REPORT TO THE CHAIRMAN,
COMMITTEE ON FINANCE
UNITED STATES SENATE

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Evaluation Of Hospital Medical Staff's Comments On Report On Review Of Medicare Payments For The Services Of Salaried Supervisory And Teaching Physicians B-164031(4)

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

AUG. 17, 1971

B-164031(4)

Dear Mr. Chairman:

Your letter of April 23, 1971, requested our evaluation of a letter dated February 22, 1971, which you had received from representatives of the medical staff of Wayne County General Hospital in Eloise, Michigan. The medical staff's letter took exception to certain matters pertaining to our December 4, 1970, report to your Committee on our review of Medicare payments for the services of salaried supervisory and teaching physicians at the hospital.

The medical staff took exception to the following matters pertaining to our report or to actions taken by the Social Security Administration or its carrier, Michigan Medical Service.

--We made a distinction between (1) the supervisory and teaching physicians who supervised the medical care provided in the hospital wards and operating rooms and (2) hospital-based specialists, such as radiologists and pathologists. The medical staff stated that all its physicians were specialists and that all had responsibilities involving teaching and supervision as well as direct patient care.

--We concluded that, on the basis of our review of the hospital's medical records for 50 Medicare patients, the professional services billed on a fee-for-service basis by the hospital on behalf of its salaried supervisory physicians generally had been provided by residents and interns and not by supervisory physicians. The medical staff stated that this was not true.

--The medical staff maintained that, to bill Medicare, documentary evidence of the services provided by them was not required by the Social Security guidelines in existence at the time the services were rendered.

--We questioned whether the fee-for-service schedule of charges was the appropriate basis for paying for the supervisory physicians' services, because it was questionable whether many of the services billed had been furnished personally by the physicians. The medical staff suggested that our conclusion was based on a retroactive application of the Social Security April 1969 guidelines which specifically required that, to bill Medicare, a supervisory physician's services be supported by entries in the patient's medical record.

--The carrier had been withholding payments for the services of the hospital's supervisory and teaching physicians from August 1969 even though the hospital had changed its method of billing for such services in response to the Social Security April 1969 guidelines. The medical staff suggested that this condition was due to the lack of clear guidance from the Social Security Administration regarding the appropriate billing procedures.

--We pointed out that, under the version of the Social Security Amendments of 1970 (H. R. 17550) which passed the House of Representatives on May 21, 1970, the salaried supervisory and teaching physicians at Wayne County General Hospital could qualify for payment on a fee-for-service basis but that, in our opinion, a cost-reimbursement method would be more appropriate. The medical staff indicated that the use of the cost-reimbursement method would result in lesser payments for the servicesof teaching physicians than would be made to physicians in private practices on a fee-for-service basis. They stated that this reflected adversely on the caliber of the professional competence of the teaching physicians.

DISTINCTION BETWEEN SUPERVISORY AND TEACHING PHYSICIANS AND HOSPITAL-BASED SPECIALISTS (RADIOLOGISTS AND PATHOLOGISTS)

We do not disagree with the medical staff's contention that all its physicians were specialists and were involved in supervising and teaching as well as in patient care. We

made a distinction, however, between the physicians supervising the medical care in the hospital wards and in operating rooms and the hospital-based specialists because, as stated on page 8 of enclosure I to our December 1970 report, the hospital had used different procedures to bill Medicare for their services. Also certain Medicare regulations relating specifically to supervisory and teaching physicians (20 CFR 405.521) generally are not applicable to radiologists and pathologists because these specialists usually do not bill in the capacity of a patient's "attending" physician.

REVIEW OF HOSPITALS' MEDICAL RECORDS

In accordance with the Committee's request, we reported what the medical records showed regarding who had provided the services for which Medicare had been billed. Hospital officials in developing their comments on a draft of our report, apparently verified that we had reported accurately what the records showed. The hospital's comments which were included in our final report stated that:

> "We have reviewed the clinical records of the patients identified to us as those audited by your staff ***.
>
> "Regrettably, our review of the aforementioned clinical records does not enable us to refute the findings reported *** that our medical staff has not documented in the clinical records that they provided all of the services for which bills were rendered. This does not mean that the services were not rendered. It does mean, however, that our Medical Staff cannot confirm by means of the clinical records that the services were rendered.
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> "The conclusion indicated *** that the professional services for which Medicare billings were rendered 'generally had been furnished by residents and interns and not by an attending physician' is considered erroneous by our Director of Medicine and our Director of Surgery."

