to use statistical sampling of nursing facility residents to develop the facts necessary to address each issue. The scope of our reviews will include information concerning Medicare residents in all Medicare or Medicaid approved nursing facilities. Additionally, Medicaid data will be evaluated as it relates to the issues under review.

This review of SNF utilization of SMI services suggests the need for further work in at least the following areas:

1. The apparent wide State-to-State variation in extended care bed day costs for particular SMI services.

2. The appropriateness of SMI payment for the millions of dollars paid each year for services normally included in the extended care benefit, and the resulting inequities in resident cost liability.

3. The adequacy of a resident's knowledge about the cost and frequency of services billed outside of the nursing facility's bill.

4. The policies and practices of various State Medicaid programs, as they contribute to program vulnerabilities in the Medicare extended care benefit.

5. The monitoring of extended care utilization over time, and review of services experiencing rapid growth without any known reason (e.g., coverage change).

6. The lack of physician involvement in some SNF stays.

COMMENTS

The HCFA commented on this report. They agreed with our conclusions and suggested a statutory "rebundling" provision for SNFs (similar to that for hospitals) is needed. We agree that this is the direction to take. To assess the impact of rebundling, our office is

presently conducting a more exhaustive analysis of services included in the extended care benefit and also covered by the Supplemental Medical Insurance program.

We thank HCFA for their comments and look forward to working closely to improve services furnished under the extended care benefit. The full text of their comments is provided in Appendix E.

ENDNOTES

1. Data from the 1993 Green Book, Overview of Entitlement Programs. Prepared for the Committee on Ways and Means, U.S. House of Representatives. Pages 138 and 140.

2. Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1992 Annual Supplement, page 97.

3. However, these services can be paid for as a home health benefit.

4. An episode of illness (or benefit period) begins on the first day the beneficiary received hospital services and ends when the patient has not been a hospital or SNF patient for 60 consecutive days.

5. The coinsurance is equal to one-eighth of the HI deductible. For example, during 1990, daily coinsurance payments for the 21st through 100th day were $74 per day.

6. 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.

7. Services not covered by Medicare include personal convenience items (e.g., television), private duty nurses, extra charges for a private room (unless needed for medical reasons), the first three pints of blood in a benefit period, and any other service, drug, or other item which could not be paid for under the hospital insurance program if furnished to an inpatient of a hospital.

8. General Accounting Office report entitled "Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse." GAO/HRD-92-1, released October 1991.

9. Every claim processed by Medicare carriers and intermediaries is maintained in the Common Working File. The CWF acts as an on-line Medicare beneficiary entitlement and utilization database and screens all claims prior to payment approval. The CWF is organized into nine localized databases called sectors. The country is divided into nine processing sectors where nine separate databases are maintained. Generally, these assignments are made on a geographic basis. Each Medicare beneficiary is assigned to only one of the nine databases; therefore, there is one CWF master record for each beneficiary. Each CWF database is maintained

by a designated host site. The Health Insurance Medicare Record (HIMR) program is an access method used typically by carriers to view the CWF record that shows complete entitlement, utilization, and claims payment data, including the beneficiary's name, sex, birth date, HIC number, deductible status, claims history, Medicare Secondary Payer (MSP) status, and hospice or HMO enrollment status.

The bulk of the statistical data collected by HCFA is a by-product of the CWF and is maintained in the Medicare Decision Support System (MDSS). The MDSS statistical files are generated by combining information from SSA on beneficiary eligibility with claims information from the CWF.

10. As provided in the Consumer Price Index for all urban consumers, the annual average medical inflation factor rose 7.4 percent from 1991 to 1992.

11. Although not SNFs, swing-bed hospitals totaled 1,318 in 1992.

12. Beneficiary liability is applied to the total 1991 and 1992 costs of rehabilitation therapy ($45 million and $55 million, respectively) and the SMI category of medical equipment, supplies, prosthetics, and orthotics ($98 million and $112 million, respectively). This cost is $310 million. Beneficiary liability is calculated by applying the 20 percent coinsurance and a deductible. Taking twenty percent of $310 million yields a coinsurance amount of $62 million. Because our data only reflected allowed amounts, we were not sure if a deductible applied for these services. However, we calculated an upper limit, due to the impact of a deductible, by assuming all stays had the $100 deductible applied to these services. Since approximately 369,100 stays had these services, the maximum deductible exposure is $37 million over the 1991 and 1992 period (1991 and 1992 deductible was $100). Adding coinsurance ($62) to the maximum deductible liability yields a beneficiary financial exposure for these services of somewhere between $62 million and $99 million.

13. OIG report entitled "Medicare Payments for Orthotic Body Jackets." OEI-04-92-01080.

14. Payment For Durable Medical Equipment Billed During Skilled Nursing Facility Stays, OEI-06-92-00860.

15. The HCFA has regionalized the processing of claims for DME, prosthetics, orthotics, and supplies into four DMERCs. The HCFA has contracted with four carriers to provided greater efficiency, promote consistency, and improve accuracy in Medicare claims processing for these suppliers, as well as to help reduce fraud, waste, and abuse in the Medicare program. The DMERCs began processing claims in 1993.

