Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CARRIER SHOPPING

A MANAGEMENT ADVISORY REPORT

Richard P. Kusserow
INSPECTOR GENERAL

NOVEMBER 1991

OFFICE OF INSPECTOR GENERAL

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This report was prepared under the direction of William C. Moran, Regional Inspector General, Office of Evaluation and Inspections and Natalie Coen, Deputy Regional Inspector General, Office of Evaluation and Inspections, Region V. Participating in this project were the following people:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CARRIER SHOPPING

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OEI-05-91-00043

EXECUTIVE SUMMARY

PURPOSE

To determine if point of sale encourages Medicare billers to shop for the best paying carrier.

BACKGROUND

Through repeated contacts with the Medicare carriers, suppliers learn which carriers pay the most for a medical supply item. They also learn just how much of a particular medical supply each carrier will allow before stopping or cutting back on payments. Armed with information collected from carrier shopping, suppliers use point of sale to turn that information into profits at the expense of the Medicare program.

Point of sale policies hold that the site where the medical supplier met with the beneficiary or received the beneficiary's call determines which carrier will have jurisdiction and process the claim. This enables suppliers to elude Medicare payments and safeguards by establishing multiple business locations in multiple carrier jurisdictions.

This study looked at Medicare payment for medical supply items. We did not examine the extent of this problem in the areas of durable medical equipment, prosthetics or orthotics.

FINDINGS

In 1989, carrier shopping may have resulted in at least $22 million in excess payments.

Point of sale compromises carrier program safeguards.

Point of sale increases the risk of fraud, abuse and waste.

RECOMMENDATION

- The Health Care Financing Administration (HCFA) should have all bills for medical supplies submitted to the carrier having jurisdiction over the beneficiary's home rather than point of sale.

This change in policy would have avoided the nearly $22 million Medicare lost in 1989 due to point of sale policies. Additional losses could also have been avoided if the same policy were applied to all durable medical equipment, prosthetics, orthotics and supplies.

AGENCY COMMENTS

The HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) were asked to comment on the draft of this report. Both ASPE and HCFA concur with our recommendation. We are pleased that we have reached agreement on this important policy and that HCFA is planning to modify its regulations. The full text of ASPE's and HCFA's comments are contained in Appendix A.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY i

INTRODUCTION 1

Purpose 1
Background 1
Methodology 2

FINDINGS 4

In 1989, carrier shopping may have resulted in at least $22 million in excess payments. 4

Point of sale compromises carrier program safeguards. 5

Point of sale increases the risk of fraud, abuse and waste. 6

RECOMMENDATION 8

APPENDIX

Draft Report Comments and OIG Response. A-1

INTRODUCTION

PURPOSE

To determine if point of sale encourages Medicare billers to shop for the best paying carrier.

BACKGROUND

Supplementary Medical Insurance, commonly referred to as Part B of the Medicare program, assists patients in paying for medical services and supplies. Part B helps patients pay for physician services and other medical services including medical supplies.

The term medical supplies, as used in this report, is limited to supplies billed to Medicare under procedure codes A4000 through A4999. Medicare payments for these supplies have increased by 75 percent during the period 1987 through 1989. In 1987, Medicare paid $232 million for medical supplies. In 1989, program spending had risen to $407 million.

Medical supplies represents a small portion of the $3 billion annual market which is composed of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). While this study focuses on medical supplies, the policies and procedures and the problems which accompany them are representative of problems encountered by Medicare in other areas of DMEPOS.

The Health Care Financing Administration (HCFA) manages the Part B program and administers benefits with the assistance of contractors called carriers. Each carrier is responsible for the adjudication of claims submitted to them by suppliers located within the carrier's geographic service area.

To clear up jurisdictional problems which occur on some medical supply claims, HCFA developed a claims processing policy known as point of sale jurisdiction. Point of sale requires suppliers to submit their claims to the carrier servicing the geographic area where the beneficiary's order for medical supplies is received. It has been hypothesized that point of sale permits large suppliers to shop around and locate their business operations in areas serviced by a carrier that pays more and/or has more liberal coverage policies.

The HCFA and carriers determine which medical supplies will be covered and under what circumstances payment will be made. The carriers, with guidance from HCFA, also:

- decide how much will be paid for each medical supply item; and,
- establish the volume and number of each medical supply the Medicare program will buy for each beneficiary in a given period of time.

