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REPORT TO THE CONGRESS

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BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Tighter Controls Needed Over Payments For Laboratory Services Under Medicare And Medicaid

Social Security Administration and Social and Rehabilitation Service

Department of Health, Education, and Welfare

Medicare and Medicaid often pay substantially more for laboratory services than the prices charged by independent laboratories. Sometimes physicians obtain the services from laboratories at the lower prices and add large markups to their bills.

The Social Security Administration has been aware of markups on laboratory services under Medicare for several years but its efforts have not been effective in eliminating them. The Department of Health, Education, and Welfare should exercise its authority to limit amounts allowed for laboratory services under Medicare and Medicaid to the lowest levels at which such services are widely and consistently available in a locality.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the need for tighter controls over payments for laboratory services under Medicare and Medicaid. We made the review because of the rapid increase in the use of laboratory tests to aid physicians in diagnosing and treating disease.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

Contents

ABBREVIATIONS

BHI	Bureau of Health Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

TIGHTER CONTROLS NEEDED OVER PAYMENTS FOR LABORATORY SERVICES UNDER MEDICARE AND MEDICAID

Department of Health, Education, and Welfare

D I G E S T

Medicare and Medicaid programs pay for laboratory tests and often pay substantially more for such services than the prices charged by independent laboratories. Sometimes physicians obtain the services from independent laboratories at the lower prices and add large markups to their bills. (See p. 5.)

The Social Security Administration which administers Medicare for the Department of Health, Education, and Welfare (HEW) has been aware of markups on laboratory services under Medicare for several years but its efforts have not been effective in eliminating them. (See p. 14.) HEW's Social and Rehabilitation Service administers Medicaid.

HEW has contracted with organizations--Medicare carriers--to help administer Medicare and some States have contracted with organizations--fiscal agents--to help administer Medicaid.

GAO's examination of billings and payment records for 182 independent laboratory services obtained by physicians or physician groups in Florida, Georgia, California, and Arizona showed that Medicare allowed markups of $1,013, or 131 percent, on 155 services for which the physicians paid $776. (See pp. 5 to 10.)

Also, the Medicare carrier for the Washington, D.C., area allowed 116 percent more for laboratory services than the prices charged by independent laboratories where the carrier determined

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Tear Sheet. Upon removal, the report cover date should be noted hereon.

that such services generally are obtained. (See pp. 10 and 11.) Further, amounts allowed for laboratory services under Medicare and Medicaid are generally higher than prices charged by independent laboratories. (See pp. 11 and 12.)

Uniform reimbursement policies have not been established for physicians' handling charges connected with services obtained from independent laboratories. There are significant differences among carriers and fiscal agents in the treatment of physicians' handling charges. (See p. 13.)

Payments were made for independent laboratory services without assurances that the laboratories were certified to perform such services. Most carriers and fiscal agents generally assumed that laboratory services were performed in physicians' office laboratories when claims did not indicate that services were performed by an independent laboratory. (See p. 21.)

When an independent laboratory was shown, some carriers and fiscal agents determined that it was on a list of certified laboratories but did not determine whether it was certified to perform the particular tests. (See p. 22.)

RECOMMENDATIONS

The Secretary of HEW, in accordance with his authority under section 224(a) of the Social Security Amendments of 1972, should limit the amounts allowed for laboratory services under Medicare and Medicaid to the lowest charge levels at which such services are widely and consistently available in a locality. Also, the Secretary should establish a policy and issue instructions on how carriers and fiscal agents should treat amounts claimed by physicians as handling charges on services obtained from independent laboratories.

Further, the Secretary of HEW should require the Social Security Administration and the Social and Rehabilitation Service to instruct carriers and fiscal agents to specifically determine the source of laboratory services, and for services provided by independent laboratories, to pay only for services performed by laboratories certified to perform such services.

AGENCY ACTIONS

HEW concurred in GAO's recommendations and advised that proposed regulations implementing the "lowest charge level" provision of section 224(a) of the 1972 amendments have been developed and are being reviewed within the Social Security Administration and the Social and Rehabilitation Service. In addition, the Bureau of Health Insurance is developing a series of guidelines and instructions with respect to those laboratory service billings subject to the carriers' regular reasonable charge criteria. (See p. 16.)

The Bureau also plans to clarify Medicare policy on handling charges. (See p. 17.)

HEW stated that the Social Security Administration will remind the carriers that physicians' bills must identify independent laboratories used and that payment may be made only for services which the laboratories are certified to perform. The Social and Rehabilitation Service will advise the States that independent laboratories must be identified on physicians' bills and that Medicare certifications regarding services which may be paid are also applicable for Medicaid. (See p. 24.)

Tear Sheet

CHAPTER 1

INTRODUCTION

Beneficiaries under Medicare and Medicaid are protected against much of the cost of medical care. Such protection includes the costs of physicians' medical and surgical services and other services such as diagnostic tests ordinarily provided as part of a physician's services.

At the Federal level, Medicare and Medicaid are administered by the Department of Health, Education, and Welfare (HEW). To help administer the programs, HEW and some States have entered into agreements with nonprofit organizations and insurance companies (carriers or fiscal agents) to receive, process, and pay claims for services provided to eligible beneficiaries.

MEDICARE

The Medicare program, established by title XVIII of the Social Security Act (42 U.S.C. 1395), as amended, provides protection against the costs of health care for eligible persons, generally age 65 and over or disabled.

One form of Medicare protection, designated as Supplementary Medical Insurance Benefits for the Aged and Disabled (part B), is a voluntary program and covers (1) physicians' services, including those employed by or compensated through hospitals and (2) a number of other medical and health benefits including outpatient hospital services, certain home health care, and diagnostic tests performed by independent laboratories. Part B is financed by premiums collected from each eligible beneficiary electing to be covered by the program and by appropriations from the general revenues of the Federal Government.

Within HEW, the Social Security Administration's (SSA's) Bureau of Health Insurance (BHI) has the primary responsibility for administering the Medicare program. HEW has contracts with about 50 organizations, called carriers, which handle part B Medicare claims.

Under part B, payments for services provided by physicians and suppliers generally are based on reasonable charges. Section 1842 of the Social Security Act provides that, in determining the reasonable charges for services, consideration shall be given to physicians' or suppliers'

customary charges for similar services, as well as to the prevailing charges for similar services in the locality.

SSA regulations provide that the reasonable charge allowed for a service may not normally exceed the lowest of (1) the actual charge, (2) the customary charge for a similar service generally made by the physician or other person furnishing the service in the locality, or (3) the prevailing charge for a similar service in the locality.

Medicare carriers develop lists of the customary charges for services rendered by the physicians and suppliers in their service areas and develop prevailing charges based on these customary charges. Carriers update customary and prevailing charges (profiles) early in each fiscal year, using the available statistics on charges physicians and suppliers have made for services during the preceding calendar year. For example, the profiles developed for use during fiscal year 1975 were based on the charges made in 1973.