APPENDIX A

HI CLASSIFICATION SERVICES	
Major Classification (2 categories)	***Components of Major Categories***
ROOM AND BOARD	
ANCILLARY SERVICES	*Pharmacy* *Lab* *Radiology* *Supply* *Inhalation Therapy* *Rehabilitation* *Other*

SMI CLASSIFICATION OF SERVICES	
Major Classification (20 categories)	***Components of Major Categories***
EVALUATION	*Office Visits* *Hospital Visits* *Emergency Room Visits* *Home Visits* *Nursing Home Visits* *Specialist Evaluation* *Consultations*
ANESTHESIA	
MAJOR AND MINOR MEDICAL PROCEDURES	*Major Procedures* *Eye Procedures* *Ambulatory Procedures* *Minor Procedures*
ONCOLOGY SERVICES	
ENDOSCOPY	
DIALYSIS SERVICES	
IMAGING AND ECHOGRAPHY	*Standard Imaging* *Advanced Imaging* *Echography* *Imaging Procedures*
LAB AND OTHER TESTS	*Lab Tests* *Other Tests* *Specimen Collection*
MEDICAL EQUIPMENT, SUPPLIES, PROSTHETICS, AND ORTHOTICS	*Durable Medical Equipment* *Braces, Trusses, and Artificial Limbs* *Casts, Splints, Fracture Reduction Devices, and Related Supply* *Surgical Dressings* *Prosthetic Devices and Related Supplies*
AMBULANCE	
CHIROPRACTIC	
DRUGS	
VISION AND HEARING SERVICES/SUPPLY	
REHABILITATION THERAPY	*Physical Therapy* *Occupational Therapy* *Speech Therapy*
RESPIRATORY THERAPY	
MENTAL HEALTH SERVICES	
PODIATRY SERVICES	
LOCAL CARRIER CODES	
MISCELLANEOUS OUTPATIENT SMI *(intermediary-processed claims not categorized above)*	
MISCELLANEOUS NON-INSTITUTIONAL SMI *(carrier-processed claims (physicians, suppliers, etc.) not categorized above)*	

APPENDIX B

1992 SMI Services by Category

(Projected from 1 percent sample)	ALLOWED	SNF STAYS WITH THIS SERVICE COUNT	PERCENT	MEAN ALLOWED PER BED DAY
EVALUATION	**$97,240,391**	**674,700**	**69%**	**$3.82**
▪ *OFFICE VISITS*	*$9,900,574*	*97,600*	*10%*	*$0.39*
NEW	6,236,946	41,000	4%	0.25
ESTABLISHED	3,663,628	66,300	7%	0.14
▪ *HOSPITAL VISITS*	*$13,549,557*	*77,500*	*8%*	*$0.53*
INITIAL	848,732	9,800	1%	0.03
SUBSEQUENT	12,527,052	71,300	7%	0.49
CRITICAL CARE	173,773	1,400	0%	0.01
▪ *EMERGENCY ROOM VISITS*	*$5,617,299*	*42,400*	*4%*	*$0.22*
▪ *HOME VISITS*	*$70,567*	*1,400*	*0%*	*$0.00*
▪ *SPECIALIST EVALUATION*	*$3,634,956*	*38,000*	*4%*	*$0.14*
PATHOLOGY	1,513,675	14,100	1%	0.06
OPTHAMOLOGY	1,227,041	20,800	2%	0.05
OTHER	894,240	4,400	0%	0.04
▪ *CONSULTATIONS*	*$10,131,326*	*84,900*	*9%*	*$0.40*
▪ *NURSING HOME VISITS*	*$54,336,112*	*583,100*	*59%*	*$2.14*
ANESTHESIA	**$2,465,554**	**9,600**	**1%**	**$0.10**
MAJOR AND MINOR MEDICAL PROCEDURES	**$29,960,523**	**122,500**	**12%**	**$1.18**
▪ *MAJOR PROCEDURES*	*$7,275,445*	*13,500*	*1%*	*$0.29*
BREAST	134,544	100	0%	0.01
CHOLECYSTECTOMY	14,684	100	0%	0.00
TRANSURETHRAL RESECTION (TURP)	82,300	100	0%	0.00
OTHER	1,971,710	6,100	1%	0.08
CARDIOVASCULAR	3,826,233	6,300	1%	0.15
OTHER	*3,826,233*	*6,300*	*1%*	*0.15*
OTHOPEDIC	1,245,974	1,900	0%	0.05
HIP FRACTURE REPAIR	*216,459*	*300*	*0%*	*0.01*
HIP REPLACEMENT	*284,231*	*300*	*0%*	*0.01*
OTHER	*745,284*	*1,300*	*0%*	*0.03*
▪ *EYE PROCEDURES*	*$2,857,836*	*1,600*	*0%*	*$0.11*
CATARACT REMOVAL/LENS INSERTION	2,272,851	900	0%	0.09
TREATMENT OF RETINAL LESIONS	106,842	200	0%	0.00
OTHER	478,143	700	0%	0.02
▪ *AMBULATORY PROCEDURES*	*$13,618,372*	*24,400*	*2%*	*$0.54*
SKIN	4,762,243	9,800	1%	0.19
MUSCULOSKELETAL	650,890	1,700	0%	0.03
INGUINAL HERNIA REPAIR	129,159	200	0%	0.01
OTHER	8,076,080	13,700	1%	0.32
▪ *MINOR PROCEDURES*	*$6,208,870*	*95,700*	*10%*	*$0.24*
SKIN	3,712,634	73,700	7%	0.15

