

GAO

Report to the Ranking Minority Member,
Committee on Commerce, House of
Representatives

August 1996

MEDICARE

Early Resolution of Overcharges for Therapy in Nursing Homes Is Unlikely



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**Health, Education, and
Human Services Division**

B-272062

August 16, 1996

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

Dear Mr. Dingell:

Medicare is the nation's largest single payer for health care. In 1995, it spent an estimated \$177 billion, or 12 percent of the federal budget. On average, Medicare spending has grown by over 10 percent a year since 1990. The costs of some services, however, have risen at a much faster rate. These services include occupational, speech, and physical therapy provided by hospitals, skilled nursing facilities (SNF), rehabilitation agencies, and home health agencies. Therapy charges billed to Medicare by such institutional providers have more than doubled, rising from \$4.8 billion in 1990 to \$10.4 billion in 1993, the latest year for which these data are available.

In March 1995, we reported that some providers were exploiting weaknesses in Medicare's payment system for therapy services delivered to nursing home patients.¹ Two weaknesses that we identified were especially notable. First, the Health Care Financing Administration (HCFA), Medicare's administrator, places no absolute dollar limits on Medicare reimbursements for occupational and speech therapy. Second, charges for therapy services are not linked through billing codes to the amount of time spent with the patient or to the specific treatment provided; it is not readily determinable whether a charge is for 15, 30, or 45 minutes of treatment. These weaknesses make it difficult for HCFA to control the amount Medicare pays for occupational or speech therapy.

Our report recommended that to avoid paying more than a prudent purchaser would, HCFA should (1) develop salary guidelines that set explicit limits on the amount Medicare will pay for occupational and speech therapists' services and (2) require that bills for these services specify time spent with patients. HCFA generally agreed with our recommendations and estimated in December 1995 that implementing salary guidelines for occupational and speech therapists—combined with

¹Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

adjusting existing salary guidelines for physical and respiratory therapists—could save \$1.4 billion over 7 years.

Because implementing these guidelines could prevent making further excessive payments from an already stressed Medicare budget, you asked us to follow up on our earlier work to (1) determine HCFA's progress in curbing overbilling and (2) assess the prospects of early resolution to the overbilling problem.

To respond to your request, we performed additional analyses of data we collected during our study reported in March 1995. To be more current, we also reviewed 618 charges for services provided to 238 patients in SNFS with more than 100 beds. The charges were submitted by seven providers to one claims-processing contractor and were paid in January 1996. In addition, we examined selected contracts between SNFS and rehabilitation companies. To determine the steps that have been taken to prevent overbilling from occurring and HCFA's ability to quickly resolve the problem of overbilling, we interviewed HCFA officials and reviewed documents. We also reviewed an industry study of therapists' salaries and interviewed industry representatives about their views on HCFA's initiatives to curb overbilling. Our work was done between December 1995 and July 1996 in accordance with generally accepted government auditing standards.

Results in Brief

Our recent work continues to show that SNFS and therapy companies are billing Medicare very high charges for occupational and speech therapy. In addition, the billing units on which these charges are based are not defined—either within the industry or on the claims submitted.

We also found that the weaknesses we reported over a year ago—the lack of salary guidelines to set limits on Medicare reimbursements for occupational and speech therapists' services and unclear billing units for these services—still exist. Although HCFA recognized as early as 1990 that Medicare was being inappropriately charged for occupational and speech therapy, it is still working to establish salary equivalency guidelines for these services. Between 1993 and 1995, HCFA proposed guidelines based on a Bureau of Labor Statistics (BLS) survey of average salaries of hospital therapists, but the industry was not satisfied and conducted its own survey. HCFA received the survey results in April 1996 and is analyzing them.

The prospect for a quick resolution to the billing problem with therapy services is unlikely. Historically, it has taken HCFA years to reduce high payment rates for supplies or services. Given the usual time involved in meeting federal notification and publication requirements for changing Medicare prices, salary equivalency guidelines may not be implemented until at least summer 1997. Reporting last September on this issue,² we asked the Congress to consider granting HCFA legislative relief from these requirements. Our recent work reinforces the need for legislative relief that would allow HCFA to promptly set maximum limits on the basis of market surveys and other methods of assessing the reasonableness of rates or—if the existing formal notification and rulemaking process is preserved—to make interim adjustments while the process takes place.