Different approaches to pricing have resulted in considerable payment variance for medical supplies among the carriers. The policies and procedures of one carrier do not necessarily mirror another's practice. Each carrier has established their own system for assigning provider numbers used by billers. Each maintains their own computer system for adjudicating claims.

METHODOLOGY

Both qualitative and quantitative data were used to prepare this report. To gather qualitative information, discussions were held with 11 carriers concerning their experiences in adjudicating medical supply claims. Selection of the carriers was not random. Carriers in 8 of HCFA's 10 regions were selected to participate in this study because they process a large volume of claims. Three others were selected due to their proximity to the HCFA regional office.

Quantitative data pertaining to medical supplies was obtained from HCFA's Part B Medicare Annual Data (BMAD) file for 1989. Only national procedure codes ranging from A4000 - A4999 were reviewed in our data analysis. In 1989, 149 different procedure codes in this range were billed to Medicare. These 149 codes were selected for indepth analysis for this study. No other procedure codes were used.

Resident carrier, as used in this report, refers to the carrier having jurisdiction for processing claims in the geographic area in which the beneficiary resides. Outside carrier refers to carriers outside the geographic area of the beneficiary's residence.

The BMAD file was used to identify beneficiaries who had medical supply items (A4000 - A4999) submitted on their behalf to outside carriers. A total of 81,159 line items were analyzed. Using zip code information, we determined that 20,344 of the 81,159 line items were paid by an outside carrier. The number and dollar value of medical supplies paid by outside carriers was determined (See Table 1). The average amount payable for each medical supply by the resident carrier was also determined. The difference between what was paid by outside carriers and what would have been paid for the medical supply items by the resident carrier is reported in this study. In some cases, the BMAD file contained no information on resident carrier pricing. When this occurred, the original amount allowed was used in our calculations. Claims submitted on behalf of railroad retirees were not included in our analysis. We also eliminated 87 line items from our analysis because we could not identify the

Table 1

	Line Items	Allowed Amount
Total Analyzed (including ESRD patients)[1]	8,124,600	$407,172,200
Unable to Identify Resident Carrier of Beneficiary	8,700	$1,544,800
Used in Analysis	8,115,900	$405,627,400
Line Items Processed by Resident Carrier	6,081,500	$230,542,600
Line Items Processed by Outside Carrier	2,034,400	$175,084,800
XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	XXXXXXXXXXXXXX
Total Analyzed (excluding ESRD patients)	7,752,600	$260,632,700
Unable to Identify Resident Carrier of Beneficiary	8,000	$463,700
Used in Analysis	7,744,600	$260,169,000
Line Items Processed by Resident Carrier	5,906,900	$183,994,200
Line Items Processed by Outside Carrier	1,837,700	$76,174,800

1 All numbers are projected based on a 1 percent sample of BMAD

resident carrier; consequently, the $407 million paid for medical supplies was reduced to $406 million in our final analysis reported in the findings.

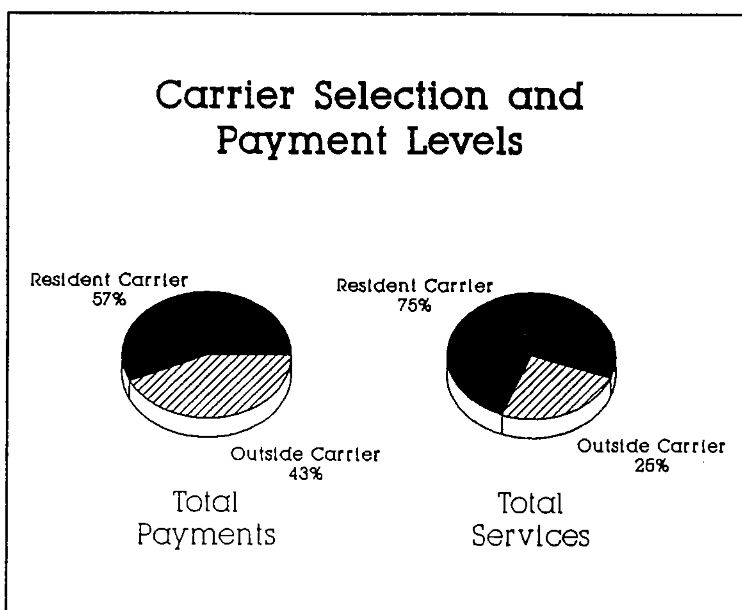
The number of beneficiaries who had medical supply claims submitted to outside carriers was further refined by identifying beneficiaries who reside in counties bordering on the outside carrier. We also considered the migration habits of beneficiaries. This analysis was conducted on a sample of 300 line items. The medical supplies beneficiaries purchased in an adjoining State and the migration habits of some beneficiaries were taken into consideration before any projections were made.

