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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D C 20548

CIVIL DIVISION

JUN 3 0 1971

Dear Mr. Ball:

We have reviewed selected payments made by Medicare carriers for drugs and biologicals furnished to Medicare beneficiaries to find out whether the charges allowed were in accordance with Social Security Administration (SSA) criteria. A sample of claims paid by the following carriers were selected for review.

--Aetna Life Insurance Company, Portland, Oregon
--Blue Shield of Florida, Inc., Jacksonville, Florida
--California Physicians' Service, San Francisco, California
--Group Medical and Surgical Service, Dallas, Texas
--Metropolitan Life Insurance Company, Utica, New York
--Pan American Life Insurance Company, New Orleans, Louisiana

An SSA physician assisted us in our review. From the sample, the physician reviewed those claims which involved charges for drugs and biologicals and indicated his opinion as to whether, based on available documentation, the carrier should have paid for those services.

MEDICARE COVERAGE OF DRUGS AND BIOLOGICALS

Title XVIII of the Social Security Act provides, in part, that Medicare coverage of drugs and biologicals shall include:

"***services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills***"

Initial instructions issued by SSA in July 1966 provided that drugs and biologicals were covered only if they were of the type that could not be self-administered by injection. Vaccinations or innoculations were covered if they were directly related to treatment of an injury or direct exposure such as antirabies treatment, tetanus, antitoxin, etc.

SSA instructed its regional offices in April 1968 that the determination of whether the drugs or biologicals are of the type

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which can be self-administered should be based on the usual method of administration rather than on the form in which they might be given in an individual case. Although drugs and biologicals which could be self-administered were excluded from Medicare coverage, the instruction provided that charges for concurrent services which the beneficiary received, such as the administration of the injection, could be covered.

Because some carriers were having difficulties in implementing the April 1968 instructions, SSA revised its instructions in April 1969. The revised instructions changed the criteria and provided that the determination of whether a drug or biological is of a type which cannot be self-administered would be based on the usual method of administration of the form of that drug or biological as furnished by the individual physician. In other words, when a physician injects a drug which is not usually self-injected, the injection charge would be covered (regardless of whether the drug may also be available in oral form) because it was not self-administered in the form actually furnished to the patient.

Under the April 1969 instructions, the primary emphasis as to whether drugs and biologicals were covered services was placed on a determination of whether these services were reasonable and necessary for the treatment of the illness or injury for which they were administered. The instructions stated that carriers should develop guidelines to screen out injection charges that did not meet the aforementioned criteria.

CARRIERS' PROBLEMS IN IMPLEMENTING INITIAL INSTRUCTIONS

The carriers' problems in administering Medicare provisions relating to drugs and biologicals first came to our attention in fiscal year 1969 during our review of procedures used by the carriers to determine the reasonableness of physicians' charges. As part of that review, we examined a random sample of 100 claims processed by each carrier and noted that

--all six carriers were allowing charges for vitamin injections which, according to the April 1968 instructions, should have been disallowed because the usual method of administering these drugs was by tablet or other self-administerable oral form,

--all six carriers were allowing charges for unidentified injections without determining whether the injections were of the type covered by Medicare, and

--two of the carriers were allowing charges for immunizations which were not covered by the program.

The reasons given by some of the carriers for allowing these charges were that (1) SSA instructions did not specifically exclude drugs or biologicals other than insulin from Medicare coverage, and (2) it was not feasible for the carriers to attempt to obtain sufficient information on a case-by-case basis to determine whether the services were covered and medically necessary. The carriers maintained that to do so would delay processing of the claims and increase administrative costs.

CARRIERS' PROBLEMS IN IMPLEMENTING REVISED INSTRUCTIONS

Recognizing that SSA revised its instructions in April 1969, we selected for review an additional 1,200 claims (200 for each carrier) processed and paid by these carriers after March 1969 to see if carriers were still having difficulties applying SSA criteria. The claims were selected from the 5 percent sample of claims routinely submitted to SSA by Medicare carriers.

Of the 1,200 claims, 214, or about 18 percent contained charges of about $2,930 for 673 injections. The 214 claims were reviewed by an SSA physician to determine whether the charges for the injections should have been allowed or disallowed under the revised criteria.

SSA's physician reviewed claims for 673 injections and expressed the opinion that 386 injections (with charges of about $1,760) should have been disallowed and/or held in abeyance until further support was furnished to justify the claim. The following table summarizes the physician's conclusion.

Carrier	Injections claimed	Injections allowed by carriers		Injections considered disallowable by physician		Injections considered questionable by physician	
		No.	Amount	No.	Amount	No.	Amount
Aetna-Oregon	161	129	$561	83	$332	7	$ 32
California Blue Shield	65	54	254	20	89	9	45
Florida Blue Shield	111	103	394	38	150	28	99
Metropolitan-New York	95	93	339	55	257	7	19
Pan-American-Louisiana	102	97	351	24	84	12	60
Texas Blue Shield	139	135	726	83	500	20	93
Totals	673	611	$2625	303	$1412	83	$348

Of the 303 injections considered disallowable, the physician expressed his opinion that,

--124 injections should not have been paid because the nature of the injections was not identified on the claims, and

--179 injections should not have been paid because they were not considered to be compatible with acceptable and necessary treatment for the diagnosed illnesses of the beneficiary.

The physician considered payments for 83 injections questionable because additional information would be needed to determine that the services were covered under Medicare.

Although the method used to select the 1200 claims for review does not provide a sound basis to make a statistical projection, we believe the following facts illustrate the potential significance of this problem.

--Of the 673 injections for which charges were made on those claims, about 57 percent should not--in the opinion of the SSA physician--have been paid or should have been held in abeyance by the Medicare carrier until further support was furnished.

--The charge per injection averaged about $4.

--The six carriers paid about 10.5 million claims for services provided to Medicare patients during the 12-month period ending March 1970.

--Of the sample claims selected in our review, about 18 percent contained charges for injections.

We were advised by the SSA physician that before claims examiners could properly determine whether charges for injections should be covered by Medicare, the examiners need detailed guidelines showing (1) the specific injections that are considered as acceptable and necessary treatment for a particular illness and (2) the frequency that injections can be administered and still be an effective treatment for the illness. He advised us also that, if claims examiners do not have detailed instructions, a nurse or medical consultant, in most instances, would have to determine whether charges for injections should be covered.

CONCLUSIONS AND SUGGESTIONS

There appears to be some misunderstanding on the part of the carriers as to the allowability of charges for drugs and biologicals provided to Medicare beneficiaries. Because our review of claims

under the April 1969 instructions was performed at SSA headquarters and did not involve a review of the carriers' records, we were not able to determine the reasons the carriers paid for drugs and biologicals which appeared questionable.

We suggest, therefore, that SSA request the carriers to explain why they allowed charges for injections which, according to the SSA physician, should have been questioned or disallowed. We suggest also that SSA carefully review the carriers' responses to determine whether there is a need for more specific guidelines on (1) the types of drugs and biologicals considered acceptable and necessary for the treatment of specific illness, and (2) the allowable frequency of such injections.

We have discussed this matter with members of your staff and agreed to furnish them with the information developed during our review.

We would appreciate being advised of any actions you take on this matter and will be pleased to discuss the subject further with you or your staff.

Sincerely yours,

Fred D. Layton

Fred D. Layton
Assistant Director

Mr. Robert M. Ball
Commissioner of Social Security
Department of Health, Education,
and Welfare