Background

In 1990, legislation took effect that required SNFs and other nursing facilities³ to assess and provide for their residents' needs for therapy services.⁴ Subsequently, the number of rehabilitation agencies providing physical, occupational, and speech therapy increased dramatically—as did Medicare spending on therapy services delivered in nursing homes.⁵

Most nursing home residents receive their therapy services from outpatient rehabilitation therapy companies (OPT) that send their employees to the nursing home. Once approved to participate in Medicare, either a SNF or an OPT can bill Medicare. Both are regarded by Medicare as institutional providers and, as billing providers, are reimbursed on a cost basis. SNFs and OPTs must file annual reports detailing the actual costs of services that were delivered to Medicare beneficiaries and billed to the program throughout the preceding year.⁶ HCFA claims-processing contractors reconcile these actual reported costs with the interim payments made to providers throughout the year, either by making

²Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

³SNFs are nursing homes that maintain a full-time staff of medical professionals who provide daily care for patients with complex medical or rehabilitative needs. Other nursing homes do not offer this level of care, do not choose to participate in Medicare, or have patients who do not require this level of care. In this report, the term “nursing facilities” includes both categories.

⁴Omnibus Budget Reconciliation Act of 1987, 42 U.S.C. 1395i-3(b), 42 U.S.C. 1396r(b).

⁵Medicare's basic nursing home benefit covers a portion of posthospitalization costs for up to 100 days in a SNF. Patients in SNFs and nursing homes who have exhausted their coverage or who do not qualify for the SNF-level of care can still receive therapy services that are paid for by Medicare.

⁶If a SNF submits a bill for OPT-provided services (in lieu of the OPT billing Medicare directly), the amount the SNF paid the OPT becomes part of the SNF's therapy costs along with therapy-related costs for services and supplies and general and administrative expenses.

additional payments to providers or by collecting overpayments from them. In the reconciliation process, the contractor determines whether the claimed costs are “reasonable.”

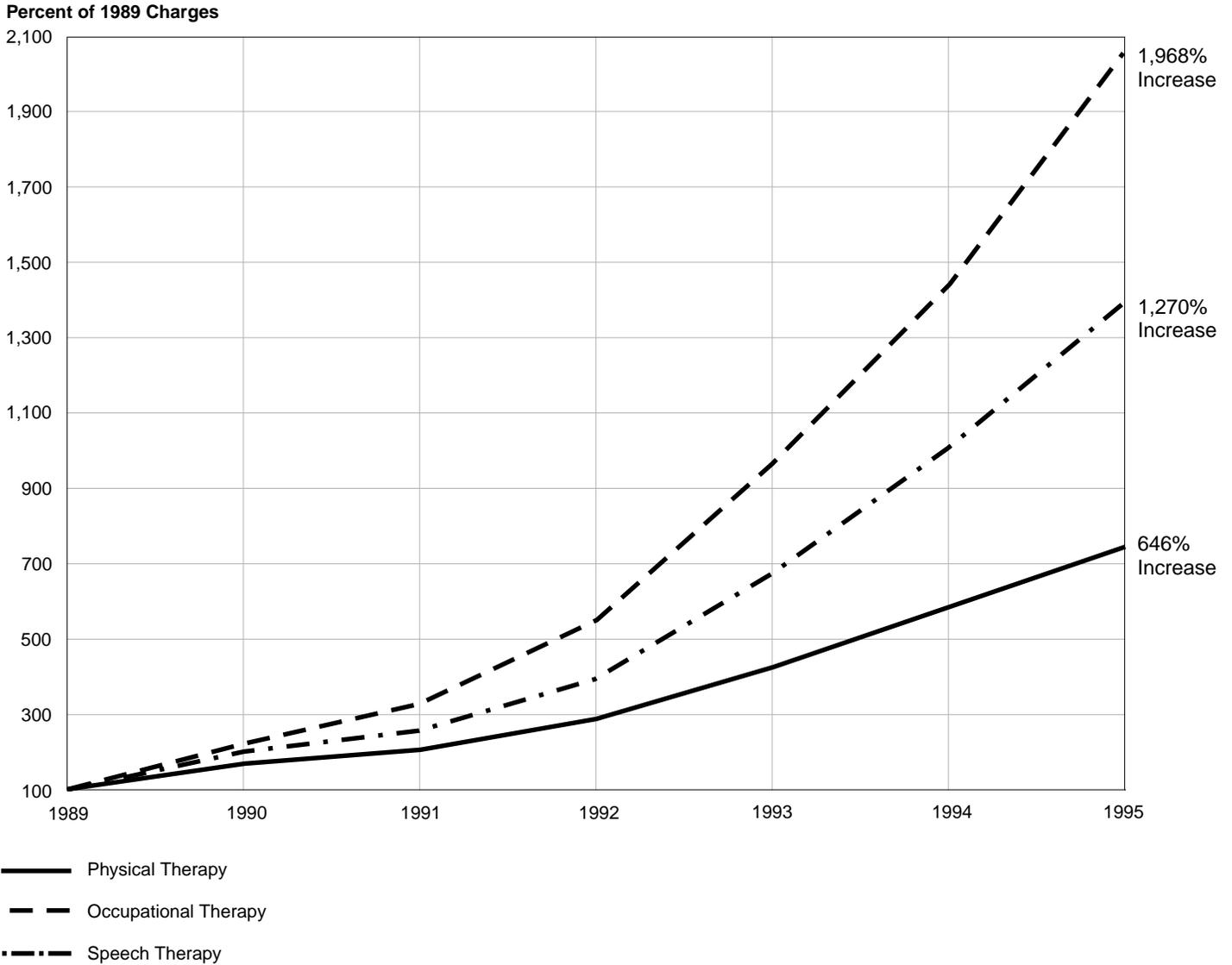
Medicare has a number of principles to ensure that only reasonable costs are used in determining its final payment, such as a prudent purchaser principle. Under this principle, Medicare compares claimed costs with the “going rate” for the item or service. For example, if a SNF contracts with an OPT at \$500 for 1 hour of therapy services and the going rate is \$100 per hour, only \$100 would be approved for inclusion in the cost report during the year-end settlement; the \$400 would be disallowed.