We also analyzed our sample to determine the impact of End Stage Renal Dialysis (ESRD) patients on our projections. This analysis indicated that more than half (55%) of all items listed by HCFA as ESRD medical supplies were paid by the resident carrier. The prevalence of carrier shopping among ESRD patients appears to be no different than for non-ESRD patients; consequently, projections reflected in this inspection include ESRD patient data.

FINDINGS

Finding #1: In 1989, carrier shopping may have resulted in at least $22 million in excess payments.

In 1989, Medicare paid $406 million for medical supplies billed under procedure codes A4000 through A4999. Approximately 43 percent of this $406 million, or $175 million, was paid by outside carriers. Resident carriers processed 75 percent of medical supply items and accounted for 57 percent of the payments. The remaining 25 percent of medical supply items were processed by outside carriers and accounted for 43 percent of the payments.



Resident carriers account for 57% of medical supply payments and process 75% of the items billed. Outside carriers account for 43% of payments but only process 25% of medical supply items.

Our analysis indicates that it may be financially advantageous for billers of medical supplies to bill an outside carrier rather than the resident carrier. The 149 different medical supply items billed to Medicare in 1989 and described by procedure codes A4000 through A4999 are, by and large, inexpensive disposable items, widely available through a number of diverse sources, including mail order houses. The beneficiary, in most cases, would have no reason to purchase these items outside their resident Medicare carrier's jurisdiction.

Our analysis of the 1989 BMAD file for procedure codes A4000 - A4999 indicates that excess payments totalling at least $22 million[1] were made by the Medicare program in

[1] The total paid by outside carriers for medical supplies was $175,084,800. To determine how much would have been paid if the beneficiary's residence carrier had paid for the medical supplies instead of an outside carrier, we used the average allowed for a HCPCS by the beneficiary's residence carrier. In cases where the beneficiary's residence carrier did not pay for a specific HCPCS, the original amount allowed for that HCPCS was used to determine what would have been paid. Using this method, the total amount that would have been paid was $153,256,300. The amount of payment made in excess of what would have been paid by the beneficiary's residence carrier was $21,832,600.

1989. These excess payments would not have occurred if the medical supplies were paid by the carrier having jurisdiction over the beneficiary's residence.

Finding #2: Point of sale compromises carrier program safeguards.

All of the carriers we interviewed believe that Medicare's point of sale policy is detrimental to the program. The carriers believe that point of sale:

- results in excessive payments;
- enables suppliers to avoid close carrier scrutiny;
- inhibits their ability to make medical necessity decisions; and,
- contributes to duplicate payments for medical supplies.

Carriers report that they receive requests from suppliers, trade publications and consultants concerning their medical supply fee schedules, prevailing charge rates and coverage policies. Suppliers then use the information they gain from polling the carriers to decide where to set up business. Establishing an office in a carrier's jurisdiction can be easy and relatively inexpensive. Telephone answering services, call forwarding and mail drops allow suppliers to ostensibly conduct business in one carrier's jurisdiction, while its operations are actually based in another carrier's jurisdiction.

Carriers feel that suppliers take advantage of jurisdictional loopholes, created by point of sale, to bill carriers that either pay the most or have the most liberal coverage policies. All 11 carriers believe that suppliers use point of sale to get their claims to the carrier which will benefit them financially. Many of the carriers believe that point of sale has financially harmed the Medicare program.

Point of sale enables suppliers to establish multiple business locations in multiple carrier jurisdictions. These multiple locations enable some suppliers to manipulate carrier program safeguards. Carriers report that some suppliers find out a carrier's tolerances for a medical supply item and then bill up to that tolerance. When one carrier's tolerance level is reached, suppliers simply change carriers and bill until that carrier's tolerance is reached. Suppliers placed on pre or post-payment review by one carrier often establish a new base of operations in another, unsuspecting, carrier's jurisdiction.

Many carriers attempt to contact their counterparts in other parts of the country to be on the alert for problem suppliers who leave their jurisdiction. Their efforts to track and control fraudulent and abusive suppliers are hampered by point of sale and the ease with which suppliers can conceal their identity by doing business under another name.