The beneficiary is usually responsible for paying the first $60 for covered medical services in each calendar year (the deductible). Medicare pays 80 percent of the reasonable charges for covered services in excess of the $60 deductible in each year, and the beneficiary is responsible for the remaining 20 percent (coinsurance).

Payment may be made either to a physician or supplier (assigned claim) or to the beneficiary (unassigned claim). If a physician takes an assignment, he agrees that the reasonable charge determined by the carrier will be the full charge and that he will not bill the beneficiary for more than the applicable deductible and coinsurance amounts. If the physician does not accept an assignment, the patient is billed for the physician's full charge and may have to pay the difference, if any, between the amount of the charge and the amount determined by the carrier to be the reasonable charge, as well as the applicable deductible and coinsurance amounts.

During fiscal year 1975, benefit payments under part B were about $3.8 billion. Approximately 24 million persons are presently enrolled under part B.

MEDICAID

The Medicaid program, established by title XIX of the Social Security Act, as amended (42 U.S.C. 1396), is a

grant-in-aid program which became effective January 1, 1966. Under this program the Federal Government shares with the States the costs of providing medical assistance to individuals--regardless of age--whose incomes and resources are insufficient to pay for health care.

State Medicaid programs are required by the Social Security Act to provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing facility services, physicians' services, home health-care services, family planning services, and early and periodic screening and treatment of eligible persons. Additional services, specified by the act, may be included in its Medicaid program if a State so chooses.

In fiscal year 1975, about 22 million people received Medicaid benefits. Depending on the per capita income in each State, the Federal Government pays from 50 to 78 percent of the costs incurred by the States' Medicaid programs. During fiscal year 1975, Medicaid benefit payments totaled about $12 billion, of which the Federal Government funded about $6.7 billion.

Within HEW, the Social and Rehabilitation Service (SRS) has the primary responsibility for administering the Medicaid program. SRS is responsible for developing program policies, setting standards, and insuring compliance with Federal legislation and regulations. The States are responsbile for initiating and administering their Medicaid programs. The nature and scope of a State's Medicaid program are contained in a State plan which, after approval by HEW, provides the basis for Federal grants to the State.

The States may contract with private organizations to help administer their programs. The responsibilities assigned to the contractors, referred to as fiscal agents, vary depending on the contractual arrangements. Some States administer the entire program through their State agencies.

Under the Medicaid program, payments for services are made as set forth in the individual State plans. Payments for many services are based on fee schedules. Participating physicians and suppliers agree that the amounts paid by Medicaid will be accepted as full payment.

SCOPE OF REVIEW

We reviewed the laws, regulations, manuals, instructions, and other documents applicable to payment for laboratory

services under Medicare and Medicaid. We made our review at SSA headquarters in Baltimore; SRS headquarters in Washington, D.C.; HEW regional offices in San Francisco, Kansas City, and Atlanta; carriers and fiscal agents involved in administering Medicare and Medicaid in the States of California, Arizona, Missouri, Georgia, Florida, Maryland, and Virginia, and in the District of Columbia; and selected laboratories in those jurisdictions. Our review covered claims for services performed during 1972, 1973, and 1974.

CHAPTER 2

EXCESSIVE PAYMENTS FOR LABORATORY SERVICES UNDER MEDICARE AND MEDICAID

Medicare and Medicaid often pay substantially more for laboratory services than the prices charged by independent laboratories. In some cases, physicians obtain the services from independent laboratories at the lower prices and receive payments that include large markups by the physicians.

The Social Security Administration (SSA) has known of markups on laboratory services under Medicare for several years, but its efforts have not been effective in eliminating them. Section 244(a) of the Social Security Amendments of 1972 gives the Secretary of Health, Education, and Welfare (HEW) the authority to limit payments for laboratory services under Medicare and Medicaid to amounts at which such services are widely and consistently available in a locality. On October 21, 1974, we suggested to the Commissioner of Social Security that use of this authority should help prevent the payment of markups. However, section 224(a) has not been implemented.

AMOUNTS PAID FOR LABORATORY SERVICES UNDER MEDICARE INCLUDE MARKUPS BY PHYSICIANS

Physicians sometimes add large markups for laboratory services obtained from independent laboratories. Medicare carriers usually pay these markups because the claims either do not show where the services were performed or indicate that the services were performed in the physicians' office laboratories.

Many laboratory officials were reluctant to cooperate with us because they feared losing physicians' business if they provided information showing amounts physicians paid for laboratory services. The laboratories that cooperated did so with the understanding that the laboratories' and physicians' names would not be disclosed. Thus, we have not discussed our findings with physicians who marked up the charges for laboratory services.

Our procedures for obtaining the data necessary to identify markups varied with each State because of differences in the availability of information on program payments to

physicians or their patients for laboratory services. Various situations in the States we visited are described below.

Florida

Although we visited several independent laboratories in Florida, only one provided such information as physicians' names, patients' names, laboratory tests made, dates of service, and amounts billed physicians. The Medicare carrier's payment records provided the prices physicians charged Medicare or beneficiaries, which we compared with the amounts independent laboratories charged the physicians for those same services.

Comparisons of 78 independent laboratory services obtained by 7 physicians (or physician groups) in Florida showed that Medicare allowed from 117 percent to 291 percent more than the physician paid for the laboratory work. On the billings reviewed, physicians paid a total of $350 for laboratory services for which Medicare was billed $965 and allowed $904.15.

In one case, a physician paid an independent laboratory $4 for a battery of tests; the physician charged $20 for the tests--a 400-percent markup--and Medicare allowed the entire amount.

The following table shows the markups for the seven physicians.

Physician	Amount paid independent laboratory	Amount billed Medicare	Amount allowed by Medicare	Markup	
				Amount	Percent
1	$ 62.00	$223.00	$186.50	$124.50	201
2	11.50	48.00	45.00	33.50	291
3	20.00	50.00	50.00	30.00	150
4	72.00	158.00	158.00	86.00	119
5	91.50	260.00	260.00	168.50	184
6	18.00	42.00	42.00	24.00	133
7	75.00	184.00	162.65	87.65	117
Total	$350.00	$965.00	$904.15	$554.15	158

In some cases, physicians indicated on their claims or billings that the services were performed in their offices. However, laboratory records showed that all 78 procedures were performed by independent laboratories. Charges to

Medicare for laboratory services involving these physicians during 1972 totaled $274,861.

In commenting on our report, Blue Shield officials stated that they have implemented several procedures to reduce such markups. For example, a system was developed to identify those laboratory procedures which are generally automated. As a result, physicians are paid no more than the reasonable charge established for an automated mode, whether they manually performed the tests or received the services from an independent laboratory.