Two problems occur in applying the prudent purchaser and other principles. First, to ensure that these rules are followed, Medicare’s claims-processing contractors must audit cost reports. But because auditing is resource intensive and funds for auditing are limited, therapy costs are rarely audited. Second, establishing a “going rate” may involve conducting a survey of current practice and pricing among comparable providers in the same geographic area, which may also be resource intensive. For these reasons, if the SNF in the example above included the full \$500 per hour contract cost in its cost report, there is little assurance that this amount would be adjusted downward.

Under certain billing conditions, salary guidelines have helped Medicare limit the amount it will pay for certain services. For example, reimbursements for OPT-provided physical therapy services that are billed by SNFs and subject to salary equivalency guidelines⁷ (and, hence, are referred to as capped) increased 646 percent between 1989 and 1995. Speech therapy and occupational therapy reimbursements, for which similar guidelines have not been imposed (referred to as uncapped), have grown at about two and three times this rate, respectively, as shown in figure 1.

⁷These guidelines were established in 1975. In 1983, salary rates were recalculated and have since been adjusted annually by an inflation factor. The American Physical Therapy Association, however, claims that the current physical therapy rates are well below market and that occupational therapy and speech therapy charges are higher than would be expected to compensate for the low physical therapy rates.

Figure 1: Comparative Growth Rates in Charges for Capped and Uncapped Therapies Billed by SNFs



Source: GAO analysis of national claims data provided by HCFA.

The absence of information on the amount of time spent providing a service also makes it difficult to determine whether a claim is reasonable

prior to payment. Under current HCFA regulations, OPTS and SNFs are not required to specify on their claims how much therapy time they are billing for or what specific service was provided. Instead, OPTS can choose one of at least six methods to bill Medicare. Although each of these methods requires costs to be associated with a “unit,” claims generally do not specify what the unit denotes. In these cases, the Medicare claims-processing contractor does not know the amount of time involved in delivering the therapy services or what the services included, making it all the more difficult to detect inflated charges and identify unreasonable costs.

Limited Progress Made to Control Overbilling for Occupational and Speech Therapy Services

SNFs and OPTS are continuing to charge excessively high rates for therapy services, particularly occupational and speech therapy, when services are provided under arrangement.⁸ Charges for claims paid during January 1996 by one contractor showed extreme variations similar to those found in our March 1995 study. Because salary guidelines and units of service have not been established, Medicare has no easy way to determine whether any of these charges were excessive or whether they resulted in excessive payments, but that is most likely the case.