Point of sale also hinders carrier efforts to ensure that the number of medical supplies provided to a beneficiary are reasonable and medically necessary. The accuracy of payments made for medical supplies depends, to a great extent, on Medicare carrier systems and personnel's ability to identify suspect services and intervene in their payment. Point of sale results in carriers receiving claims from all over the United States. The carriers who receive claims on behalf of beneficiaries residing outside their jurisdiction have no payment history or other information on which to make coverage or use decisions. This makes review of claims for medical necessity very complex, costly and time consuming, often relying on coordination of efforts and information by more than one carrier.

Finally, point of sale increases the risk of duplicate payments. Eight of 11 carriers have found evidence of duplicate billing. One of these carriers has evidence indicating that duplicate payments are being made by carriers for medical supplies provided to beneficiaries receiving Medicare skilled nursing benefits. The most common duplicate billing cited by carriers involves fraudulent suppliers that fragment or unbundle medical supplies sold in kits. The kit is billed to one carrier and individual components of the kit are billed to another. Carriers believe that duplicate payments caused by unbundling would be less likely to go undetected if current point of sale policies were abandoned by Medicare.

The Medicare program has paid at least $22 million in excess payments due to point of sale polices which allow large suppliers to shop around and locate their business operations in areas serviced by carriers that pay more and/or have more liberal coverage policies. Point of sale policies have also made the Medicare program vulnerable to duplicate payments and supplier actions which circumvent carrier utilization safeguards. Duplicate payments and inability of carriers to control use will add to the amount of money Medicare has lost under the current point of sale policy.

Finding #3: Point of sale increases the risk of fraud, abuse and waste.

Differences in carrier reimbursement rates for medical supplies has led to a number of schemes designed to financially enrich some suppliers. One such scheme involves the purchase of sales receipts from suppliers in lower paying carrier jurisdictions. These sales are then submitted for reimbursement to higher paying carriers.

Another scheme, investigated by the Office of Investigations (OI), involved a supplier that made initial contacts with beneficiaries at their homes. The first bill for medical supplies was sent to the carrier having jurisdiction for the beneficiary's residence. In subsequent months, beneficiaries received calls from company offices in other States. Bills were then submitted to the carrier having jurisdiction of the office where the phone call was made. By rotating billing through four different carriers, this supplier not only was able to bill the best paying carriers, but also avoided detection for providing supplies in excess of patient needs. The scheme was uncovered by the

carriers but their efforts were hindered by the number of different aliases and provider numbers used by the supplier.

Other schemes investigated by OI involve medical suppliers who not only circumvented program safeguards but also blatantly falsified claims. One criminal case involved $4 million in Medicare payments for incontinence supplies. These incontinence supplies turned out to be no more than diapers and 35 to 60 cents worth of plastic gloves, towellettes and iodine swabs in a plastic bag. The OI found that as carriers stopped paying or cut payments because the volume of services being provided to individual patients appeared excessive, the supplier simply moved to another State and began billing another carrier with a new provider number.

The OI has also successfully prosecuted suppliers who fraudulently received duplicate payments by billing one carrier for medical supply kits and another carrier for the individual components in the kits. Other cases involving duplicate payments, kickbacks, forged certificates of medical necessity and shady business arrangements are under investigation.

RECOMMENDATION

The current system for determining carrier jurisdiction for the payment of medical supplies results in a financial loss to the Medicare program.

- The HCFA should have all bills for medical supplies submitted to the carrier having jurisdiction over the beneficiary's residence rather than point of sale.

Additional savings would also accrue to the Medicare program if the same policy were applied to all of the items considered DMEPOS.

AGENCY COMMENTS ON THIS REPORT

The HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) were asked to comment on the draft of this report. Both ASPE and HCFA concur with our recommendation. We are pleased that we have reached agreement on this important policy and that HCFA is planning to modify its regulations. The full text of ASPE's and HCFA's comments are contained in Appendix A.

APPENDIX A

Draft Report Comments and OIG Response

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

AUG 9 1991

TO: Richard P. Kusserow
Inspector General

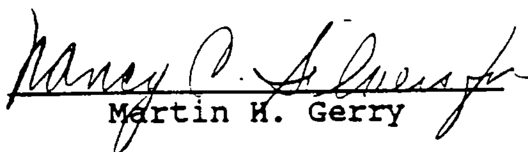
FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Carrier Shopping"
(OEI-05-91-00043)--CONCURRENCE WITH COMMENT

I concur with the draft Office of Inspector General (OIG) report entitled "Carrier Shopping" which concludes that the current system for determining carrier jurisdiction for the payment of medical supplies results in a financial loss to the Medicare program.