DOCUMENTATION REQUIRED TO BILL MEDICARE FOR TEACHING PHYSICIANS' SERVICES

As indicated by several of our reports to your Committee, the question of what backup documentation was required to support a bill for the services of supervisory and teaching physicians before the Social Securit April 1969 guidelines has been a matter of contention between the Social Security Administration and the teaching hospitals and their affiliated medical schools.

Notwithstanding the lack of implementing instructions before April 1969, Social Security officials have maintained that the language of the August 1967 regulations implied that the bills for the teaching physicians' services should be supported by documentary evidence. These officials point out that such language as "personal and identifiable direction" and "the carrying out by the physician of these responsibilities would be demonstrated by such actions as ***" clearly indicates that a teaching physician's charges for his professional services to a particular patient should be susceptible of verification.

In addition, there were certain generally accepted standards of the Joint Commission on Accreditation of Hospitals which pertained to hospital medical records in existence before April 1969 and which indicated to us that, if a teaching physician was acting as a Medicare patient's attending physician, some evidence should have been included in the patient's medical records.

In accordance with section 1865 of the Social Security Act (42 U.S.C. 1395bb), the Wayne County General Hospital has been eligible to participate in the Medicare program by virtue of its accreditation by the Joint Commission on Accreditation of Hospitals.

The 1964 version of the reference material explaining the standards for medical records used by the Joint Commission in surveying hospitals contained the following questions and answers.

> "What are the recommendations of the Joint Commission regarding signatures on medical records?

"Each clinical entry should be signed by the attending physician. This includes the face sheet *** as well as history, physical examination, operative report, progress notes, and orders for treatment."

* * * * *

"Our attending staff physicians object to signing or authenticating the interns' or residents' histories and physicals. They claim it might be held against them. Why does the Joint Commission require it?

"The Joint Commission states in the Explanatory Supplement: 'In hospitals with house officers, the attending physician should countersign at least the history and physical examination and the summary written by the house officer.' This requirement was made for two reasons. First, the house officer's years are learning years. If a hospital medical staff does not supervise by reading, amending, criticizing, and authenticating these documents of the house officer, they are not living up to their responsibilities and are plainly guilty of exploitation."

At Wayne County General Hospital, our comparision of part B bills with the medical records applicable to 50 Medicare patients included 33 charges for the first day of hospitalization (initial visit). The initial visit generally was billed at $15 and included a medical diagnosis, physical examination, and preparation of the patient's medical history. According to the medical records applicable to these 33 charges:

--In one case, the staff or attending physician in whose name the service was billed was involved.

--In one case, a staff physician other than the one in whose name the service was billed was involved.

--In the remaining 31 cases, only residents and interns were involved.

In our opinion, the foregoing findings indicated that, if the salaried staff physicians at the hospital were acting as the Medicare patients' attending physicians, the applicable medical record accreditation standards for hospitals had not been complied with.

CONCLUSIONS NOT BASED ON RETROACTIVE APPLICATION OF SOCIAL SECURITY APRIL 1969 GUIDELINES

The 50 Medicare patients covered by our review were hospitalized before the effective date of the Social Security April 1969 guidelines; however, as indicated in our December 1970 report, the carrier's auditors, in December 1969, reviewed 100 patients' medical records at the hospital and concluded that the Social Security April 1969 guidelines were not being complied with, because the medical records for 74 of the patients did not support the hospital's bills. According to the carrier the patients had been hospitalized during August and September 1969, or about 3 months after June 1, 1969, the effective date of the April 1969 guidelines.

Therefore our conclusion questioning the appropriateness of the fee-for-service method of paying for physicians' services to this hospital was based on information applicable to periods before and after the effective date of the Social Security April 1969 guidelines.