	ALLOWED	SNF STAYS WITH THIS SERVICE COUNT	PERCENT	MEAN ALLOWED PER BED DAY
MUSCULOSKELETAL	638,531	7,700	1%	0.03
OTHER	1,857,705	18,800	2%	0.07
ONCOLOGY	**$20,746,148**	**12,300**	**1%**	**$0.82**
RADIATION THERAPY	20,562,892	10,500	1%	0.81
OTHER	183,256	2,100	0%	0.01
ENDOSCOPY	**$7,364,074**	**14,100**	**1%**	**$0.29**
UPPER GASTROINTESTINAL (G.I.)	3,005,764	6,600	1%	0.12
SIGMOIDOSCOPY	136,635	1,600	0%	0.01
COLONOSCOPY	2,233,372	2,700	0%	0.09
CYSTOSCOPY	1,272,835	2,300	0%	0.05
BRONCHOSCOPY	348,085	600	0%	0.01
LARYNGOSCOPY	139,724	1,000	0%	0.01
OTHER	227,659	1,500	0%	0.01
DIALYSIS SERVICES	**$16,156,502**	**12,500**	**1%**	**$0.64**
PROCEDURES	15,659,218	11,900	1%	0.62
SUPPLIES	497,284	1,000	0%	0.02
IMAGING AND ECHOGRAPHY	**$45,304,645**	**312,000**	**32%**	**$1.78**
▪ ***STANDARD IMAGING***	***$31,823,040***	***296,700***	***30%***	***$1.25***
CHEST	7,578,630	170,500	17%	0.30
MUSCULOSKELETAL	8,834,755	131,900	13%	0.35
BREAST	68,959	1,300	0%	0.00
CONTRAST GASTROINTESTINAL (G.I.)	2,574,734	18,300	2%	0.10
NUCLEAR MEDICINE	1,725,879	7,600	1%	0.07
OTHER	1,975,380	30,100	3%	0.08
TRANSPORT AND SETUP OF X-RAY EQUIPMENT	9,064,703	91,500	9%	0.36
▪ ***ADVANCED IMAGING***	***$8,785,003***	***21,800***	***2%***	***$0.35***
CAT SCAN - HEAD	4,359,456	11,400	1%	0.17
CAT SCAN - OTHER	2,811,082	8,200	1%	0.11
MRI - BRAIN	879,609	2,100	0%	0.03
MRI - OTHER	734,856	1,200	0%	0.03
▪ ***ECHOGRAPHY***	***$3,387,823***	***17,600***	***2%***	***$0.13***
EYE	91,569	1,000	0%	0.00
ABDOMEN/PELVIS	703,711	5,500	1%	0.03
HEART	1,432,706	4,300	0%	0.06
CAROTID ARTERIES	586,324	2,600	0%	0.02
PROSTATE, TRANSRECTAL	16,990	200	0%	0.00
OTHER	556,523	5,600	1%	0.02
▪ ***IMAGING PROCEDURES***	***$1,308,779***	***2,000***	***0%***	***$0.05***
HEART (e.g., cardiac catheritization)	278,450	200	0%	0.01
OTHER	1,030,329	1,800	0%	0.04