Georgia

Four independent laboratories in the Atlanta metropolitan area furnished information that enabled us to compare the laboratories' charges to 11 physicians or physician groups for 29 independent laboratory services. Markups did not exist on three of the services involving two physicians. For the remaining 26 services, involving 9 physicians, Medicare allowed from 5 percent to 276 percent more than the physicians paid for the laboratory services. The nine physicians paid a total of $192.20 for laboratory services for which Medicare was billed $488 and allowed $409.92.

For example, a physician in Atlanta obtained a complete blood count from a local independent laboratory. The laboratory billed the physician $2.50 for this service. The physician charged $12 for the service, which was allowed by Medicare.

The following table shows the markups for the nine physicians.

Physician	Amount paid independent laboratory	Amount billed Medicare	Amount allowed by Medicare	Markup Amount	Markup Percent
1	$ 76.50	$150.00	$136.30	$ 59.80	78
2	40.00	133.00	113.95	73.95	185
3	15.00	76.00	56.40	41.40	276
4	12.50	28.00	23.35	10.85	87
5	3.00	6.00	6.00	3.00	100
6	3.00	10.00	6.80	3.80	127
7	21.00	40.00	22.12	1.12	5
8	18.00	40.00	40.00	22.00	122
9	3.20	5.00	5.00	1.80	56
Total	$192.20	$488.00	$409.92	$217.72	113

Most physicians indicated on their claims or billings that the services were performed in their offices. However, laboratory records showed that all 26 procedures were performed by independent laboratories.

California

We obtained data on billings to physicians by three independent laboratories in California. For each of the 2 Medicare carriers in the State, we examined claims for 25 procedures obtained by physicians from the 3 laboratories.

Occidental Life Insurance Company of California

For the 25 cases reviewed, physicians paid independent laboratories a total of $162.30 for laboratory services for which Medicare was billed $244.15, a markup of 50 percent. However, 10 cases were for procedures not covered by Medicare and payment was not allowed; 4 cases were for procedures for which there were either no markups or the markups were not allowed; and in 2 cases, the markups were identified as handling charges.

For the remaining 9 cases, involving 6 physicians, the amount allowed by Occidental totaled $83.90, or 64 percent more than the $51.15 the laboratories charged. A table showing these nine markups for the six physicians follows.

Physician	Amount paid independent laboratory	Amount billed Medicare	Amount allowed by Medicare	Markup Amount	Markup Percent
1	$ 5.15	$ 6.00	$ 6.00	$ .85	17
2	4.50	7.50	7.50	3.00	67
3	4.50	8.00	8.00	3.50	78
4	12.50	20.00	18.40	5.90	47
5	10.00	20.00	20.00	10.00	100
6	14.50	25.00	24.00	9.50	66
Total	$51.15	$86.50	$83.90	$32.75	64

Although all nine procedures were performed by independent laboratories, the physicians indicated on four claims that the procedures were performed in their own offices. For the remaining five cases, there was no indication as to where the procedures were performed.

Blue Shield of California

For the 25 cases we reviewed, physicians paid independent laboratories a total of $97 for services for which Medicare was billed $224, a markup of 131 percent. Medicare allowed $198 of the $224. The entire markup was allowed in 23 of the 25 cases. On the two cases where the markups were not allowed, the physician indicated on the billing the name of the laboratory that did the work. On four cases where the physicians indicated the name of the laboratory and identified the additional amounts as handling charges, they were allowed. In one case, the physician indicated the name of the laboratory but did not identify the markup as a handling charge, and the markup was allowed. However, this appeared to result from a clerical error.

The 19 cases where markups, other than handling charges, were allowed for payment by Blue Shield involved claims submitted by 4 physicians. These markups totaled $83 or 160 percent more than the $52 charged by the laboratories. A table showing these 19 markups for the 4 physicians follows.

Physician	Amount paid independent laboratory	Amount billed Medicare	Amount allowed by Medicare	Markup Amount	Markup Percent
1	$24.00	$ 76.50	$ 76.50	$52.50	219
2	14.50	24.50	24.50	10.00	69
3	6.50	14.00	14.00	7.50	115
4	7.00	20.00	20.00	13.00	186
Total	$52.00	$135.00	$135.00	$83.00	160

All 19 procedures were performed by independent laboratories. The physicians indicated that the procedures were performed by an independent laboratory in one case and in their own offices for seven cases. There was no indication as to where the procedures were performed for the remaining 11 cases.

Arizona

At Aetna Life and Casualty, the Medicare carrier, we examined physicians' claims for 25 procedures obtained from two laboratories. Physicians paid the laboratories $153.50 for the services for which Medicare was billed $305, a markup of 99 percent. The markups ranged from $.50 to $16. The

highest markup was 300 percent, a $2.50 test billed by a physician as $10. The entire markup was allowed for 17 of the 25 procedures and partially allowed for six procedures.

The 23 cases where markups were allowed by Aetna involved claims submitted by 13 physicians. The markups totaled $124.90, or 96 percent more than the $130.50 charged by the laboratories. A table showing the markups for the 13 physicians follows.

Physician	Amount paid independent laboratory	Amount billed Medicare	Amount allowed by Medicare	Markup Amount	Markup Percent
1	$ 5.00	$ 11.00	$ 11.00	$ 6.00	120
2	7.00	20.00	15.00	8.00	114
3	9.50	30.00	26.00	16.50	174
4	7.00	15.00	15.00	8.00	114
5	7.00	13.00	13.00	6.00	86
6	6.00	12.00	12.00	6.00	100
7	6.00	15.00	15.00	9.00	150
8	14.00	21.00	21.00	7.00	50
9	9.00	32.00	25.00	16.00	178
10	10.00	21.00	20.00	10.00	100
11	16.00	25.50	25.50	9.50	59
12	26.00	46.50	43.90	17.90	69
13	8.00	13.00	13.00	5.00	63
Total	$130.50	$275.00	$255.40	$124.90	96

Although all 23 procedures were performed by independent laboratories, the physicians' claims indicated that 19 were performed in their own offices. For the remaining four cases, there was no indication as to where the procedures were performed.

Washington, D.C., metropolitan area

Medical Service of the District of Columbia, the Medicare carrier for the Washington, D.C., metropolitan area, allowed considerably more for laboratory services than the prices charged by independent laboratories where the carrier determined that such services generally are obtained. We did not determine where the services were obtained.

We compared the amounts Medicare paid 12 physicians or groups of physicians for 10 selected laboratory procedures with the prices charged by independent laboratories. The

physicians generally did not indicate that the laboratory services were performed by an independent laboratory. However, a telephone survey of physicians conducted by the carrier in early 1974, showed that many physicians were using independent laboratories and identified the laboratories generally used. We selected, for the comparison, the laboratories identified by the carrier as most often used by each physician.

In most instances, the amounts Medicare allowed for the services were much higher than the independent laboratories' charges.

The amounts physicians billed, the amounts Medicare allowed, and the amounts the independent laboratories usually charged the physician for the laboratory services are shown in the following table.