HCFA Attempts to Implement Salary Guidelines Have Not Yet Been Successful

Since 1990, HCFA has taken a number of interim and long-term actions to curb inappropriate charges for SNF therapy services. HCFA has focused its efforts on implementing salary equivalency guidelines for those providing occupational and speech therapy services under arrangement.

Between 1990 and 1992, HCFA received numerous complaints about inappropriate charges for therapy services. In 1993, it established a task force to address the problem. As a result of this task force, HCFA sent a series of memorandums in 1993 and 1994 to its claims-processing contractors, advising them of the nature of existing problems—such as inflated therapy service charges—and providing guidance on how to focus review activities.⁹ HCFA outlined a number of steps that contractors could take to ensure that services were medically necessary and to help determine whether costs were reasonable and allowable. For example, HCFA suggested that contractors audit any provider with therapy costs exceeding \$95 per hour. However, this measure was probably ineffective:

⁸“Under arrangement” refers to a contractual relationship whereby the OPT bills the SNF for services it provides and the SNF in turn bills Medicare. The OPT’s charges become the SNF’s costs.

⁹In April 1994, HCFA also took the unusual step of arranging with the Journal of the American Medical Association to publish an appeal from the HCFA Administrator for physicians to resist pressure to authorize excessive therapy services.

“Per hour” rates cannot be determined without intensive auditing because units of service are not defined in units of time. Moreover, some providers that had been billing significantly less than \$95 per hour reacted by simply raising their charges close to that level.

In 1995, HCFA developed draft salary guidelines for those providing occupational and speech therapy, and revised guidelines for other therapies, reviewing for this purpose 22 separate data sources. The recommended levels were based on the 75th percentile of hospital salaries for therapists (as surveyed by BLS) plus a 5-percent differential to adjust for likely differences between hospital and SNF salaries.¹⁰ In August 1995, a clearance package containing a notice of proposed rulemaking was sent to the Secretary of the Department of Health and Human Services (HHS). Forwarding this package was a significant step, given the complex and lengthy process that HCFA must go through to lower payment rates.

At this point, however, officials of the rehabilitation industry complained that the HCFA guidelines were inappropriate and out of date because they were based on 1991 hospital salaries for therapists. Industry representatives offered to commission their own survey of SNFs that employ therapists. HCFA agreed and put implementation of salary guidelines on hold pending completion of the survey. HCFA officials told us that, in their judgment, this would increase the prospects for developing fair and effective guidelines and reduce the chance of a time-consuming and expensive legal challenge.

HCFA reviewed the design for this survey, which ultimately encompassed both hospitals and SNFs. The raw survey data and an industry analysis were delivered to HCFA in April 1996. However, the survey response rate was low (10 percent for hospitals and 30 percent for SNFs), which raises questions about how representative the data are.¹¹ HCFA is conducting its own analysis of the results to determine if they are meaningful. According to HCFA, a proposed regulation should be published shortly after its analysis is complete. The final regulation is then likely to be issued sometime in 1997.

¹⁰The Clinton administration’s legislative proposal subsequently recommended a 10-percent differential.

¹¹Official government surveys generate a much higher response rate. The BLS White Collar Pay Survey (one component of which was the hospital salary data survey on which the draft guidelines were based) had an overall response rate of 82 percent. Typically, BLS response rates exceed 80 percent.

HCFA Has Not Defined Units of Service

Claims for therapy services are required to specify the number of service units provided; claims-processing contractors' databases store this information in terms of "units" or "services." These units, however, are not defined. In our March 1995 report, we recommended that HCFA define units on the basis of time, such as 15-minute intervals. In commenting on that report, HCFA said it did not agree with using time as the basis and believed it would be better to have therapy units defined by the procedures actually performed. HCFA has not yet defined billable therapy units for SNFs in terms of either the exact procedure furnished or the amount of time actually spent with the patient.¹² Therefore, Medicare does not know how much service it is buying at the time it pays the claim.