	ALLOWED	SNF STAYS WITH THIS SERVICE COUNT	PERCENT	MEAN ALLOWED PER BED DAY
LAB AND OTHER TESTS	**$71,603,409**	**436,600**	**44%**	**$2.81**
▪ *LAB TESTS*	*$62,518,808*	*424,900*	*43%*	*$2.46*
ROUTINE VENIPUNCTURE	3,760,398	261,900	27%	0.15
AUTOMATED GENERAL PROFILES	11,949,187	253,000	26%	0.47
URINALYSIS	1,986,947	167,100	17%	0.08
BLOOD COUNTS	8,001,061	256,300	26%	0.31
GLUCOSE	1,627,472	44,300	5%	0.06
BACTERIAL CULTURES	6,964,804	166,000	17%	0.27
OTHER	28,228,939	326,900	33%	1.11
▪ *OTHER TESTS*	*$6,393,609*	*65,900*	*7%*	*$0.25*
ELECTROCARDIOGRAM	1,773,822	38,400	4%	0.07
CARDIOVASCULAR STRESS TEST	42,628	600	0%	0.00
EKG MONITORING	681,614	3,800	0%	0.03
OTHER	3,895,545	31,700	3%	0.15
▪ *SPECIMEN COLLECTION*	*$2,690,992*	*208,400*	*21%*	*$0.11*
MEDICAL EQUIPMENT, SUPPLIES, PROSTHETICS, AND ORTHOTICS	**$112,190,827**	**201,500**	**20%**	**$4.41**
▪ *DURABLE MEDICAL EQUIPMENT*	*$10,599,100*	*69,000*	*7%*	*$0.42*
HOSPITAL BEDS AND ACCESSORIES	2,056,934	15,900	2%	0.08
OXYGEN EQUIPMENT AND SUPPLIES	3,591,583	10,800	1%	0.14
WHEELCHAIRS AND ACCESSORIES	1,861,161	26,500	3%	0.07
OTHER DME	1,020,939	13,600	1%	0.04
WALKERS	904,402	13,500	1%	0.04
CANES AND CRUTCHES	118,657	3,600	0%	0.00
COMMODES	609,216	8,500	1%	0.02
SEAT/PATIENT LIFTS	130,808	1,100	0%	0.01
TRANCUTANEOUS/NEUROMUSCULAR ELECTRICAL NERVE STIMULATION (TENS)	43,991	200	0%	0.00
PRESSURE PADS, CUSHIONS, AND MATTRESSES	261,409	2,700	0%	0.01
▪ *BRACES, TRUSSES, ARTIFICIAL LIMBS*	*$11,898,957*	*13,700*	*1%*	*$0.47*
BRACES AND TRUSSES	5,678,758	11,500	1%	0.22
BRACES AND TRUSSES - BODY JACKETS	*1,131,419*	*1,200*	*0%*	*0.04*
ARTIFICIAL LIMBS	6,220,199	2,500	0%	0.24
▪ *CASTS, SPLINTS, AND FRACTURE REDUCTION DEVICES*	*$2,591,566*	*6,200*	*1%*	*$0.10*
RECUMBENT ANKLE POSITIONING SPLINT (i.e., multi-podus)	*2,320,190*	*3,700*	*0%*	*0.09*
▪ *SURGICAL DRESSINGS*	*$6,478,678*	*7,500*	*1%*	*$0.25*
SURGICAL DRESSINGS (PRIMARY)	331,716	800	0%	0.01
GAUZE, BANDAGES, AND TAPE	2,825,298	5,900	1%	0.11
ADHESIVE AND REMOVER	3,321,664	4,600	0%	0.13
▪ *PROSTHETIC DEVICES AND RELATED SUPPLY*	*$80,622,526*	*131,800*	*13%*	*$3.17*
ENTERAL NUTRITION EQUIPMENT AND	57,530,045	58,700	6%	2.26

	ALLOWED	SNF STAYS WITH THIS SERVICE COUNT	PERCENT	MEAN ALLOWED PER BED DAY
SUPPLY				
FEEDING SUPPLY KITS AND MISC. SUPPLY	*23,949,537*	*57,700*	*6%*	*0.94*
TUBING	*700,335*	*17,700*	*2%*	*0.03*
FORMULAE	*24,664,781*	*57,900*	*6%*	*0.97*
INFUSION PUMPS	*8,215,392*	*41,900*	*4%*	*0.32*
PARENTERAL NUTRITION EQUIPMENT AND SUPPLY	2,599,228	400	0%	0.10
NUTRITION SOLUTIONS	*2,227,200*	*400*	*0%*	*0.09*
INFUSION PUMPS	*137,460*	*300*	*0%*	*0.01*
ADMINISTRATION KITS (per day) AND MISC. SUPPLY	*234,568*	*400*	*0%*	*0.01*
MEDICAL AND SURGICAL SUPPLIES	14,303,140	66,800	7%	0.56
SKIN BARRIER	*216,288*	*2,800*	*0%*	*0.01*
LUBRICANTS	*833,024*	*4,800*	*0%*	*0.03*
STERILE SALINE	*919,116*	*9,000*	*1%*	*0.04*
OSTOMY IRRIGATION KITS	*2,283,084*	*1,400*	*0%*	*0.09*
TRACHEOSTOMY CARE KITS	*814,878*	*1,300*	*0%*	*0.03*
APPLIANCE CLEANER	*23,652*	*500*	*0%*	*0.00*
DISPOSABLE UNDERPADS	*238*	*200*	*0%*	*0.00*
SURGICAL TRAYS	*1,000*	*100*	*0%*	*0.00*
OTHER	*8,778,189*	*52,900*	*5%*	*0.35*
CATHETERS AND RELATED ITEMS	4,930,637	36,700	4%	0.19
TRACHEOSTOMY DEVICES AND ITEMS	317,387	900	0%	0.01
OSTOMY AND RELATED ITEMS	524,958	5,200	1%	0.02
MISCELLANEOUS DME RELATED SUPPLIES	50,512	500	0%	0.00
OTHER MEDICAL DEVICES AND SUPPLY	366,619	1,000	0%	0.01
AMBULANCE	**$36,103,575**	**75,600**	**8%**	**$1.42**
BASIC LIFE SUPPORT TRANSPORT	20,245,753	65,300	7%	0.80
ADVANCED LIFE SUPPORT	9,954,273	33,100	3%	0.39
NON-EMERGENCY TRANSPORT	5,300,324	21,200	2%	0.21
OXYGEN AND MEDICAL SUPPLIES	603,225	19,300	2%	0.02
CHIROPRACTIC SERVICES	**$11,298**	**100**	**0%**	**$0.00**
DRUGS AND BIOLOGICALS	**$2,259,165**	**19,400**	**2%**	**$0.09**
CHEMOTHERAPY DRUGS	949,169	2,100	0%	0.04
OTHER DRUGS/INJECTIONS	1,309,996	18,700	2%	0.05
VISION AND HEARING SERVICES AND SUPPLY	**$293,717**	**1,700**	**0%**	**$0.01**
VISION SERVICES AND SUPPLY	293,717	1,700	0%	0.01
REHABILITATION THERAPY	**$55,070,239**	**30,200**	**3%**	**$2.16**
▪ *PHYSICAL THERAPY*	*$32,086,132*	*23,100*	*2%*	*$1.26*
▪ *OCCUPATIONAL THERAPY*	*$16,095,257*	*11,800*	*1%*	*$0.63*
▪ *SPEECH THERAPY*	*$6,888,850*	*4,700*	*0%*	*$0.27*
RESPIRATORY THERAPY	**$12,235**	**400**	**0%**	**$0.00**