Amounts Allowed By Medicare in Excess of Prices for Services by Independent Laboratories

Physician	Amount physician billed	Amount allowed by Medicare	Independent laboratories' price	Excess allowed by Medicare Amount	Excess allowed by Medicare Percent
1	$ 6,384.00	$ 4,548.35	$ 1,796.00	$ 2,752.35	153
2	8,133.20	6,285.20	3,598.50	2,686.70	75
3	4,103.50	2,741.50	1,396.00	1,345.50	96
4	8,378.00	7,512.25	3,285.00	4,227.25	129
5	5,473.20	4,876.45	2,207.00	2,669.45	121
6	3,756.00	3,676.50	1,827.00	1,849.50	101
7	5,747.50	4,228.70	1,755.00	2,473.70	141
8	2,313.50	1,931.50	1,097.00	834.50	76
9	2,320.50	1,830.50	1,305.50	525.00	40
10	2,252.00	1,677.00	860.40	816.60	95
11	16,081.50	11,547.20	4,448.00	7,099.20	160
12	200.00	141.50	76.50	65.00	85
Total	$65,142.90	$50,996.65	$23,651.90	$27,344.75	116

AMOUNTS ALLOWED FOR LABORATORY SERVICES ARE HIGHER THAN PRICES CHARGED BY INDEPENDENT LABORATORIES

We compared physicians' prevailing charges for laboratory procedures established by the Medicare carriers in Missouri

and the Washington, D.C., metropolitan area with the prices independent laboratories in those areas charged. Also, we compared the fee schedules established by the District of Columbia, Maryland, and Virgina Medicaid agencies for 10 selected laboratory procedures with the highest price charged for each of the procedures by independent laboratories.

The amounts allowed under both Medicare and Medicaid were generally higher than the prices charged by independent laboratories. A discussion of independent laboratory prices, Medicare prevailing charges in Missouri and the Washington, D.C., metropolitan area, and Medicaid charge limits in Maryland, Virginia, and the District of Columbia follows.

Missouri

We compared the physicians' prevailing charges for 10 laboratory procedures established by 2 Medicare carriers in Missouri with the prices being charged for the procedures by 3 independent laboratories in Kansas City and 3 independent laboratories in the St. Louis area. (See app. I.)

The Kansas City physicians' prevailing charges for the 10 procedures totaled $78.50 and the highest prices for the procedures at the Kansas City laboratories totaled $57.50, a difference of $21, or 37 percent.

The St. Louis physicians' prevailing charges for the 10 procedures totaled $87.40 and the highest prices for the procedures at the St. Louis laboratories totaled $70, a difference of $17.40, or 25 percent.

Washington, D.C., metropolitan area

Medicare

Physicians' prevailing charges for 10 laboratory procedures established by Medical Service of the District of Columbia totaled $86, and the highest prices of the independent laboratories for the procedures totaled $50.25, a difference of $35.75, or 71 percent. (See app. II.)

Medicaid

Medicaid fees for the District of Columbia, Maryland, and Virginia generally exceeded the highest independent laboratory prices for the same services. The largest price differences were in Virginia where the Medicaid fee of $79

for nine procedures exceeded the highest independent laboratory price of $42.75 by $36.25, or 85 percent. For example, the Medicaid fee of $20 for triglycerides exceeded the highest independent laboratory price of $6 by $14, or 233 percent.

Although the overall price differences were not as great in Maryland and the District of Columbia as in Virginia, there were considerable differences on some procedures. For example, the Maryland Medicaid fee of $8.50 for triglycerides exceeded the highest independent laboratory price of $6 by $2.50, or 42 percent, and the District of Columbia Medicaid fee of $20 for an SMA-12 exceeded the highest independent laboratory price of $7.50 by $12.50, or 167 percent.

District of Columbia Medicaid officials said they are working on a new fee schedule which will permit grouping automated tests at correspondingly lower fees. When the fees are finalized, they expect that only those laboratories or physicians who are efficient and automated will be willing to provide those particular tests.

A comparison of the Medicaid fees and the highest independent laboratory prices for selected procedures is shown in appendix III.

INCONSISTENT TREATMENT OF PHYSICIANS' HANDLING CHARGES

SSA and the Social and Rehabilitation Service (SRS) have not issued any instructions or guidelines as to how carriers or fiscal agents should treat amounts claimed by physicians as handling charges on services obtained from independent laboratories. Some carriers and fiscal agents allow handling charges on procedures performed by independent laboratories. Others do not.

Following are examples of how Medicare carriers and Medicaid fiscal agents treat physicians' handling charges.

--The only collection and handling charge allowed under Medicare by Blue Shield of California is for the drawing of blood specimens regardless of whether or not the physician is billing for the laboratory tests.

--Medicaid in Maryland does not allow physicians additional fees for specimen collection. Such fees are restricted to independent laboratories and only

in those cases where medical necessity requires special handling.

--Medicaid in Missouri does not allow any handling charges on laboratory services.

--Medicaid in Virginia does not allow any handling charges on laboratory procedures billed by a physician. Physicians are allowed a fee, however, for their interpretation and report on laboratory services if they are not also billing for the complete procedure. Such fees ranged from $1.50 to $7.50 for 10 laboratory procedures we selected for review.

CONCLUSIONS

SSA has been aware of large markups on laboratory services under Medicare for several years. A November 1972 report on a study of laboratories by the Bureau of Health Insurance (BHI) regional office in Atlanta stated that Medicare had allowed charges by physicians in Florida as high as 1,300 percent, and averaging about 420 percent, of the amounts charged by independent laboratories.

We examined billings and payment records for 182 independent laboratory services obtained by physicians or physician groups in the States of Florida, Georgia, California, and Arizona. Ten of the services were not covered by Medicare and there were no markups or the markups were not allowed on 17 services. Physicians paid independent laboratories $776 for the remaining 155 services for which Medicare was billed $1,950, a markup of 151 percent. The markups allowed for payment by the carriers for these procedures totaled $1,013, or 131 percent more than the $776 laboratories charged.

In other cases where we did not ascertain the source of services, Medicare and Medicaid paid substantially more for laboratory services than the prices being charged by independent laboratories in the area.

In 1968, SSA informed its carriers of the importance of determining whether laboratory services were performed in a physician's office or by an independent laboratory. If the physician obtained the service from an independent laboratory, the carriers were required to determine the reasonable charge for the service on the basis of the independent laboratory's charge to the physician. Carriers,

however, were permitted to assume, in the absence of information to the contrary, that tests were performed in the physician's office unless bills identified an independent laboratory.

In November 1973, SSA revised its instructions to require that the laboratory where the services were obtained must be identified. However, four of the eight carriers and six of the seven fiscal agents we visited generally assumed that laboratory services were performed in physicians' office laboratories when claims did not indicate where the services were performed. (See p. 21.) In addition, many of the physicians' claims or billings indicated that the services were performed in their offices, while laboratory records showed that the work was performed by independent laboratories.