Neither HCFA nor the industry observe any standard usage for "unit" or "service," as illustrated by the wide variation in "per unit" charges. While some interpret "unit" as 15 minutes, there is no consensus.¹³ We analyzed data from five HCFA claims-processing contractors¹⁴ for 1988 through 1993 and found extreme variations in "per unit" charges. For each therapy type, per unit charges for the highest quartile of providers were more than double those of the lowest quartile, and differences among individual providers were even more extreme. Results were similar for our more recent data set. For this follow-on, we also reviewed a range of hourly rates identified in contracts between OPTs and SNFs under the jurisdiction of one HCFA contractor. In those contracts that specified hourly rates for occupational therapy, the rates varied considerably, from \$54 to \$210 per hour.

Prospects Poor for Rapid Resolution of the Problem

As we reported in 1995, Medicare has paid substantially more than market rates for some services, which not only increases Medicare costs but also can encourage providers to supply excessive services. We also reported that HCFA has generally been slow in addressing overpricing problems. Delay in drafting and implementing regulatory changes such as price corrections and salary guidelines is inherent in the rulemaking process

¹²The Clinton administration's current Medicare legislative proposals include a provision to require use of HCFA's Common Procedure Coding System to identify more precisely what services were performed.

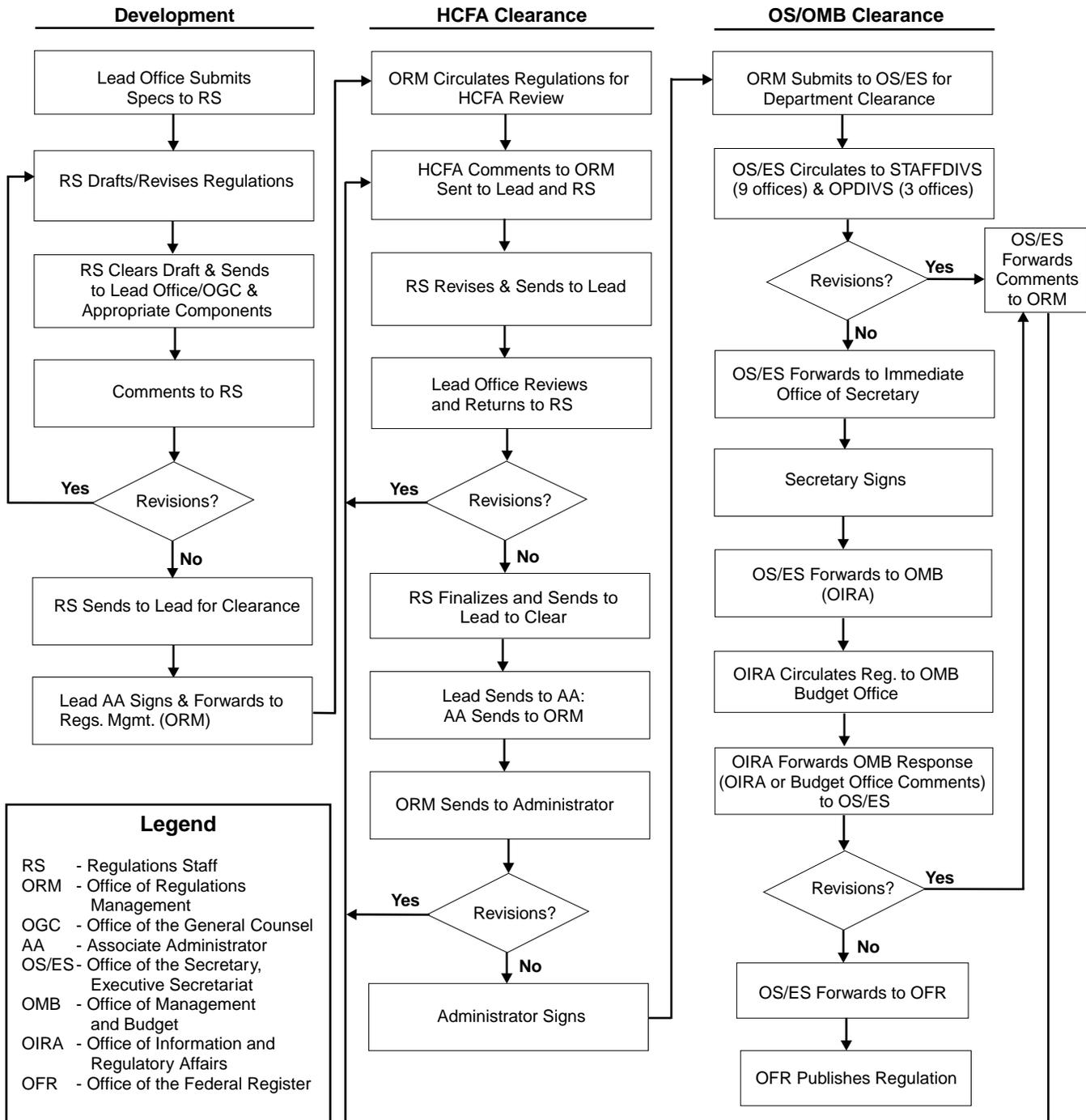
¹³This uncertainty does not apply in all circumstances. The 1996 Medicare resource-based relative value fee schedule has several codes for at-home training done by occupational and physical therapists. These codes have values of about \$18 for each 15-minute period.