	ALLOWED	SNF STAYS WITH THIS SERVICE COUNT	PERCENT	MEAN ALLOWED PER BED DAY
MENTAL HEALTH SERVICES	**$5,360,954**	**28,100**	**3%**	**$0.21**
PODIATRY SERVICES AND ROUTINE FOOT CARE	**$622,665**	**23,500**	**2%**	**$0.02**
MISCELLANEOUS INSTITUTIONAL PART B (OUTPATIENT)	**$6,112,422**	**38,000**	**4%**	**$0.24**
BLOOD AND RELATED SUPPLY	1,555,118	4,100	0%	0.06
ACCOMODATIONS	1,800	100	0%	0.00
MISCELLANEOUS UNDEFINED INSTITUTIONAL SERVICES	4,214,976	33,500	3%	0.17
PROFESSIONAL FEES	340,528	2,800	0%	0.01
OTHER	**$776,426**	**16,800**	**2%**	**$0.03**
UNDEFINED CODES	737,710	15,800	2%	0.03
CARRIER LOCAL CODES	**$7,772,638**	**42,800**	**4%**	**$0.31**

APPENDIX C

1992 State Bed Day Costs and Utilization

	BENEFICIARIES	SNF STAYS	COVERED DAYS TOTAL	COVERED DAYS PERCENT	ALLOWED CHARGES	BED DAY COST	% of STAYS WITH SMI
ALABAMA	97	133	3,831	1.5%	$6,755,362	$17.63	86.0%
ALASKA	3	3	43	0.0%	$32,738	$7.61	33.0%
ARIZONA	132	165	3,364	1.3%	$6,058,188	$18.01	79.0%
ARKANSAS	77	97	2,312	0.9%	$4,562,636	$19.73	85.0%
CALIFORNIA	948	1,219	26,520	10.4%	$49,780,921	$18.77	79.0%
COLORADO	116	145	3,345	1.3%	$4,948,417	$14.79	80.0%
CONNECTICUT	132	180	6,827	2.7%	$14,490,384	$21.23	94.0%
DELAWARE	23	29	735	0.3%	$2,375,904	$32.33	93.0%
DISTRICT OF COLUMBIA	2	2	113	0.0%	$55,343	$4.90	100.0%
FLORIDA	524	671	18,819	7.4%	$47,478,140	$25.23	85.0%
GEORGIA	95	129	4,405	1.7%	$7,863,700	$17.85	85.0%
HAWAII	7	7	207	0.1%	$573,305	$27.70	71.0%
IDAHO	36	44	1,000	0.4%	$469,379	$4.69	66.0%
ILLINOIS	401	536	12,611	5.0%	$22,578,139	$17.90	82.0%
INDIANA	274	330	8,965	3.5%	$15,833,670	$17.66	80.0%
IOWA	162	174	2,532	1.0%	$3,017,020	$11.92	76.0%
KANSAS	118	148	2,343	0.9%	$2,997,192	$12.79	82.0%
KENTUCKY	95	132	4,169	1.6%	$5,584,659	$13.40	73.0%
LOUISIANA	99	124	1,856	0.7%	$6,459,883	$34.81	85.0%
MAINE	12	14	284	0.1%	$114,053	$4.02	71.0%
MARYLAND	82	105	3,160	1.2%	$7,760,926	$24.56	89.0%
MASSACHUSETTS	228	302	9,827	3.9%	$15,260,372	$15.53	86.0%
MICHIGAN	295	376	11,135	4.4%	$28,942,464	$25.99	90.0%
MINNESOTA	244	326	8,131	3.2%	$8,020,712	$9.86	71.0%
MISSISSIPPI	56	65	1,633	0.6%	$3,192,947	$19.55	85.0%
MISSOURI	287	359	7,017	2.8%	$12,132,267	$17.29	80.0%
MONTANA	40	66	1,190	0.5%	$333,979	$2.81	56.0%
NEBRASKA	79	87	1,596	0.6%	$3,225,369	$20.21	74.0%
NEVADA	26	31	790	0.3%	$1,026,019	$12.99	84.0%
NEW HAMPSHIRE	16	22	620	0.2%	$700,244	$11.29	86.0%
NEW JERSEY	95	114	3,617	1.4%	$8,988,924	$24.85	90.0%
NEW MEXICO	22	23	615	0.2%	$1,236,606	$20.11	65.0%
NEW YORK	411	494	18,799	7.4%	$44,984,916	$23.93	92.0%
NORTH CAROLINA	176	204	7,309	2.9%	$16,227,163	$22.20	86.0%
NORTH DAKOTA	34	44	1,042	0.4%	$972,147	$9.33	64.0%
OHIO	409	532	13,832	5.4%	$28,281,110	$20.45	87.0%
OKLAHOMA	81	93	1,564	0.6%	$2.374,019	$15.18	77.0%
OREGON	81	96	2,373	0.9%	$3,864,239	$16.28	73.0%
PENNSYLVANIA	483	645	16,260	6.4%	$53,011,381	$32.60	92.0%
PUERTO RICO	10	12	212	0.1%	$448,999	$21.18	75.0%
RHODE ISLAND	41	48	1,535	0.6%	$2,435,235	$15.86	94.0%
SOUTH CAROLINA	65	82	2,553	1.0%	$8,113,384	$31.78	82.0%
SOUTH DAKOTA	38	55	924	0.4%	$1,704,265	$18.44	89.0%
TENNESSEE	135	173	4,832	1.9%	$9,815,559	$20.31	87.0%
TEXAS	406	512	11,731	4.6%	$25,449,934	$21.69	74.0%
UTAH	50	63	1,274	0.5%	$782,883	$6.15	60.0%
VERMONT	8	8	129	0.1%	$50,580	$3.92	75.0%
VIRGINIA	97	112	3,833	1.5%	$10,168,266	$26.53	93.0%
WASHINGTON	155	190	3,950	1.6%	$5,559,224	$14.07	80.0%
WEST VIRGINIA	53	62	1,613	0.6%	$2,854,498	$17.70	79.0%
WISCONSIN	179	228	6,487	2.6%	$7,247,442	$11.17	75.0%
WYOMING	17	22	489	0.2%	$232,301	$4.75	73.0%
	7,752	9,833	254,353		$517,427,407		