Although not binding on physicians, the American Medical Association's resolution 71 states that:

> "The attending physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission, or profit on the services rendered by a laboratory is exploitation of the patient."

Sections 1842(b)(3)(E) and 1903(i)(1) of the Social Security Act, as amended by section 224(a) of the Social Security Amendments of 1972 (H.R. 1), gives the Secretary of HEW the authority to establish reasonable charges for laboratory services under Medicare and Medicaid at the lowest charge levels at which such services are widely and consistently available in a locality.

The report of the Senate Committee on Finance accompanying H.R. 1 stated that:

> "The Committee believes that it would be advisable for the Secretary to give priority attention to items of service or equipment most frequently paid for under the program. The committee also believes that there are certain items of service for which special reasonable charge rules can be readily established. * * * schedules of allowances should be established by geographic or medical service area, where appropriate, for routine laboratory work--including interpretation of results--for tests not ordinarily included in the charge for a physician's

visit. The scheduled allowance should be based on the costs of tests (including common groupings of tests) when undertaken by qualified, efficient, and economical sources--such as independent automated laboratories--to which physicians in an area have reasonable access." [S. Rept. 1230, 92d Cong., 2d sess. 193.]

In an October 21 1974, letter to the Commissioner of Social Security, we suggested that implementation of section 224(a) could reduce the costs to Medicare for laboratory services and should help to prevent physicians from being paid amounts they mark up on services obtained from independent laboratories. However, SSA has not implemented section 224(a) to limit the amounts paid for laboratory services.

There is a need to establish a policy and instruct carriers and fiscal agents on how to treat claims by physicians for handling charges on services obtained from independent laboratories.

RECOMMENDATIONS

We recommend that the Secretary of HEW, in accordance with his authority under section 224(a) of the Social Security Amendments of 1972, limit the amounts allowed for laboratory services under Medicare and Medicaid to the lowest levels at which such services are widely and consistently available in a locality.

We recommend also that the Secretary establish a policy and issue instructions on how carriers and fiscal agents should treat amounts claimed by physicians as handling charges on services obtained from independent laboratories.

AGENCY AND OTHER COMMENTS

HEW provided their comments on our findings and recommendations in a letter dated July 20, 1976. (See app. IV.) HEW concurred in our recommendations and said that proposed regulations implementing the "lowest charge level" provision of section 224(a) of the 1972 Amendments have been developed and are being reviewed within SSA and SRS. In addition, BHI is developing a series of guidelines and instructions with respect to those laboratory service billings subject to the carriers' regular reasonable charge criteria.

According to HEW, BHI is revising its Part B Intermediary Manual to instruct carriers in paying for laboratory tests

using automated equipment. The instructions will direct the carriers to recognize the effect of automated testing on reasonable charges. HEW mentioned action by a number of carriers to reduce excessive payments to physicians for tests performed by independent laboratories. These carriers, including Blue Shield of Florida (see p. 7,) have established guidelines whereby laboratory services generally performed on automated equipment will be paid at the automated rate.

According to HEW, Medicare policy permits carriers to allow a nominal amount for the drawing of specimens and other handling charges, where it is the customary practice of the physician and the accepted medical and prevailing practice in the locality to make such charges. (However, BHI officials advised us there were no specific instructions stating this policy, although it had been informally communicated to the regional offices over the years in response to specific inquiries.)

HEW stated that guidelines being developed will clarify Medicare policy on handling charges so that it can be uniformly applied by all carriers. The guidelines will also help prevent overly generous interpretations of the term "nominal amount."

American Medical Association comments

In commenting on our draft report (see app. V), the American Medical Association stated that it did not believe our small sample of laboratory services justified the conclusion that Medicare and Medicaid often pay substantially more for laboratory services than the prices charged by independent laboratories.

Our statement regarding Medicare and Medicaid payments is based not only on the cases where there were markups, but also on comparisons of the Medicare and Medicaid allowances for laboratory services performed by physicians with the amounts independent laboratories charge for such services. Excluding Maryland's Medicaid program, the amounts allowed physicians were usually much higher.

Not only did our review show that in some cases physicians obtained the services from independent laboratories and added large markups to their bills, but also SSA's 1972 study (see p. 14) indicated that physicians were routinely adding markups to charges by independent laboratories.

The Association also stated that there is nothing in the report which would deny justification for the markups and notes that we did not discuss them with the physicians. As discussed on page 5, to obtain cooperation from laboratories which were concerned about losing the physicians' business, we agreed not to contact the physicians.

We do not take exception to paying physicians' handling charges. Amounts identified as handling charges on the claims we examined were not considered markups. The markups we discussed involved claims where (1) it was falsely stated that the physician performed the tests or (2) it was not indicated where the tests were performed, although Medicare regulations and American Medical Association policy call for physician disclosure of the independent laboratory.

The Association was also concerned that an overly strict interpretation of section 224 of Public Law 92-603 could result in allowed charges being based solely in terms of costs without the availability, quality, and continuity of services being properly considered. The Association stated that beneficiaries of Federal programs should not be denied services which are, in the judgment of the attending physician, most appropriate for the patient.

Section 224 requires that reasonable charges be based at the lowest charge levels at which such services are widely and consistently available in a locality. Thus, a strict interpretation should satisfy the Association's concern about availability and continuity.

Independent laboratories must meet HEW standards in order to be certified to perform specific tests. The following chapter of our report points out the need for greater efforts to assure that laboratories be paid only for tests they are certified to perform. While laboratory services provided by physicians' office laboratories are not subject to HEW's standards, enforcement of certification should help assure the quality of services provided by the independent laboratories.

Section 224 relates to the amounts to be paid for services rather than whether such services are reimbursable. Thus, we assume the Association's concern that beneficiaries may be denied necessary services is based on the belief that an inadequate allowed charge could result in nonavailability of needed services. The section 224 requirement that rates be based on charges at which services are widely and consistently available should prevent this possibility.

We also obtained comments from the carriers and fiscal agents discussed in our report and their views have been considered in the report.

CHAPTER 3

INADEQUATE CONTROLS TO ASSURE THAT LABORATORY SERVICES ARE PROVIDED BY APPROVED LABORATORIES

To qualify for reimbursement under the Medicare program, independent laboratory services must be provided by independent laboratories certified for Medicare participation under section 1861(s)(10) and (11) of the Social Security Act. Where State or local laws provide for licensing laboratories, the laboratories must be licensed pursuant to such law or be approved by the State or locality responsible for such licensure. Also, the statute requires that independent laboratories meet such standards as the Secretary of HEW finds necessary to assure the health and safety of individuals for whom tests are performed.

The conditions for certification were developed by the Social Security Administration (SSA) and the Public Health Service in consultation with such groups as the American Society of Clinical Pathologists, the College of American Pathologists, the American Association of Bioanalysts, and State health departments.