¹⁴These claims data were provided by five Aetna Life Insurance Company field offices (California, Connecticut, Florida, Illinois, and Pennsylvania).

established by the Administrative Procedures Act¹⁵ as well as in the complexities of intra- and interagency coordination (see fig. 2).

¹⁵U.S.C. 551.

Figure 2: HCFA's Regulatory Process



For it to fully satisfy formal rulemaking requirements, HCFA has projected that it could take 7 years or longer from the time it learned of the problem, and almost 3 years from the time it started assembling salary data, to establish salary equivalency guidelines for professionals providing therapy services. HCFA, therefore, has drafted proposed legislative language under which salary equivalency guidelines for occupational and speech therapists would be established directly by statute, negating the need for formal rulemaking. The proposal was included in the December 1995 summary of the President's Medicare proposal.

In our September 1995 report, we suggested a similar approach to the effect that the Congress consider allowing the Secretary of HHS to set maximum prices on the basis of market surveys or, if the formal rulemaking process is preserved, allowing the Secretary to make an interim adjustment in fees while the studies and rulemaking take place.

HCFA officials consider the establishment of salary guidelines the most urgent step in solving the problem of inappropriate therapy charges. They do not believe it is absolutely necessary to achieve a standard definition of a therapy unit, such as a 15-minute interval, especially since this process would take another 2 or 3 years. Their reasoning is that salary guidelines would provide the necessary link (through the cost report settlement process) between hours of therapy time and costs claimed. Auditors could then confirm that Medicare payments did not exceed salary limits.

However, as discussed earlier, such an approach is vulnerable to abuse because few cost reports are audited in sufficient detail to permit such judgments to be made and any audit may be delayed a year or more even when one is performed. Moreover, as long as units are not defined on a time basis as we suggested or on the basis of the exact procedures performed as HCFA believes would be better, Medicare's claims reviewers—even after salary guidelines are implemented—will not be sure of the amount of services being provided. This in turn makes it more difficult to assess the medical necessity for therapy services.

For a long-term solution to the problem of therapy overcharges, HCFA officials emphasized the importance of more systematic legislative approaches, such as requiring unified billing. We presented this option in a report released earlier this year:¹⁶ Unified (or consolidated) billing would require nursing facilities to bill Medicare for all services they are

¹⁶Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

authorized to furnish to patients. OPTS rendering these services would be prohibited from directly billing Medicare; financial liability and medical responsibility would reside with the nursing facility. This would make it easier for Medicare to identify all the services furnished to residents, which in turn would facilitate controlling payments for these services.

Conclusion

Despite HCFA's efforts to deal with the problem, SNFS and OPTS continue to bill Medicare high charges for occupational and speech therapy. To correct this problem without expending large amounts of administrative resources, HCFA needs to implement salary equivalency guidelines for occupational and speech therapists as soon as possible. Given HCFA's experience with payments for physical therapy, such guidelines should help moderate payment growth rates.

Legislation to limit reimbursement, as we suggested last September, is the most practical way to enable Medicare to avoid continuing excessive payments for overpriced services.

Agency Comments and Our Evaluation

In a letter dated June 19, 1996, HCFA generally agreed with our concerns about inappropriate billing and delivery of therapy services. It also agreed with the first recommendation in our March 1995 report that HCFA should develop salary guidelines to establish explicit cost limits on occupational and speech therapy services, though not necessarily with our assessment of the current status of these guidelines. HCFA officials did not entirely agree with our second recommendation, that bills for these services specify the time spent with patients.