Unprojected Data
(from 1 percent sample)

APPENDIX D

1992 Provider Specialties By State

(Percent of SMF charges provided by this specialty or outpatient)

	Supplier	Lab	Outpatient	Physician	Ambulance	Other
ALABAMA	36.4%	9.0%	27.0%	7.4%	13.8%	4.7%
ALASKA	0.0%	12.9%	52.6%	3.6%	0.0%	30.9%
ARIZONA	17.4%	5.8%	27.7%	25.6%	9.6%	10.1%
ARKANSAS	45.5%	1.7%	23.3%	10.2%	4.6%	14.1%
CALIFORNIA	12.8%	3.4%	33.9%	28.3%	5.8%	11.0%
COLORADO	3.9%	7.5%	41.1%	18.8%	10.6%	15.6%
CONNECTICUT	15.4%	5.4%	35.0%	16.5%	15.6%	4.2%
DELAWARE	12.6%	4.8%	36.6%	19.4%	7.7%	8.7%
DISTRICT OF COLUMBIA	0.0%	13.0%	0.0%	0.0%	0.0%	40.6%
FLORIDA	22.6%	5.6%	40.2%	11.4%	3.1%	10.0%
GEORGIA	15.8%	8.6%	46.2%	8.6%	10.5%	8.1%
HAWAII	37.1%	2.3%	34.0%	17.5%	5.5%	3.6%
IDAHO	0.0%	4.4%	46.4%	26.1%	0.0%	16.6%
ILLINOIS	20.3%	5.2%	26.9%	23.0%	5.8%	12.7%
INDIANA	19.5%	4.3%	48.2%	12.8%	4.6%	6.4%
IOWA	18.0%	1.3%	21.2%	26.6%	2.5%	26.9%
KANSAS	13.9%	1.8%	14.1%	27.7%	1.2%	36.7%
KENTUCKY	49.1%	8.3%	12.8%	11.8%	5.7%	10.0%
LOUISIANA	6.9%	0.5%	32.3%	41.2%	1.4%	16.8%
MAINE	7.9%	3.5%	0.0%	36.2%	0.0%	32.0%
MARYLAND	24.9%	8.0%	30.3%	9.3%	11.5%	5.9%
MASSACHUSETTS	12.5%	9.0%	30.0%	16.6%	11.3%	3.6%
MICHIGAN	19.4%	4.5%	43.2%	4.7%	3.0%	7.6%
MINNESOTA	15.6%	1.6%	50.8%	16.2%	2.2%	10.4%
MISSISSIPPI	4.2%	3.8%	70.6%	8.6%	0.4%	11.9%
MISSOURI	13.6%	2.6%	40.1%	23.0%	2.3%	11.7%
MONTANA	6.6%	1.5%	0.0%	65.1%	4.8%	21.2%
NEBRASKA	24.0%	1.1%	45.8%	15.4%	1.8%	11.6%
NEVADA	11.0%	5.9%	23.9%	26.9%	3.6%	16.4%
NEW HAMPSHIRE	2.1%	7.0%	45.4%	19.2%	0.0%	5.3%
NEW JERSEY	28.5%	9.6%	29.5%	12.6%	6.4%	3.8%
NEW MEXICO	32.8%	1.4%	49.3%	5.6%	3.0%	7.1%
NEW YORK	31.6%	6.7%	19.3%	16.6%	8.7%	7.7%
NORTH CAROLINA	22.7%	3.5%	56.0%	7.8%	2.7%	4.9%
NORTH DAKOTA	25.6%	1.2%	46.6%	12.3%	2.9%	10.5%
OHIO	17.3%	8.1%	37.5%	12.4%	7.9%	8.4%
OKLAHOMA	27.7%	2.8%	20.4%	29.7%	1.4%	15.3%
OREGON	12.9%	3.4%	52.9%	16.7%	3.3%	6.8%
PENNSYLVANIA	15.1%	3.0%	45.4%	11.1%	12.3%	6.1%
PUERTO RICO	35.8%	0.0%	0.0%	56.3%	0.0%	7.9%
RHODE ISLAND	26.2%	10.7%	11.8%	20.8%	9.8%	2.5%
SOUTH CAROLINA	24.8%	2.3%	46.5%	6.1%	15.6%	3.0%
SOUTH DAKOTA	4.7%	2.5%	66.7%	9.4%	0.0%	14.8%
TENNESSEE	27.2%	5.8%	40.2%	12.2%	6.7%	6.7%
TEXAS	17.9%	2.5%	39.0%	17.2%	9.8%	11.1%
UTAH	11.0%	8.7%	0.0%	29.4%	9.2%	26.4%
VERMONT	0.0%	0.0%	36.4%	29.1%	0.0%	20.5%
VIRGINIA	26.9%	4.2%	49.2%	7.0%	3.6%	6.8%
WASHINGTON	13.9%	6.6%	35.4%	15.5%	5.0%	14.4%
WEST VIRGINIA	23.5%	1.0%	43.8%	15.1%	3.1%	12.0%
WISCONSIN	23.5%	3.8%	42.0%	14.2%	4.1%	7.6%
WYOMING	2.5%	5.8%	3.3%	43.7%	0.0%	44.8%