These conditions involve the supervision and qualifications of laboratory personnel, proficiency testing, competency to perform certain tests, and the maintenance of laboratory records, equipment, and facilities.

Under agreements entered into with the Secretary of HEW, State agencies determine whether independent laboratories meet the conditions for participating under Medicare. Based on the State agencies' determinations that independent laboratories meet the conditions for participation, the Bureau of Health Insurance (BHI) regional offices send the laboratories written notices of certification. The State agencies also resurvey laboratories to ascertain continued compliance with requirements for participating in Medicare.

Independent laboratories are to be reimbursed only for procedures within the specialities or subspecialities for which they are certified to perform. SSA furnishes quarterly lists to carriers showing the specialities and subspecialities for each certified laboratory.

Until November 1973, SSA instructions provided that

> "When an attending physician providing services in an office setting includes in his bill services obtained from a laboratory outside of his office, the laboratory where the services were obtained should be identified."

Carriers were permitted to assume, in the absence of information to the contrary, that tests were performed in the physician's office unless bills identified an independent laboratory. Information to the contrary included such things as tests not normally performed in physicians' offices, tests not usually performed by the particular physician, and tests requiring special equipment when the physician does not specialize in this field of testing. In November 1973, SSA revised its instructions to require that the laboratory where the services were obtained must be identified.

Carriers are permitted to develop and maintain current files showing tests particular physicians customarily perform in their own laboratories or establish a similar method for determining a physician's source of laboratory services. If a physician's bill does not indicate the source of laboratory services and the carrier cannot determine the source from information in its files, the carrier is to determine such source by contacting the physician.

To be eligible for Medicaid reimbursement, a laboratory must be either participating under Medicare or meet the requirements for participation. The Social and Rehabilitation Service (SRS) has not, however, issued any instructions or guidelines requiring fiscal agents to determine the source of laboratory services if not shown on the claim.

SOURCE OF LABORATORY SERVICES NOT IDENTIFIED

Physicians often do not identify the sources of laboratory services on their Medicare and Medicaid claims. In such cases, carriers and fiscal agents sometimes assume that the services were performed in the physicians' office laboratories. As a result, they may pay for services performed by independent laboratories that are not certified to provide the services.

Four of the eight carriers and six of the seven fiscal agents we visited generally assumed that laboratory services were performed in physicians' office laboratories when claims

did not indicate they were performed by an independent laboratory.

For example, we selected 73 Medicaid claims for laboratory services submitted to the Missouri Division of Family Services. The Division assumed that the services were performed in physicians' office laboratories, although none of the claims identified where the services were performed. Division officials told us they are preparing instructions to physicians and independent laboratories which will require identifying the facility performing the laboratory procedures.

PAYMENT FOR SERVICES WITHOUT ASSURANCE THAT LABORATORIES ARE CERTIFIED TO PERFORM SUCH SERVICES

Carriers and fiscal agents paid for independent laboratory services without assurances that the laboratories were certified to perform such services. Three of eight carriers and five of seven fiscal agents we visited determined that laboratories were on a list of certified laboratories but did not determine that the laboratories were certified to perform the particular tests included on claims. We determined that, in some instances, Medicare and Medicaid paid for tests performed by laboratories not certified to perform the tests.

Examples of the situations we found are presented below.

Blue Shield of Florida--the Medicare carrier for all but two Florida counties (before July 1, 1975, Blue Shield was the carrier for the entire State of Florida)--does not insure that payments are made only for tests performed by laboratories certified to perform such tests. Blue Shield officials told us that, if a laboratory is certified for at least one specialty, their policy is to allow payments for any work performed by the laboratory.

We did not attempt to estimate total payments made for services provided by laboratories not certified to perform such services. However, our analysis of payments made by the carrier to 10 independent laboratories during 1973 showed that 6.5 percent of all payments to 8 of the laboratories were for procedures they were not certified to perform.

A carrier official told us that specialty screens were installed in the computer system in January 1976 to assure correct payments to independent laboratories.

The Missouri Division of Family Services--the Medicaid fiscal agent for Missouri--determines whether laboratories are certified for Medicare, but does not determine whether laboratories are certified to perform the tests included on claims. Our review of 58 claims received by the Division from 10 laboratories showed that 11 of the claims were for tests performed by laboratories not certified to perform the tests.

The Florida Division of Family Services--the Medicaid fiscal agent for Florida--only checked to determine whether laboratories providing services were State licensed. As a result, the Division paid for services provided by 19 independent laboratories that were not certified by Medicare. We found that 4 of the laboratories were paid about $8,900 during a 16-month period. After we brought this matter to the attention of Division officials, they established procedures requiring that payments be made for independent laboratory services only when provided by laboratories certified by Medicare to perform the services.

Officials of Blue Shield of Kansas City--the Medicare carrier for 30 Missouri and 2 Kansas counties--told us that their computer is programed to determine whether a laboratory is certified for Medicare, but was not programed to determine which tests a laboratory is certified to perform. Thus, claims may have been paid for tests performed by laboratories not certified to perform the tests. In commenting on our report, Blue Shield officials stated that each quarter they select a number of claims submitted by each independent laboratory and manually check them against their records to see if the laboratories are certified to perform the tests. When the laboratories are not certified they deny payment.

The Department of Human Resources--the Medicaid fiscal agent for the District of Columbia--determines whether laboratories are certified for Medicare, but does not determine whether laboratories are certified to perform the particular tests included on claims.

CONCLUSIONS

Since (1) many physicians, as discussed above and in Chapter 2, do not identify the sources of laboratory services on their Medicare and Medicaid claims and (2) many carriers and fiscal agents erroneously assume that when the source of laboratory services is not identified, such services are provided in the physicians' offices, we believe that SSA and SRS should require that physicians indicate whether the services were provided in the physician's office or an independent laboratory.

Where the services are provided by independent laboratories, the carriers and fiscal agents should be required to (1) ascertain whether the laboratories are certified to perform such services and (2) pay only for services performed by laboratories certified to perform such services.

RECOMMENDATION

We recommend that the Secretary of HEW instruct SSA and SRS to require carriers and fiscal agents to determine the source of laboratory services, and for services provided by independent laboratories, to pay only for services performed by laboratories certified to perform such services.

AGENCY COMMENTS

HEW concurred in our recommendation and stated that SSA will remind the carriers that physicians' bills must identify independent laboratories used and that payment may be made only for services which the laboratories are certified to perform. SRS will advise the States that independent laboratories must be identified on physicians' bills and that Medicare certifications regarding services which may be paid are also applicable for Medicaid.

We believe that the actions which SSA and SRS plan to take should provide greater assurance that laboratory services reimbursed under Medicare and Medicaid are provided by approved laboratories.

PHYSICIANS' PREVAILING CHARGES AND PRICES CHARGED BY INDEPENDENT LABORATORIES IN MISSOURI

Laboratory procedure	Physicians' prevailing charges	Independent laboratory price			Physicians' prevailing charge higher (lower) than highest independent laboratory price
		Lab A	Lab B	Lab C	
Blue Shield of Kansas City					
Complete blood count	$ 6.50	$5.00	$6.00	$6.00	$ .50
Blood urea nitrogen	5.00	4.00	5.00	3.00	-
Cholesterol	5.00	4.00	5.00	3.00	-
Sodium	6.00	3.00	5.00	3.00	1.00
Potassium	6.00	4.00	5.00	3.00	1.00
Total protein	5.00	3.00	5.00	4.50	-
Protein bound iodine	10.00	Not done	Not done	3.75	6.25
Triglycerides	10.00	5.00	10.00	4.50	-
T4	10.00	6.00	Not done	6.00	4.00
SMA-12	15.00	5.00	Not done	6.75	8.25
Total	$78.50				$21.00
General American Life Insurance Company					
Complete blood count	$ 6.00	$ 6.00	$3.00	$4.00	-
Blood urea nitrogen	5.00	5.00	1.50	2.00	-
Cholesterol	5.00	5.00	1.50	3.00	-
Sodium	5.00	6.00	3.00	3.00	($1.00)
Potassium	10.00	6.00	3.00	3.00	4.00
Total protein	5.40	Not done	3.00	3.00	2.40
Protein bound iodine	10.00	Not done	4.00	5.00	5.00
Triglycerides	10.00	10.00	5.00	6.00	-
T4	15.00	9.00	7.50	5.00	6.00
SMA-12	16.00	15.00	7.50	5.00	1.00
Total	$87.40				$17.40

PHYSICIANS' PREVAILING CHARGES AND PRICES CHARGED BY INDEPENDENT LABORATORIES IN THE WASHINGTON, D.C. METROPOLITAN AREA

Procedure	Physicians' prevailing charges	Independent laboratory price					Physicians' prevailing charge higher (lower) than highest independent laboratory price
		Lab A	Lab B	Lab C	Lab D	Lab E	
Complete blood count	$ 6.50	$3.00	$3.15	$3.85	$2.00	$2.50	$ 2.65
Blood urea nitrogen	5.00	2.00	2.70	2.10	1.00	1.75	2.30
Cholesterol	5.50	2.00	2.70	2.10	1.00	1.75	2.80
Sodium	5.00	2.00	2.70	3.85	2.50	3.00	1.15
Potassium	5.00	2.00	2.70	3.65	5.50	3.00	(.50)
Total protein	8.00	3.00	2.70	3.85	3.00	2.00	4.15
Protein bound iodine	10.50	4.00	6.80	3.65	2.00	2.50	3.70
Triglycerides	10.00	4.00	4.75	6.00	5.00	5.00	4.00
T4	10.50	4.00	7.50	5.75	6.00	5.00	3.00
SMA-12	20.00	6.00	6.80	5.75	5.00	7.50	12.50
Total	$86.00						$35.75

MEDICAID FEES AND HIGHEST INDEPENDENT LABORATORY PRICES IN THE WASHINGTON, D.C. METROPOLITAN AREA

Procedure	Highest independent lab price	DISTRICT OF COLUMBIA Medicaid fee amount	DISTRICT OF COLUMBIA Medicaid fee higher (lower) than highest independent lab price	MARYLAND Medicaid fee amount (note a)	MARYLAND Medicaid fee higher (lower) than highest independent lab price	VIRGINIA Medicaid fee amount	VIRGINIA Medicaid fee higher (lower) than highest independent lab price
Complete blood count	$3.85	$ 4.00	$ .15	$ 5.25	$1.40	$10.00	$ 6.15
Blood urea nitrogen	2.70	2.40	(.30)	3.50	.80	5.00	2.30
Cholesterol	2.70	4.00	1.30	3.75	1.05	5.50	2.80
Sodium	3.85	4.00	.15	4.25	.40	6.00	2.15
Potassium	5.50	4.00	(1.50)	4.25	(1.25)	5.00	(.50)
Total protein	3.85	8.00	4.15	3.50	(.35)	5.00	1.15
Protein bound iodine	6.80	8.00	1.20	6.25	(.55)	10.00	3.20
Triglycerides	6.00	16.00	10.00	8.50	2.50	20.00	14.00
T4	7.50	-	-	7.00	(.50)	12.50	5.00
SMA-12	7.50	20.00	12.50	10.50	3.00	-	-

a/Where medical necessity requires special handling, the Maryland program also allows specimen collection and referral fees to independent laboratories that range from $1.75 to $5.25. These amounts are not reflected in the above fees.

APPENDIX IV

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUL 20 1976

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Need for Improved Controls Over Costs of Laboratory Services Under Medicare and Medicaid." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX IV

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED, "NEED FOR IMPROVED CONTROLS OVER COSTS OF LABORATORY SERVICES UNDER MEDICARE AND MEDICAID"

General

The Social Security Administration has been aware of the problem of physicians adding markups to charges by independent laboratories and considerable effort has and is being made by SSA to correct this situation. Carriers have been alerted concerning the importance of determining whether laboratory services were performed in the office of the physician or by an independent laboratory. If the physician purchases the service from an independent laboratory, the carriers are required to determine the reasonable charge for the service on the basis of the independent laboratory's charge to the physician. The carriers have been advised to develop profiles on physicians in their service area which would indicate the laboratory tests commonly performed in the physician's office, the tests usually referred to an independent laboratory, and the name of the laboratory to which the tests were referred. The carriers have also been advised to train their staffs to utilize the profiles and to recognize these situations so that appropriate determinations of reasonable charges would be made.

There are, however, practical limitations on the extent to which independent laboratory involvement in the services provided by physicians can be detected through claims review procedures. For this reason, we are now attempting to resolve this problem by attacking its fundamental source, the differential between charges allowed for tests performed by physicians and by independent laboratories. Further information on our current efforts is presented as indicated in our comments on the specific recommendations included in the report.

Over the past several years there has been a dramatic increase in the number of large laboratories capable of running tests using automated equipment. The cost per test at the automated laboratory is substantially lower than the cost of manual testing which would be found in the smaller laboratory or in the physician's office. The Bureau of Health Insurance is revising its Part B Intermediary Manual to instruct carriers in paying for laboratory tests utilizing automated equipment. In brief, the instructions direct the carriers to recognize the effect of automated testing on reasonable charges. In this connection, action has been taken by a number of carriers--including Florida Blue Shield, which is cited in the GAO report--to reduce excessive payments to physicians for laboratory tests they personally did not perform. These carriers, in consultation with pathologists and members of the medical community, have established guidelines whereby laboratory services commonly performed by automated equipment will be paid at the automated rate.

The Department's comments on the specific recommendations in GAO's draft report are set forth below.

GAO Recommendation

That the Secretary, HEW:

--In accordance with his authority under section 224(a) of the Social Security Amendments of 1972, limit the amounts allowed for laboratory services under Medicare and Medicaid to the lowest charge levels at which such services are widely and consistently available in a locality;

--Establish a policy and issue instructions on how carriers and fiscal agents should treat amounts claimed by physicians as handling charges on services obtained from independent laboratories.

Department Comment

Proposed regulations implementing the "lowest charge level" provision of section 224(a) of the 1972 Amendments have been developed and are being reviewed within the Social Security Administration and the Social and Rehabilitation Service. The Bureau of Health Insurance is also developing a series of guidelines and instructions with respect to those laboratory service billings subject to the carriers' regular reasonable charge criteria--i.e., customary and prevailing charges. In this connection, Medicare policy permits carriers to allow a nominal amount for the drawing of specimens and other handling, where it is the customary practice of the physician and the accepted medical and prevailing practice in the locality to make such charges. The guidelines will clarify the policy, so that it can be uniformly applied by all carriers. The guidelines will also help prevent overly generous interpretations of the term "nominal amount." At present, the schedule of payments allowed under Medicare for similar services would be the upper limit for charges which could be recognized under Medicaid.

GAO Recommendation

That the Secretary of HEW instruct SSA and SRS to require carriers and fiscal agents to determine the source of laboratory services and, for services provided by independent laboratories, to pay only for services which the laboratories are certified to perform.

Department Comment

GAO's report recognizes that, on a quarterly basis, SSA does supply each carrier with a list showing the specialities and subspecialities that each independent laboratory is certified to perform. The report recognizes also that Medicare instructions require that the laboratory at which

services were obtained must be identified in physicians' billings. SSA will remind the carriers that physicians' bills must identify independent laboratories used and that payment may be made only for services which the laboratories are certified to perform. SRS will advise the States that independent laboratories must be identified on physicians' bills and that Medicare certifications regarding services which may be paid are controlling also for Medicaid.

Other Matters Discussed in GAO's Draft Report

On the draft report cover, in the Digest section, and in the body of the report, a statement is made to the effect that for several years SSA has been aware of significant markups on laboratory services but has not taken corrective action. Earlier in these comments, we described some of the steps SSA has taken to alleviate the problem of physician markups. In light of the numerous steps that have been taken, we believe that the statement in the report is incorrect and should be deleted.

[See GAO note.]

GAO note: Material no longer related to this report has been deleted.

APPENDIX V

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(751-6200)

June 17, 1976

Mr. Gregory J. Ahart
Director
United States General
Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

This is in response to your submission to us for review of a draft GAO report entitled "Need for Improved Controls Over Costs of Laboratory Services Under Medicare and Medicaid." We appreciate having the opportunity to review the document.

The draft report raises concerns inasmuch as the findings of GAO suggest that some physicians have billed for laboratory services in excess of proper charges. To the extent that any charges are improper, the AMA deplores such practice. As you know, this Association has long had a policy viewing such practices as unprofessional.

Our policy was well stated during the Annual meeting of the House of Delegates in 1969 in both a Judicial Council Report and in a Resolution of the House of Delegates, both of which statements were adopted by the House of Delegates.

The Resolution adopted at that time set out the AMA policy and view that it is preferable that the laboratory, and not the attending physician, bill and collect from the patient or third party payor for laboratory services. It did, however, recognize that "where circumstances make this impractical or where increased costs to the patient would result, the bill submitted by the attending physician to his patient or third party payor should state the name of the laboratory performing the services for his patient and the exact amount of the charge paid or to be paid by the physician to the laboratory." The policy statement also recognized that the attending physician is entitled to "fair compensation for the professional services he renders."

As to laboratory services which the physician performs for his own patients, his bill should provide information to show where such services were performed, as well as an adequate description of the services provided and the specific charges made.

That policy as adopted does not, however, contemplate that a physician forwarding a sample to a laboratory should not be entitled to a fair charge for his own professional service, which may include an interpretation of results of the laboratory tests, and does not preclude any proper handling charges for collecting and forwarding samples.

As to the draft GAO Report, we note that it is based on an extremely small sample of physician charges for laboratory services. For example, statistics cited are based upon: 78 services ordered by 7 physicians in Florida, 29 services ordered by 11 physicians or physician groups in Georgia, 50 cases in California from two different carriers (only 28 cases were cited as involving 10 physicians and were the cases cited as excessive), 23 cases pertaining to 13 physicians in Arizona , and 10 procedures ordered by 12 physicians or groups in the Washington, D. C. metropolitan area.

It is obvious from even a cursory reading of the Report that the numbers of physicians and cases cited is extremely small. Moreover, the total group sampled, if there in fact was a true sampling process, is not identified.

The fact that the numbers cited are very small in terms of the total number of physicians in any area and in terms of the total number of laboratory procedures performed in each area does not condone improper activities. However, it is equally improper to cite significantly few statistics to support the conclusions of the draft report that "Medicare and Medicaid <u>often</u> pay substantially more for laboratory services than the prices charged for such services by independent laboratories" (emphasis ours). Moreover, there is nothing in the report which would deny justification for the "markup" or any portion thereof. As a matter of fact the Report specifically acknowledges that the findings were not discussed with physicians "who marked up on laboratory services." We believe that unsubstantiated general conclusions give an unfair impression that the Report identified widespread abuse.

APPENDIX V

We are also concerned that the limited data cited spans a period of three years (1972-1974).

As to Section 224 of P. L. 92-603, implementation of which is cited by the Report as necessary, we are concerned that an overly strict interpretation of its provisions by Medicare and Medicaid would result in its imposing upon laboratory reimbursement a level which corresponds to the lowest cost for which a laboratory service has been offered in the area without any proper determination of whether such services are "widely and consistently available in a locality."

If section 224 is interpreted solely in terms of cost, we are concerned that the imposition of "lowest level" (determined on the basis of statistics alone) will not properly consider availability, continuity, and quality. Cost, although of a concern, must be secondary to quality. Beneficiaries of federal programs should not be denied services which are, in the judgment of the attending physician, most appropriate for the patient.

We would therefore urge caution in strict and over-zealous imposition of Section 224 on laboratory service reimbursement.

In conclusion we would like to point out that the AMA supports proper reimbursement for physicians performing professional services. We also support reasonable, necessary actions taken to assure that possible fraud or abuse in health programs will be prevented. It is necessary, however, to recognize that the overwhelming proportion of physicians practice in a responsible manner.

In our view the draft Report lacks proper balance and lacks clear identification of a proper methodology. Accordingly, we would urge that the Report not be issued in the present form.

We would again express our appreciation in having the opportunity to review the draft Report.

Sincerely,

James H. Sammons, M.D.

James H. Sammons, M. D.

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1976	Present
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER OF SOCIAL SECURITY:		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973

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