In its comments on a draft of this report, HCFA claimed that "the emphasis on excessive charges obscures the fact that Medicare is not actually paying the reported charges," and asked that our report "specifically state that GAO has not identified any specific instances in which excessive charges are actually paid." As discussed on pages 3 and 4 of this report, the amount Medicare actually pays is not known until long after the service is rendered and the claim processed. Although aggregate payments are eventually determinable, existing databases do not provide actual payment data for any individual claim—hence, our focus on charges. In any case, we found HCFA's own estimate of a potential \$1.4 billion in savings over 7 years as a result of implementing salary guidelines (and revising those already in place) to be persuasive evidence that excessive payments are being made.

With regard to the uniform definition of time units, we concur with HCFA that “Ideally, we would prefer reporting that would identify the exact procedure furnished, not just on the basis of time units.” Either way of defining the unit of service for therapy would be better than leaving the unit undefined. More specific claims would make it easier to determine whether charges are appropriate for the actual services provided and whether the patients needed those services.

We also concur with HCFA on the importance of systematic approaches, such as unified billing, to resolving concerns over payment for therapy services. As we stated in correspondence last September,¹⁷ unified billing would make it easier for Medicare to identify all the services furnished to a facility’s residents, which in turn would make it easier to control payments for those services.

Other HCFA comments were incorporated in the report where appropriate. See the appendix for a copy of HCFA’s comments.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to the Secretary of HHS, the Administrator of HCFA, interested congressional committees, and other interested parties. We will also make copies available to others on request.

Please call Barry Tice, Assistant Director, at (202) 512-7119 if you or your staff have any questions about this report. Other major contributors include Audrey Clayton, Andrea Kamargo, Steve Machlin, and Karen Sloan.

Sincerely yours,



Edwin P. Stropko
Associate Director, Health
Financing and Public Health Issues

¹⁷Preventing Abusive Medicare Billing (GAO/HEHS-95-260R, Sept. 5, 1995).

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 19 1996

TO: Edwin P. Stropko
Associate Director
Health Financing and Public Health
General Accounting Office

FROM: Bruce C. Vlad 
Administrator

SUBJECT: Request for Comments on General Accounting Office's (GAO)
Draft Report "Medicare: Early Resolution of Overcharges for
Therapy in Nursing Homes is Unlikely"-- INFORMATION

We appreciate the opportunity to comment on the GAO draft report, "Medicare: Early Resolution of Overcharges for Therapy in Nursing Homes is Unlikely." We share many of the concerns that GAO expresses in this and a preceding report ("Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes," March 1995) about assuring that Medicare payments for therapy services are appropriate.

The current report focuses on the status of the recommendations that the GAO made in the prior report. GAO had recommended, in order to avoid paying more than a prudent purchaser, the Health Care Financing Administration (HCFA) should (1) develop salary guidelines that set explicit limits on the amount Medicare will pay for occupational and speech therapy services, and (2) require that bills for these services specify the time spent with the patient. While we agree with the first recommendation, we do not entirely agree with GAO's characterization of the current status of development of the occupational and speech therapy guidelines. We also do not entirely agree with GAO's second recommendation.

As in the previous report, GAO bases its findings on an analysis of therapy charges, rather than actual payments. We would like to reiterate our comment on the prior report, that the emphasis on excessive charges obscures the fact that Medicare is not actually paying the reported charges. It is certainly legitimate to express concern that the program's reasonable cost principles and auditing procedures are adequate to assure that excessive charges are not actually paid. However, the report should specifically state that GAO has not identified any specific instances in which excessive charges are actually paid.

See p. 12.

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The current report correctly notes that Medicare program payments for therapy services are based not on charges but rather on the actual costs of providing the services. Medicare makes interim payments to providers for therapy services through the year, and then makes a final payment determination on the basis of the reasonable costs reported in the provider's cost report. Medicare employs a number of methods to assure that costs are reasonable, including the "prudent buyer" principle and, for respiratory and physical therapy services, salary equivalency guidelines which strictly limit the amount that can be paid for services performed under arrangement. The fiscal intermediary has authority to apply the "prudent buyer" principle and has been actively pursuing this authority. (The GAO discussion of the "inherent reasonableness" process is not applicable in this situation.)