APPENDIX E

HCFA COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date SEP 2 1994

From Bruce C. Vladeck
Administrator

Subject June Gibbs Brown
Inspector General

To

Office of Inspector General (OIG) Draft Reports: "Medicare Services Provided to Residents of Skilled Nursing Facilities, An Overview," (OEI-06-92-00863) and "Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays," (OEI-06-92-00860)

We reviewed the subject reports which examined Part B services for skilled nursing facility patients and provided an overview of many of the abusive practices and program vulnerabilities that unbundling of services encourages. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on these reports. Please advise us if you would like to discuss our position on the reports' recommendations at your earliest convenience.

Attachment

NOTE

These comments from HCFA pertain to two OIG reports. Comments specific to this report can be found on page 4. Other comments pertain to our report entitled "Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays."

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Reports: "Medicare
Services Provided to Residents of Skilled Nursing Facilities,
An Overview," (OEI-06-92-00863) and
"Payments for Durable Medical Equipment (DME)
Billed During Skilled Nursing Facility (SNF) Stays"
(OEI-06-92-00860)

OIG Recommendation

HCFA should improve the place of service coding system. HCFA could:

a) Develop guidelines which eliminate the use of the "other" code for DME billing, or develop a specific list of circumstances under which "other" may be used to bill.

b) Educate the Durable Medical Equipment Regional Carriers (DMERCs) on the accurate use of place of service codes.

c) Require the DMERCs to provide ongoing education to the suppliers on the accurate use of place of service codes.

d) Suggest that the DMERCs develop an item for inclusion in their data base, that is transmitted to the Common Working File (CWF), to provide a continuing history of the patient's location.

HCFA Response

a) We do not concur. We believe carriers should have the option to use the category "other" to indicate place of service (POS). Further, it would not be possible to predict every possible POS that might occur. To remove this option will impede the claims process and unnecessarily burden the beneficiaries and suppliers.

A more appropriate action would be to have the DMERCs, with data provided by the Statistical Analysis DME regional carrier (SADMERC), perform reviews on those suppliers who consistently use the "other" POS category and take appropriate action, such as supplier education, based on the reviews.

b) We concur. We believe that the DMERCs are knowledgeable about the use of the POS category because of the clear requirements developed for its use. We believe it is important to maintain this

knowledge, and plan to follow-up through routine monitoring and educational activities.

c) We concur. Currently, the DMERCs actively educate suppliers regularly through various methods such as: educational seminars, newsletters, meetings, and provider education telephone lines and bulletin boards. Most significantly, the DMERCs utilize the supplier manual as an effective training tool, a method not previously used by local carriers.

Each supplier who bills the DMERC receives a manual and regular educational updates. The manual includes billing instructions, explanations of Medicare rules and regulations, and explanations of the DMERCs medical review policies.

d) HCFA concurs. We currently transmit the POS with every claim to the CWF and store in the CWF. This provides continuing information regarding the patient's location. Short of manually reviewing each and every DME claim submitted to determine the beneficiary's true location, which is highly impractical, we believe a combination of this method and the one described in "a" above is appropriate.