In order for the report to be consistent with a HCFA proposed rule on this subject (i.e., Carrier Jurisdiction for Claims for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, and Clarification of Other Issues Involving Supplier Claims, BPO--102-P), I recommend that references to "point of delivery" in the OIG report be changed to "beneficiary residence." Given that the two references reflect the same meaning, this change simply cuts down on any confusion that might result by using different references.

If you have any questions, please contact Elise D. Smith at 245-1870.



Martin H. Gerry

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

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Memorandum

Date SEP 16 1991

From Gail R. Wilensky, Ph.D.
Administrator

Subject OIG Draft Management Advisory Report: "Carrier Shopping," OEI-05-91-00043

To Inspector General
Office of the Secretary

We have reviewed the subject draft management advisory report which describes how the Health Care Financing Administration's (HCFA) current durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) billing policy of "point of sale" encourages "carrier shopping." Under the "point of sale" policy, DMEPOS suppliers bill the Medicare carrier who has jurisdiction over the site where the medical supplier met with the beneficiary or received the beneficiary's call. "Carrier shopping" refers to the practice of DMEPOS suppliers learning which carriers pay the most for an item, and establishing a billing office in that carrier's jurisdiction to maximize the supplier's payments from the Medicare program.

The report found that the "point of sale" billing policy for DMEPOS should be changed. The Office of Inspector General (OIG) recommends that HCFA should have all bills for DMEPOS submitted to the carrier having jurisdiction over the "point of delivery" rather than the "point of sale." HCFA agrees that the "point of sale" policy must be changed. However, we do not concur with the OIG recommendation as it is currently worded. HCFA advocates a policy of "beneficiary residence" rather than "point of delivery". Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please advise us if you agree with our position on the report's recommendation at your earliest convenience.

Attachment

IG ✓
PDIG ✓
DIG-AS ✓
DIG-EI ✓
DIG-OI ✓
AIG-MP
OGC/IG ✓
EX SEC
DATE SENT 9/16

HHS/OIG
OFFICE OF EVALUATION AND INSPECTION – ROV
SEP 25 1991

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Management Advisory Report - "Carrier Shopping," OEI-05-91-00043

Recommendation

The HCFA should have all bills for medical supplies submitted to the carrier having jurisdiction over the point of delivery rather than point of sale.

HCFA Response

HCFA agrees that the "point of sale" policy should be changed. OIG's report supports the decision that we have made to implement changes in the carrier jurisdiction policy for claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). However, we are concerned that OIG is using the terminology "point of delivery." We believe a more accurate description of the policy evaluated by this report is "beneficiary residence." While most beneficiaries will have mail and telephone ordered items delivered to their homes, or the nursing home within which they reside, some companies deliver to sales outlets, and the beneficiaries pick-up the ordered items. Under the "point of delivery" policy, suppliers could still manipulate the actual delivery site. HCFA would concur with this recommendation, if the term "point of delivery" was changed to "beneficiary residence."

General Comments

The OIG estimates that $26 million more was paid in 1989, under the "point of sale" policy than would have occurred under a "beneficiary residence" policy. During HCFA's study on carrier shopping, we estimated that the savings for 1 year would be $2-3 million. We believe that OIG should evaluate the effects of the following points and adjust their savings estimate accordingly:

- o Most of the difference between HCFA's and OIG's savings figures resulted because OIG used the difference in the average price paid per unit by the resident and outside carriers for each code. However, the units used by different carriers for these codes are not necessarily comparable. If the units are not equal, a difference between the average price paid per unit by the different carriers would not produce meaningful results.

This methodology also does not take into account the "cap" placed on the total amount that can be paid for dialysis supplies per patient per month. This provision, which became effective in 1990, must be considered when developing a "savings" estimate.

- OIG's sample carriers for the study were not randomly chosen. To project national savings, the carriers chosen for the study should be representative of the entire nation. Also, the sample size of the actual paid claims was too small. Only 1 percent of paid claims for calendar year 1989 were used, and only 149 national billing codes out of over 1,500 codes covering the full range of DMEPOS were examined. HCFA's savings estimate is based on a 100 percent sample.