Furthermore, the report sometimes cites statistics concerning therapy charges without indicating the sources of the information. For example, page 2 of the report states that per unit occupational therapy charges submitted to one claims processing contractor ranged from \$40 to \$1,495." Without knowing the source of this information, it is impossible to determine whether this is representative of therapy charges in general, or simply reflects isolated instances. Similarly, specific sources for Figures 1 and 2 are not indicated. It is thus impossible to determine, for example, whether the "5 HCFA contractors" mentioned in connection with Figure 2 are representative.

The report indicates that HCFA has been engaged for three years in developing appropriate salary guidelines for occupational and speech therapy services, and in revising the existing guidelines for physical and respiratory therapy services. The report also recounts that HCFA actually developed a draft regulation to establish these guidelines in 1995. However, publication of this regulation was suspended when the industry objected that the proposed guidelines would be based on inappropriate and outdated data. Industry representatives offered to commission a survey that would provide more current and industry-specific data with which to develop guidelines.

The report correctly notes that, in the agency's judgment, allowing the industry to conduct and submit an industry-specific survey could potentially increase the prospects for developing fair and effective guidelines and reduce the chance of a time-consuming and expensive legal challenge. However, the report should also note that the agency had a sound basis for that judgment. HCFA's view was that the Bureau of Labor Statistics (BLS) survey data was the best available source of data. We also recognized that while the BLS survey was extremely well designed and had an excellent response rate, it was neither current (the survey dated from 1991) nor specific to the nursing home industry. It would thus have been difficult for the agency to explain a refusal to accept the industry's offer since regulatory authority specifically exists for HCFA to consider statistically valid

Discussion of inherent reasonableness deleted.

Sources added.

Statement deleted.

Sources added.
Figure 2 of draft deleted.

We did not question the agency's judgment.

Page 3

data from other sources. In this context, it should also be noted that HCFA is considering the industry's survey in conjunction with all the available data sources in order to determine the most appropriate basis for setting fair and effective guidelines. HCFA will use the industry-sponsored survey in setting the new therapy salary guidelines to the degree warranted by rigorous analysis of its statistical validity and representativeness.

With regard to the second recommendation, we do not entirely agree that establishing a uniform definition of time units is necessary. While it is obviously essential that costs be evaluated in relation to the amount of service rendered, it is perhaps simplistic to attempt to relate "units" of service to time spent with a patient. In fact, the most explicitly defined and quantified classification system that Medicare and most other payers use, the HCFA Common Procedure Coding System (HCPCS), does not always reference units of time, and gradually has been moving away from such an arbitrary measurement. Of the 42 codes listed for physical medicine and rehabilitation in 1996, only 25 specify units of time. In essence, it is more useful to precisely identify what was done rather than how much time was spent doing it. Merely knowing how much time was spent does not disclose whether it was appropriately spent.

Under the current system of collecting cost data and charge data, and establishing a cost-to-charge ratio (described on pages 3 and 4 of the GAO draft report), the de facto "reporting units" are the dollars in the charge. While Medicare does not pay the charges, the program does use them to calculate its share of the costs. Providers who report high charges per patient are readily identifiable, and charges across providers are readily comparable. This arguably provides a better basis for evaluation than would a conversion to time units.

Ideally we would prefer reporting that would identify the exact procedure furnished, not just on the basis of time units. The Administration's current Medicare legislative proposals include a provision to require use of HCPCS codes. Adoption of this provision would enhance medical review of claims and facilitate denial of unnecessary services, as well as facilitate limiting payment for covered services to amounts that are appropriate for what was actually done.

Finally, we would like to reiterate our comments about the importance of systematic legislative approaches, such as unified billing, to resolving concerns over payment for therapy services. As the report notes, unified (or consolidated) billing would make it easier to control payment for services by requiring that nursing homes bill for all services. We propose to initially establish limits on ancillary services followed by a prospective payment system that would establish a pre-determined payment for all services provided to a beneficiary.

See p. 13.

See p. 13.

**Appendix
Comments From the Health Care Financing
Administration**

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We hope you will find these comments useful in the process of finalizing the report for Mr. Dingell. Should you have any questions or require any additional information, kindly contact Ron Miller of the Executive Secretariat staff at (410) 786-5237.

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