OIG Recommendation

HCFA should improve the supplier knowledge of beneficiary location. HCFA could:

a) Ensure that the DMERCs instruct suppliers of their responsibility for determining the location of a beneficiary, before billing Part B DME.

b) Suggest to the DMERCs that suppliers should be required to verify the patient's location on every claim submitted for Part B DME, to determine if the beneficiary is currently in their home and using the DME.

c) Require the supplier to review the accuracy of payment for DME made during a 6-month period.

HCFA Response

a) We concur. As noted in our response above, we will have the DMERCs use the many educational methods at their disposal (see "c" in response above) to remind suppliers of this responsibility.

b) We do not concur and believe this is impractical. We suggest that the DMERCs perform sample reviews of claims to verify a supplier's record at the National Supplier Clearinghouse and share with the other DMERCs, so that all can take appropriate action on that supplier's claims.

c) We do not concur. By submitting the information on the claim, a supplier is attesting to his or her belief in the accuracy of the information. We believe the methods of education and sample review discussed above are the appropriate methods of determining the accuracy of payment made.

OIG Recommendation

HCFA should review the DMERC processes. HCFA could:

a) Assess the effectiveness of the new CWF edit of Part B DME and SNF charges, and evaluate whether additional edits should be developed to review all SNF bills, upon submission, for overlap with DME billing.

b) Require annual reviews, during the first few years following DMERC implementation, of DME billed and allowed during an SNF stay, to examine the impact of DMERC implementation on this problem.

HCFA Response

a) We concur. It has always been our intention to determine other edits that could be put into place to improve this process. We are continually striving to improve CWF editing. We have been waiting for DMERC transition activities to be completed before making improvements. It is important to establish and stabilize a system before improving upon it. The final States transitioned in July. As we finish transition-related activities, we will move forward with improving the edits.

b) We do not concur. While we will strongly encourage the DMERCs to examine this problem, we do not believe we should require such reviews. We believe it is important to allow the DMERCs the flexibility to use the limited review resources available to them on immediate problems they have identified in their respective regions, or major problems which they have learned of through the SADMERC that may have even greater impact on the process.

Comments on Report (OEI-06-92-00863)

On page 19 of the Overview report, a "vulnerability in the definition of extended care services" is discussed. The implication is that a change in this definition would remove the vulnerability. We do not agree. The cited definition merely describes services that can be covered under Part A. It does not mandate billing in any particular manner. Similar language appears in section 1861(b)(2) of the Social Security Act with respect to inpatient hospital services, and does not create a vulnerability there. To achieve the result desired by both OIG and HCFA, a statutory "rebundling" provision for SNFs (similar to that for hospitals) is needed. That would require SNFs to bill for all services furnished to the residents, thus preventing beneficiaries from paying deductibles and coinsurance they would not otherwise incur under Part A. It would also help us to develop an effective SNF prospective payment system by preventing services from being billed outside of the SNF benefit.

We agree with OIG's conclusions. In addition, we believe that: (1) for many dually-eligible Medicare/Medicaid patients based on the Medicaid State plans payment ceiling, the Medicare program is reimbursing the provider fully for the services provided to the dually-eligible patient; (2) some of the items billed to the carriers as DME may have also been claimed on the Medicare cost report as either routine or ancillary medical equipment even though a supplier provided the equipment; (3) because SNFs are allowed to unbundle ancillary services, we have not found an excessive amount of items and services that could only be billed as routine, being billed in some other payment method; and (4) the excessive payments for rehabilitation services were made to SNFs providing therapy services under arrangements with outside contractors and outpatient physical therapy providers which are both paid on a cost basis, rather than independent therapists which are paid on a charge basis.

GLOSSARY

Artificial Limb - Replacement for a natural limb (prothesis).

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. Back braces are used to treat certain kinds of backache.

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. It is indicated whenever it is necessary to establish a precise and definite diagnosis in order to determine whether heart surgery is necessary and to plan the surgical approach.

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.

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. Coverage may begin sooner, if the patient participates in a self-care dialysis training program provided by an approved facility. Also, coverage may begin on admittance to a hospital to receive a kidney transplant or to receive dialysis before the transplant.

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.

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 - A person who comes to the hospital, clinic, or dispensary for diagnosis and/or treatment but does not occupy a bed.

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. The practice of physical therapy includes the administration, interpretation, and evaluation of tests and measurements of bodily functions and structures and planning, administration, evaluation, and modification of treatment and instruction, including the use of physical measures, activities, and devices for preventive and therapeutic purposes.

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. The source of radiation may be outside the body of the patient (external radiation therapy) or it may be an isotope that has been implanted or instilled into abnormal tissue or a body cavity.

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).

Satellite Contractors - All Medicare contractors are "satellites" in the common work file (CWF) system; this term is used to describe a Medicare contractor's relationship to the CWF Host as a satellite sends and receives data from the CWF database maintained by the Host; See Common Working File.

Sector - A geographically defined area consisting of one Host contractor and its satellite contractors. Sector is based on historical geographic claims processing patterns; there are 9 sectors nationwide. See Common Working File, Satellite Contractor.

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. Current is supplied by a hand-held, battery-operated pulse generator.

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.