- Of the 149 codes examined by OIG, 38 are included in the prosthetic and orthotic fee schedule. The amounts paid for these items are being reduced closer to the national average amount by the limiting price provisions in section 4153 of the Omnibus Budget Reconciliation Act of 1990. Accordingly, the new carrier jurisdiction policy will produce only limited savings with respect to these codes.

- Only 86 codes studied by OIG are for supplies that are neither covered by the fee schedule nor subject to capped reimbursement. In HCFA's study, paying claims for these codes under "beneficiary residence" rules rather than "point of sale" rules would have produced only $200,000 in savings.

- The range of codes selected by OIG for study was not appropriate because the range contains the codes for hemodialysis supplies. The high incidence of out-of-State billing for hemodialysis supplies is due to the fact that these supplies are not generally available except through mail order. We do not believe these claims should have been included in the study because it is impossible to separate the effects of the appropriate out-of-State billing for these supplies and any incidence of "carrier shopping."

- A "beneficiary residence" policy would increase payments to many small companies, primarily equipment and prosthetic companies.

OIG Response to ASPE and HCFA comments

Both ASPE and HCFA concur with our recommendation. We are pleased that we have reached agreement on this important policy and that HCFA is planning to modify its regulations.

Both ASPE and HCFA suggested changing the wording of our recommendation from "point of delivery" to "beneficiary residence." We agree with this suggestion and have changed the wording of our recommendation.

At our own initiative, we recalculated our cost estimate using the same methodology as used by HCFA in its study. This resulted in a more conservative cost estimate of $22 million versus the $26 million in our original draft report.

The HCFA had a number of comments regarding our methodology and its resulting cost estimate. Primarily, HCFA feels our sample size was inadequate because it did not included all DMEPOS procedure codes. The HCFA feels that our sample over estimates the extent of the problem. Their Carrier Jurisdiction study estimated that savings for one year would be $2-3 million if the policy were changed from "point of sale" to "beneficiary residence."

Considerable differences exist between HCFA's study and our study which could have a direct bearing on cost estimates.

- The HCFA used 1500 DMEPOS HCPCS codes. Many of which are unlikely to be bought out of area. Based on our interviews with the carriers, we targeted the 179 HCPCS acceptable to the Medicare program in the A4000 - A4999 procedure code range. We found that 149 of these 179 HCPCS were billed in 1989.

  Analysis of the HCFA study indicates that 24 of the top 100 procedure codes billed to an outside carrier were included in our study. While these 24 codes represent 15.5 percent of dollar volume for the top 100 codes in HCFA's study, they represent 40.5 percent of all out of area spending. These numbers also suggest that much of the carrier shopping occurs within the procedure codes we used in our study.

- Approximately 30 percent of data HCFA collected for its study was classified as outlier data and excluded from HCFA's analysis because extreme variations in carrier payments existed. Except for 87 line items where we could not identify the carrier for the beneficiary's residence, no data in the range of codes we studied was excluded from our analysis.

- The HCFA used 9 months of 1988 claims data. We sampled 12 months of 1989 BMAD data.

- When HCFA was unable to identify the beneficiaries residence they considered the claim to have been paid as an in area claim. We excluded cases where we were unable to identify the carrier for the beneficiary residence.

The HCFA points out that our selection of carriers was not random. We agree, our sample of carriers was not randomly chosen. The 11 carriers were chosen solely for the collection of qualitative data. Their considerable experience in processing medical supply claims was a valuable source of information for this study. However, we did not base our estimate of losses on these 11 carriers. Our estimate is based on a statistically valid BMAD sample.

The HCFA also believes that ESRD data is over represented in our sample. After discussing this issue with HCFA personnel, we examined the effect of ESRD patients on our dollar projections. We found that 19 of the 34 procedure codes listed as ESRD supplies were paid by the resident carrier in 1989; they were not out of state billings.

The HCFA admits in the executive summary of their study that:

> "A total savings of under $5 million seems unreasonable since during the last year over $2 million in overpayments have been assessed against a few urological companies for not complying with carrier jurisdiction rules."[1]

Our study did not attempt to project potential dollar savings; our estimate reflects losses due to the "point of sale" policy in 1989. We cannot attribute differences in HCFA's and our estimates to any single factor. We believe the method we used to arrive at our projections is valid and stand by our estimate that the Medicare program lost nearly $22 million in 1989.

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[1] Carrier Jurisdiction Study, September 1990, pg 3.