SUSPENSION OF MEDICARE PAYMENTS SINCE AUGUST 1969

As indicated by the carrier's comments included in our December 1970 report, the carrier concluded that a per diem rate for each day of hospitalization would be a more appropriate basis for reimbursing the hospital under part B for the services of its salaried physicians than would the fee-for-service method. The carrier also advised us that it would be in a better position to make a more accurate assessment of the situation when the results of the intermediary's audit of the hospital's Medicare cost reports became available.

We have been informed by the intermediary that its audit for the 6-month period ended December 31, 1966, and for each of the years ended December 31, 1967, 1968, and 1969, was substantially completed in May 1971. The carrier told us that the results of the audit would be used to determine (1) the amount of the excessive part B payments to the hospital from 1966 to 1969 and (2) the proper per diem rate for paying for services provided during later periods.

In other words it appears that part of the delay in resuming payments for the services of the salaried physicians has been due to delays in completing the Medicare cost audits at the hospital.

COMMENTS ON PROPOSED LEGISLATION

In our December 1970 report to your Committee, we pointed out that, under the provisions of House bill 17550--which had passed the House of Representatives in May 1970--the supervisory physicians at Wayne County General Hospital could qualify for payments on a fee-for-service basis but that, in our opinion, a cost-reimbursement method would be more appropriate.

Under the version of the bill as reported by your Committee on December 11, 1970, and passed by the Senate on December 29, 1970, but which was not enacted during the ninety-first Congress, the supervisory physicians at the hospital would not qualify for payment on a fee-for-service basis.

Under the Senate version of the bill, Medicare would pay for the services of teaching physicians on a reasonable-cost basis under part A rather than on a fee-for-service basis under part B, except when

--a bona fide relationship of "private patient" to physician has been established or

--the hospital, in the 2-year period ended December 31, 1967, and subsequently, customarily had charged all patients on a fee-for-service basis and had collected from a majority of them.

According to your Committee's report that accompanied House bill 17550 (S. Rept. 91-1431), the criteria for establishing that a bona fide relationship of "private patient" to physician existed would be that (1) the physician saw the patient in his office before the hospital admission, arranged the patient's admission to the hospital, treated the patient during his hospital stay, and ordinarily would be available to provide follow-up care after the patient's discharge, (2) the Medicare patient legally was obligated

to pay the physician's charges billed, including the deductible and coinsurance amounts, and the physician routinely and regularly sought to collect such charges.

We believe that Medicare patients at the Wayne County General Hospital did not meet the above criteria of a "private patient" because (1) a patient usually was assigned to a staff physician upon admission and (2) historically, the staff physicians did not bill hospital patients--the hospital billed the patients in the physician's name.

We believe further that the hospital could not meet the second exception to the proposed cost reimbursement method of paying for teaching physicians' services because, before the effective date of Medicare (July 1, 1966), only patients with private health insurance were charged for physicians' services on a fee-for-service basis. Other patients, including those covered by the federally aided Medical Assistance for the Aged program, were charged an all-inclusive hospital per diem rate that included physicians' services.

The legislation as proposed by your Committee in December 1970 for paying supervisory and teaching physicians was adopted by the House Ways and Means Committee in reporting out the Social Security Amendment of 1971 (H. R. 1) on May 26, 1971, and was passed by the House of Representatives on June 22, 1971.

Neither the comments in our December 1970 report nor the legislation proposed by your Committee and subsequently adopted by the House, in our opinion, should be construed as adversely reflecting upon the caliber of professional competence of the teaching physicians at Wayne County General Hospital or at any other hospital. Under the proposed legislation, the teaching physicians' salaries would provide the basis for Medicare reimbursement for their services to individual patients in the same manner as the salaries have provided the basis for reimbursement for their services involving administration, teaching, and supervision under the hospital insurance (part A) portion of the Medicare program.

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We plan to make no further distribution of this report unless copies are specifically requested, and then we will make distribution only after your agreement has been obtained.

Sincerely yours,

Comptroller General
of the United States

The Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate