CAN IMPROVED COMPLIANCE WITH THE REGULATORY FLEXIBILITY ACT RESUSCITATE SMALL HEALTH CARE PROVIDERS?

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

WASHINGTON, DC, APRIL 10, 2002

Serial No. 107–53

Printed for the use of the Committee on Small Business

U.S. GOVERNMENT PRINTING OFFICE

79–640 WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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CAN IMPROVED COMPLIANCE WITH THE REGULATORY FLEXIBILITY ACT RESUSCITATE SMALL HEALTHCARE PROVIDERS?

WEDNESDAY, APRIL 10, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:06 a.m. in room 2360, Rayburn House Office Building, Hon. Donald Manzullo presiding.

Chairman MANZULLO. The Committee will come to order. First of all, I want to thank the witnesses for showing up. I want the record to indicate that two weeks ago our office received a letter that Administrator Scully would be appearing at this hearing. And I want that letter to be made part of the record.

Subsequent to that time, Mr. Scully has expressed a desire that he wanted to be on the panel by himself. And the Chairman of Small Business Committee sets the rules, not the witnesses. And one of the reasons that we like to put people from the Administration on panels with the people that are affected by Administration directives is the fact that the purpose of this Committee is to solve problems. We are problem-solvers.

Mrs. Velázquez and I have had over 40 hearings. And in all of those hearings we have been in total agreement on every issue that was brought up at the hearings at the full Committee level. And the reason for that is the fact that we are here to represent small businesses, how they are affected by rules and regulations.

We unfortunately had to issue an subpoena last night to Mr. Scully. The subpoena was duly served. Mr. Scully appeared in this Committee room approximately 15 minutes ago he advised our staff that notwithstanding the Congressional subpoena, that he was not going to appear today at this hearing.

We, of course, will take every precaution necessary and every measure necessary, because we represent small businesspeople. And he did not like the fact that he had to appear at a table with lobbyists, end of quote. And we said it is important that you appear at the table with people who are affected by regulation. Tom Sullivan is part of the Administration; it does not bother him to be here.

So it is very disheartening that the person who is in charge of making all the rules and regulations for the delivery of health care services, for Medicare and Medicaid, purposefully, willfully, inten-

tionally is ignoring a subpoena of the Chairman of the Small Business Committee of the United States House of Representatives.

This is extremely, extremely serious. But notwithstanding that, we are going to have the hearing. And I am going to encourage the members of the Committee to address their questions to the empty chair.

Mr. Scully put his testimony on the table. His testimony will not be admitted into the record. The testimony of all the other witnesses will be admitted into the record, the full and complete written testimony. In addition to that, I am going to leave the record open for a couple of weeks. Anybody who wants to submit testimony to be part of this record can do so. Keep your comments to under two typewritten pages, and get those to Mr. Pineles, who is seated next to me.

The purpose of this hearing is to complement what President Bush said on March 19, 2002. He is a Member of the Administration. He should be; he is a great President.

But he stated that 'every agency is required to analyze the impact of new regulations on small businesses before issuing them. This is important law.

The problem is that it has often been ignored. The law is on the books. The regulators do not care that the law is on the books. From this day forward they will care that the law is on the books. We want to enforce the law.' End of quote. That is what President Bush said on March 19 of 2002.

I concur with the President, the law must be enforced. This Committee will play its part in ensuring that the regulators comply with the law because it is important to small businesses.

This is the first hearing to ensure that the regulators will care that the law is on the books. The Health Care Financing Administration, or HCFA as I will continue to refer to it, not by the new name—you know, you do not change the nature of a substance by giving it a new name. It is still the old name. Unfortunately, the old habits continue. I am not going to refer to it as the CMS, because they have not deserved the dignity of being given a new name unless they come up with a new product.

Today's hearing focuses on HCFA's compliance with the Regulatory Flexibility Act, or RFA. In particular, the Committee will be examining HCFA's analysis, or more to the point the lack of analysis, in implementing the physician fee schedule.

HCFA's failure to comply with RFA in developing the physician fee schedule is emblematic of an endemic problem at HCFA. The regulators do not care that RFA is on the books. From this day forward, HCFA will care that the RFA is on the books. And I may issue a subpoena every day to Mr. Scully to have him come here, and just for the purpose of showing up and asking questions, so he will learn that he is an unelected official.

The purpose of this Committee, one of the purposes is oversight. We oversee, they show up; they do not determine the rules. The Committee is not interested in excuses or crabbed interpretation by lawyers at HCFA to avoid compliance with RFA.

The Committee expects that HCFA, if it wants to demonstrate that it is a new agency, will comply with the RFA. HCFA should evaluate the cost of the regulations on small health care providers,

and examine alternatives that are less burdensome to our health care providers.

I would now yield to our ranking Minority Member for an opening statement.

Ms. VELÁZQUEZ. Thank you, Mr. Chairman. Today's hearing is the fourth in a series of hearings we have convened to examine the Center for Medicare and Medicaid Services, and its heavy impact on small businesses.

We are here to hold accountable this very aloof federal agency for ignoring the law that requires it to reach out and involve small businesses in drafting the regulations that affect them the most.

The Regulatory Flexibility Act has been in effect for more than 20 years. Yet federal agencies still feel free to ignore its mandate. Well, I want to ask the chief representative of CMS what he does not understand about following the law.

Doctors and dentists in private practice are the quintessential small businesses. In fact, two-thirds of all doctors' offices employ fewer than 25 workers. Most dentists are solo practitioners with no more than four employees. This means that the great bulk of our medical service providers lack the resources they need to absorb administrative burdens and costs put upon them by federal paperwork and regulation requirements.

With Medicare the burdens are extreme. The senior health insurance compensation system has more than 10,000 pages of rules, policies, and regulations. The effect of this complexity should be obvious.

A recent survey indicated one-third of doctors spend one hour on Medicare paperwork for every one to four hours of patient care. For dentists, this burden can be outright debilitating.

And the end result is what should really concern us. These health care providers get fed up with the hassle and decreasing compensation, so they stop taking new Medicare patients.

Making matters worse is the operation of the Centers for Medicare and Medicaid Services. This agency has been particularly delinquent in reaching out to small business during the development of regulations. This is one of the requirements of Reg Flex that the agency has chosen to ignore.

Regulations can be fair, balanced, and provide the necessary protection to our health, welfare, and environment. CMS must work to determine the impact its regulations have on small businesses, explore the regulatory options for reducing that impact, and allow itself to be held accountable for the final choice on a regulatory approach.

Mr. Chairman, I just would like to add that the action and behavior of Mr. Scully today are just incredible.a And the lack of respect to this Committee, and to you, and to all the members of this Committee. I do not understand why he cannot come and answer questions. Why is it that they are so hostile to small businesses?

So I am ready, I am willing, I am prepared to work with you. And if we need to hold him in contempt, we will do so.

Thank you, Mr. Chairman.

Chairman MANZULLO. We are going to change the rules a little bit. I am going to allow two more opening statements. I have invited Dr. Weldon to come and be on the panel today. I am going

to have him give an opening statement. And then Dr. Christian-Christensen will also give an opening statement.

Mr. PASCRELL. I have a question.

Chairman MANZULLO. Yes, go ahead, Bill.

Mr. PASCRELL. Mr. Chairman, not as an opening statement, but a statement. We have an emergency situation in this country. In the last two months a disproportionate number of physicians have ceased being Medicare providers. This is a dangerous situation. And for this Administrator not to be here at the bequest, at the request of this Committee is an absolute travesty. And I want you to know personally that I look at it as a travesty. And I want you, as our Chairman, to do something about it.

Chairman MANZULLO. We will do that. Thank you. Dr. Weldon.

Dr. WELDON. Thank you, Mr. Chairman. And I am honored to be able to join with one of my other physician colleagues in the House to speak on this issue. And I would imagine she may say the same thing that I am going to say.

I practiced medicine for 15 years prior to being elected to the House of Representatives, and I still see patients about once a month at the VA clinic. And I made significant use of portable x-ray services in five nursing homes where I took care of my own patients in those nursing homes.

In the typical scenario where I would use it, I would be seeing patients in my office, and I would get a phone call from one of the nursing homes. And I would get on the phone with a nurse, and the nurse would tell me that my patient had a fever and a cough, or had fallen and hurt their wrist or their arm or their knee. And I was really faced with a simple dilemma in that situation.

And the simple dilemma was, do I put this patient in an ambulance and transfer them to my office, and try to evaluate them in my office? And then put them back in an ambulance and send them back to the nursing home, at a substantial cost? Or do I send them by ambulance to the emergency room, at substantially higher costs? Or do I call one of the portable x-ray providers if I needed a film?

And I found the portable x-ray service to be extremely helpful. They would typically be there in less than an hour, which was often quicker than they could get the x-ray in the emergency room, amazingly. And they would have it developed, and then they would have a radiologist calling me with the results of the x-ray, mind you at no additional charge, which is something that I could only get with extreme difficulty out of the hospital.

Often the information was extremely valuable. It was no fracture, and we could begin a course of anti-inflammatory agents, splinting, Ace bandages. The results on the chest x-ray would be no evidence of pneumonia. Even if there was evidence of a pneumonia, if the patient was not in any distress I could begin an antibiotic regimen at the nursing home.

The long and the short of it is I felt like these portable nursing services, or portable x-ray services were saving Medicare, in my particular experience, thousands and thousands of dollars a year on unnecessary transportation costs, unnecessary visits to the emergency room. They were extremely helpful to the patient. I mean, it is incredibly traumatic.

My colleague from the U.S. Virgin Islands knows this. Take one of these elderly people and load them into an ambulance, transport them, it is extremely traumatic to them. And I found it to be nothing short of a cost-saver, hands down.

And frankly, for those people here from CMS, I understand Mr. Scully refused——

Chairman MANZULLO. Excuse me, is anybody here from CMS?

Dr. WELDON. Nobody is here from CMS, not a single person.

Chairman MANZULLO. Anybody here? Not one person here from CMS.

Dr. WELDON. Well, this is disgraceful. Mr. Chairman——

Chairman MANZULLO. Just a second. Let the record, let the record show that we have approximately 70 people in the hearing room today, and that not one person here in this hearing room is from CMS, HCFA. [Laughter.]

Could you conclude so we could——

Dr. WELDON. Yes, I am sorry. I could go on and on about this, but you know, to me this is just——

Chairman MANZULLO. Well, let me make it easier for you. You can ask questions later on.

Dr. WELDON. I will ask questions later on.

Chairman MANZULLO. Thank you.

Dr. WELDON. Thank you, Mr. Chairman.

Chairman MANZULLO. All right. Dr. Christian-Christensen, Congresswoman Christian-Christensen?

Ms. CHRISTIAN-CHRISTENSEN. Thank you. Mr. Chairman, I would like to submit my statement for the record.

Chairman MANZULLO. All the statements will be received for the record, with the exception of Mr. Scully's statement.

Ms. CHRISTIAN-CHRISTENSEN. Thank you. At the outset I just want to express my extreme disappointment in what is happening here this morning. To me it says a lot about the willingness of HCFA to really reform and to be responsive to the needs of our providers.

As we were walking down the hall today and talking about the hearing that we were about to have, which I want to take this opportunity to also thank you and your ranking Member for holding, for attempting to hold a hearing and hold CMS, or HCFA, more accountable. Because certainly we have had a lot of complaints and needs that have to be addressed on behalf of our small business.

But as we were walking down here this morning, we were talking about the hearing and what we hoped to accomplish from this meeting. And it was not to be a confrontational meeting, it was to be a problem-solving meeting, with everyone at the table, as we have sought to do with other agencies. And so this is extremely, extremely disappointing. And it makes me wonder about how well the listening sessions are going. Because if the Administrator is not willing to be here and listen and dialogue with us, then I am not sure what is happening out here.

But as my other colleague said, you know, this is a real crisis in health care that we are facing. Many of us are committed to increasing access for all Americans to quality health care. And what is happening in this case is exactly the opposite. Our seniors, our disabled, our poor, those who are most in need are not being able

to access health care. And the providers are going out of business. They are opting out now. But this is a serious crisis that has to be addressed.

I have another shot at this on Friday. I think I am going to make sure that the press is there. The Congressional Black Caucus Brain Trust is having a hearing, along with the other minority caucuses, on how well the Department is addressing the disparities in health care. CMS is our last panel. The Chief Operating Officer is supposed to be there. I am going to make sure the press is there, because at that hearing we will also be having community-based organizations who will be joining us on the panel. I want to see what is going to happen.

I would also like to suggest that, as we do in every other instance, when we are having difficulty with someone on one level we go to the boss. And I would like to suggest that we call the Secretary in and have him come in, along with Mr. Scully, and begin to address some of these issues for us.

So with that, I am going to not say any more.

[Ms. Christian-Christensen's statement may be found in appendix.]

Chairman MANZULLO. Appreciate that very much.

Ms. CHRISTIAN-CHRISTENSEN. And I look forward, I welcome our witnesses. I want to especially welcome my President, the President of the American Academy of Family Physicians, Dr. Jones, who was willing to join us, and all of our panelists here this morning.

Thank you.

Chairman MANZULLO. Thank you. Congresswoman Napolitano, did you have a couple words in the opening statement?

Ms. NAPOLITANO. Let's go on with it.

Chairman MANZULLO. Okay. Thank you very much. The first witness will be Mr. Tom Scully. Do you have his bio here? Could you start the clock, please? Okay.

Could you please state your name for the record?

[No response.]

Chairman MANZULLO. Let the record indicate that the seat reserved for Mr. Scully that has the Honorable Thomas Scully in front of it is vacant.

Let the record further indicate that this witness is under subpoena by the United States Congress. If anybody in here is from HCFA and you do not want to raise your hand, we will give you the opportunity to get on the phone and get Mr. Scully from down the hall or outside, where he may have secreted himself. And he is welcome to join this panel at any time within the next half-hour.

Could you stop the clock, then? Thank you for your comments, Mr. Scully.

The first real witness is a man who has done a tremendous job as the Head of the Office of Advocacy. He is also a member of the Administration that enjoys appearing on panels with the people that are affected by administrative rules and regulations.

The purpose of this Committee is to solve problems, not to divide Administration and people affected by the Administration into separate camps or separate panels. That is why we like to have one panel, so we can have a good cross-discussion going on.

And Mr. Sullivan, I look forward to your testimony. Thank you for your tremendous leadership that you have provided as the Head of the Office of Advocacy. Please.

STATEMENT OF THOMAS SULLIVAN, CHIEF COUNSEL FOR ADVOCACY, UNITED STATES SMALL BUSINESS ADMINISTRATION

Mr. SULLIVAN. Good morning, and thank you for the opportunity to appear before the Committee this morning to address the adequacy of CMS's compliance with the Regulatory Flexibility Act.

Before proceeding, let me state that consistent with the Office of Advocacy's statutory independence, this statement was not circulated through the Executive Branch for comment. Because of this, these views do not necessarily reflect the position of SBA or the Administration.

I thank the Chairman for accepting my complete written statement into the record. And I will now summarize just the key points to keep within the five-minute time limit.

It is our goal at the Office of Advocacy that CMS more fully consider the consequences of their regulatory actions on small employers prior to finalizing their rules. That is, after all, the primary tenet of the Reg Flex Act.

Recently the President singled out the Reg Flex Act in his small business plan. In a speech three weeks ago yesterday here in Washington, President Bush said, 'I want to make sure people understand that we are going to do everything we can to clean up the regulatory burdens on small businesses.'

The President then talked specifically about the Reg Flex Act, saying, 'Already it is under current law. Every agency is required to analyze the impact of new regulations on small businesses before issuing them.'

The President did not stop there. The Chairman read this part of the President's speech in his opening statement. The President said, 'From this day forward, they, the regulators, will care that the law is on the books.' I was right there when the President said that, and no one in the Reagan Center clapped louder.

Generally speaking, Advocacy believes that CMS should do a better job of following that law. Two recent rulemakings served to highlight Advocacy's ongoing concern with CMS's lack of compliance with the Reg Flex Act.

In July, 1999, CMS's predecessor, HCFA, issued an interim final rule entitled 'Medicare and Medicaid Programs, Conditions of Patients' Rights.' The rule contained standards for the use of patient restraints in hospitals. After reviewing the rule, Advocacy concluded that the one-hour restriction on the use of restraints was particularly burdensome on rural hospitals, primarily because it called for the treating physician to make a face-to-face assessment of the patient within one hour of initiating restraint or seclusion.

Interestingly, the rule became the subject of a lawsuit filed in the United States District Court of D.C. In September, 2000, the Court upheld the rule. But because HCFA failed to comply with the Reg Flex Act, the Court remanded the rule back to the agency for the completion of a regulatory flexibility analysis.

The Court's decision reads, 'The Secretary' the named Defendant was Donna Shalala, 'did not obtain data or analyze available data on the impact of the final rule on small entities. Nor did she properly assess the impact the final rule would have on small entities.'

The Office of Advocacy continues to insist that CMS complete the regulatory analysis, as ordered by the Court. This analysis still has not been done.

Why do the analysis after the fact? Because if CMS can produce regulatory analyses of the rule's impacts on small health care entities for the one-hour rule, they can, and hopefully will, do it for others.

The second rule making is the portable x-ray rule. On three occasions since 1998, the Office of Advocacy has filed comments with CMS concerning the agency's determination of payment policies as they apply to the portable x-ray and EKG industry.

We believed that pursuant to the Reg Flex Act, CMS should have analyzed the impact on this industry separately. Only then would the agency have been in a position to decide whether to certify no impact under the Reg Flex Act, or whether to perform further analysis.

I know that the portable x-ray rule will be discussed more by other witnesses on this panel. So I will conclude my statement by saying that Advocacy is working to implement the President's commitment towards a full agency compliance with the Reg Flex Act.

We applaud the President's renewed emphasis toward Government accountability to the small employer community. My office has found that early consultation with small business works. And we are willing to work with CMS to ensure legitimate small business input.

It is my hope and my desire that the Office of Advocacy and CMS will develop a working relationship that will result in better communication and better compliance with the Regulatory Flexibility Act.

Chairman MANZULLO. Thank you very much. Before we go to the next witness, do you know when the last communiqué was to, from your office to CMS was, on the portable x-rays?

Mr. SULLIVAN. I am told by my counsel that the last letter to CMS was on December 28, Mr. Chairman.

Chairman MANZULLO. Okay, thank you.

[Mr. Sullivan's statement may be found in appendix.]

Chairman MANZULLO. Our next witness is, is Dr. David R. Nielsen, M.D., who is a member of the American Academy of Otolaryngologists, ENTs. And he has written in their journal, I am not going to try to mention the name of that again——

[Laughter.]

Chairman MANZULLO [continuing]. A very well-esteemed and well-respected surgeon. We look forward to your testimony, Dr. Nielsen.

STATEMENT OF DAVID R. NIELSEN, M.D., THE AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY

Dr. NIELSEN. Thank you, Mr. Chairman, and members of the Committee. I want to thank each of you for the opportunity to tes-

tify today. And I concur with the spirit which you expressed, Mr. Chairman, about the purpose of this meeting.

I am not a lobbyist. I am not an administrator. I am a private-practicing physician, and we felt that would be more useful to the Committee, and more useful to CMS, to have that kind of input, rather than simply lobbying activities.

My name is David Nielsen. I am a practicing otolaryngologist. I have no Federal Government contracts. I currently work at the Mayo Clinic in Scottsdale, Arizona, but prior to that I was a solo private practitioner for 13 years. So I can assure the members of the Committee that I can speak personally about the concerns that we have about the burdens that are placed on small businesses and private practitioners in medicine.

We have a common frustration with the barrage of burdensome Medicare regulations and guidelines, and the constant struggle that we face to remain compliant. Rather than talk about all of the issues that I have in my written testimony, let me get right to the meat of what it is that we want to share with you today.

The RFA requires that each federal agency perform and make available to the public an initial and a final regulatory flexibility analysis of any rule that will have a significant economic impact on small businesses, including physician practices. It also states that in this analysis, the Agency must describe any significant alternative proposals that could achieve the rule's objectives at a lower cost to small entities, and explain why each alternative was rejected in favor of the final rule. This has not been done.

Against a backdrop of dramatically increasing practice costs and falling reimbursement rates, federal regulations often have a particularly dramatic and significant effect on physicians. We are subject to a wide array of federal regulations, which includes, but is not limited to, the Health Insurance Portability and Accountability Act regulations on medical privacy and electronic transactions; Medicare and Medicaid fraud and abuse regulations, including the Starek Physician Self-Referral Laws, the Federal Anti-Kickback Statute, and the False Claims Act; the limited English proficiency guidance, and the associated need to provide interpreter services for the deaf, which is required under the Americans with Disabilities Act; and evaluation and management documentation guidelines.

These are simply a few of the regulations that we struggle with.

Let me give you some specific examples. As otolaryngologists who deal with speech and hearing and communication problems on a daily basis, I can assure the Committee members that there is no one more interested in good communications with our patients.

However, the limited English proficiency guidance issued by the Department of Health and Human Services requires physicians who receive payment from Medicaid to provide, at their own expense, trained and competent interpretation and translation services for all of their limited-English-proficient patients.

As an example, an otolaryngologist who practices in the state of Kansas would pay $70 per hour, often with a two-hour minimum, including transportation costs, for an interpreter. But Medicaid would only reimburse the otolaryngologist between $12 and $28 for that visit. That reimbursement not only does not cover practice

costs, but can create hundreds of dollars of out-of-pocket expenses for a physician who wishes to treat Medicaid patients. And hence, people are dropping out of coverage, because it would not be unusual for someone who lived in an area where there was a large multi-lingual population to have more expenses for interpretive services than revenue in the course of the practice day.

We acknowledge that the goals of this departmental issuance are laudable, but forcing small businesses to bear the burden of paying for an ever-growing crop of unfunded regulatory mandates threatens the financial liability of physician practices, and may ultimately threaten patient access to care.

This is not about physician costs, and it is not about physician income. It is about access to care, which is being severely curtailed.

In the context of the Medicare physician fee schedule, CMS could potentially take into account the high costs of compliance through the Medicare economic index, which is a component of the physician fee schedule update formula. Although CMS references this and has included the physician practice expense in the MEI, federal health care regulatory compliance costs are not explicitly taken into account, because the measures are based on price data which come from across the country, from the economy as a whole.

Despite the RFA's requirements and CMS's own admission that physicians are small businesses and qualify for coverage, CMS did not engage in a full regulatory flexibility analysis in the final rulemaking and publishing of the 2002 Medicare Physician Fee Schedule. They do reference the rule.

Moreover, CMS has an obligation to respond to all the comments which were submitted to the proposed rule, pursuant to the Administrative Procedure Act. CMS's failure to perform an analysis of the costs of regulatory compliance under the RFA, or to acknowledge the comments which were submitted, undermines the integrity of the regulatory process.

In summary—I am going to run out of time here, but let me just summarize—we intended to do what you suggested, Mr. Chairman, which is to provide solutions. We really want to find a way to solve these problems. And we recommend the following.

Number one. We urge that all House Members encourage their Senate colleagues to pass the Medicare Regulatory and Contracting Reform Act, H.R. 3391. And we want to specifically thank Representatives Toomey and Berkley, who are responsible for proposing the initial H.R. 868, from which I believe this came. And we are grateful for their interest and support of the legislation.

Second, we recommend that Congress direct CMS and all other agencies to comply fully with the RFA in order to better protect small business entities, like physician practices, from the onerous and costly regulations which we now face.

Third, we recommend that Congress expand the RFA to cover subregulatory issuances to help ensure that small businesses are not unnecessarily burdened. Right now we suffer from such issuances as program memoranda, contractor letters, guidance documents and coverage decisions, which are not technically regulations, and therefore they fall beneath the radar screen of the RFA. These create a significant regulatory burden to small businesses.

And finally, we hope to remove the requirement that small business physicians be forced to arrange for, provide, and pay out of pocket for services for which they cannot be reimbursed.

I would be happy to take any questions later on. And thank you, Mr. Chairman.

[Dr. Nielsen's statement may be found in appendix.]

Chairman MANZULLO. Thank you very much. Congresswoman Christian-Christensen, would you like to introduce the next witness?

Ms. CHRISTIAN-CHRISTENSEN. Thank you. As a family physician, it is my pleasure to introduce Dr. Warren A. Jones, a family physician and retired Navy Captain who is President of the American Academy of Family Physicians. He was elected in 2000.

He previously served on the Board. And the American Academy of Family Physicians represents more than 93,500 family physicians and family practice residents and medical students nationwide. He is a Fellow of the Academy.

He is also Professor of Family Medicine at the University of Mississippi Medical Center, and Assistant Professor of Family Medicine at Howard University School of Medicine, and Deputy Director of the Mississippi Area Health Education Centers.

He recently retired from his position as Medical Director of Tri-Care Military Health Program, the military's health insurance program. So he brings practice experience, as well as management of a health insurance program, to his testimony today.

He previously served as Director of Medical and Clinical Services for the Pacific Region of Tri-Care. He has received numerous military honors, including the Defense Superior Service Medal and the Navy Commendation Medal for Superior Performance. And he has received the Meritorious Service Medal three times.

It is a pleasure for me to welcome you, Dr. Jones, to our Committee.

Chairman MANZULLO. I think we need a man like him to be in charge of HCFA, don't you, Congresswoman? Would you second that nomination?

Before we get into your testimony, Dr. Jones, Dr. Nielsen, where did you come from to be here today?

Dr. NIELSEN. I work at the Mayo Clinic in Scottsdale, Arizona, and I will be the new incoming Executive Vice President of the American Academy of Otolaryngology Head and Neck Surgery.

Chairman MANZULLO. And so you traveled all the way from Scottsdale to be here today?

Dr. NIELSEN. Yes, sir.

Chairman MANZULLO. And then, Dr. Jones, same question?

Dr. JONES. I traveled from the Jackson, Mississippi area, sir.

Chairman MANZULLO. To be here today. And Mr. Evans, same question?

Mr. EVANS. Mr. Chairman, I traveled from Kansas City, Missouri.

Chairman MANZULLO. Okay. And Mary.

Ms. HARROUN. I traveled from Richmond, Illinois.

Chairman MANZULLO. Okay. And let the record indicate that these witnesses have traveled here at their expense. They had been advised in advance that Mr. Scully would be here. Perhaps we

should get all your expenses and send him a bill, and have him pay it personally. But I do not know how that would go over. He just had to come from across the street.

Dr. Jones, we look forward to your testimony. And could you pull the mike closer?

STATEMENT OF WARREN A. JONES, M.D., THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. JONES. Yes, sir, Mr. Chairman. And I would just like to say before my time begins that if you submitted him a bill for our expenses, we would only get paid 40 cents on the dollar.

Mr. Chairman, Ranking Member Velázquez, Representative Christian-Christensen, my good friend and respected colleague, members of the Committee. We thank you for this wonderful opportunity to be here today to comment on the small medical practices and the impact on these practices across the country, especially those of family physicians and other primary care docs who work in our communities to take care of our patients, and to meet their needs.

We particularly appreciate your interest in the CMS implementation of the Medicare physician fee update as it relates to the Regulatory Flexibility Act. We would suggest that the best solution to the problems created by the flawed formula that determines this update is enactment of the recommendations of the Medicare Payment Advisory Commission.

You have already heard about the Academy and who we are. And I would just like to share with you that, in case you may not know, there are three Members of Congress who are members of our organization, including a member of this Committee. And we thank you for all of the leadership you provide in helping to make sure we meet the needs of our patients across America.

I guess some of you may wonder why I am here. But it is important to point out that most of the members of the American Academy of Family Physicians can be characterized in their practices as small businesses. Moreover, recent studies show that the presence of a family physician in a rural community is a substantial economic stimulus.

The study by the Santa Fe Health Policy Research for the Oklahoma State University Health Sciences Center found that, on average, each family physician will generate, both direct by and secondarily, an estimated 50 full-time jobs. And these jobs will generate over $1.1 million income annually for each of these communities. It is definitely a small business worth protecting.

Mr. Chairman and members of the Committee, physicians and other health care practitioners have experienced a sharp 5.4 percent across-the-board reduction in Medicare payments as of January 1. Although it is called a physician fee update, these cuts apply to all services in the more than one million health professionals, including therapists, advanced health professionals, nurse practitioners, chiropractors, and optometrists. And many of these provide services in their own individual offices and serve as small businesses.

The Medicare Payment Advisory Commission has called for the elimination of the current update formula, and warned that cuts of

the magnitude expected under this formula could raise concerns about the adequacy of payments and beneficiary access across our nation. And that is one of the things I wanted to talk to you about.

I wanted to tell you a couple of stories, if I might. I want to tell you a story about a young family physician, Dr. Casey, who dreamed of being a family physician and entered medical school late in life. And her goal was to go back to her town in Kentucky, a small town, Pikeville, and take care of her neighbors.

Well, while in medical school she had her second child, and then her third child, and came out with about $145,000 in debt. But she still went back to the small town, and she delivered care.

But what she is finding now, after three years in practice, she found that she could barely meet her bills. But then she found that the income from Medicare patients decreased so dramatically that, at six years in practice, she is having to go into her savings to keep her practice afloat. With her own savings, she is subsidizing her practice.

She now says that unless the Medicare fee schedule is fixed, she can only stay in practice two more years. She has limited taking any new Medicare patients. This is emblematic of what has occurred.

And as you heard from the introduction, I now live in Mississippi. And one of my tasks will be to help to increase the number of health care providers in the Mississippi Delta and other areas in our state. But I can tell you that the current reimbursement schedule is a major disincentive to young people to choose health care, and to deliver care to the population that is most in need. It is going to be difficult for me to accomplish that task, and difficult for you to see that your communities are served.

I will show you this. And I apologize for not having a copy for each of you right now. But this is a map that shows the United States and what is recognized as health service shortage areas. To give you an idea of the magnitude of family physicians as small businesses, this currently shows in red the areas that are considered small business, excuse me, underserved areas.

But if these family physicians in practice now are unable to remain in practice, and they end up leaving their communities, the areas in red will now become health shortage areas.

Chairman MANZULLO. Doctor, could you show both of those pictures to the people that are in the back? Matthew, would you hold that up so the people who are visiting today can take a look at each of those?

And again, the first map is?

Dr. JONES. The first map is the state of primary health care underserved areas in the United States. And this is including family physicians and all other primary care provides. And if these small practices of family doctors would go out of business, these red areas would represent the underserved areas.

In reality, these small practices deliver care where Americans live.

What we ask you to do today, sir, is to continue what you are doing. Hold these hearings, hold CMS accountable, and be as responsive as possible to the need to make sure that we get the kind

of appropriate reimbursement, not to make money, but to make sure we keep our offices open.

When we have to lay off nurses and we have to lay off staff in order to be able to take care of our patients, we limit access. Seventeen percent of family physicians responded on the survey last year that they have limited Medicare access; they are not accepting any new Medicare patients. If we were to do that survey today, following the 5.4-percent decrease, I am sure it would be up to 25 percent.

And with the continued negative growth rate that is projected under the current formula, we will get to a point where we will have a 17-percent decrease in reimbursement. And no small business can remain in effect and in practice with a negative growth rate like that.

Thank you for the opportunity to be here, and I look forward to entertaining any questions.

[Dr. Jones's statement may be found in appendix.]

Chairman MANZULLO. Thank you, Doctor. The exhibits will be made part of the record. I would like to work with you, and perhaps your association, afterwards to get enough color pictures of that to send to every Member of Congress with a dear colleague. I am sure Mrs. Velázquez would join with me in showing the critical area we are in with so many doctors that will be fleeing the practice.

Thank you for your testimony.

Our next witness is Zach Evans, who is with the National Association of Portable X-Ray Providers. He currently serves as the Chairman of the Board for the National Association of Portable X-Ray Providers; is a provider himself. We look forward to your testimony, Mr. Evans.

STATEMENT OF MR. ZACHARY EVANS, PRESIDENT, NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS

Mr. EVANS. Thank you, Chairman, Ranking Member Velázquez, and distinguished Committee members. I also want to recognize Congressman Weldon. I believe that the proceedings here today will be of great interest to him.

Mr. Chairman, I appear before you today under a cloud of fear: fear of reprisal from CMS for speaking to this Committee, fear of being punished by a federal agency that has targeted my industry for daring to tell the truth.

Just five weeks ago our association testified before this Committee regarding CMS' illegal rulemaking against our industry. The day before the hearing, while John Cavalier, the President of our association, was here in Washington to meet with this Committee, his small business was subjected to an unannounced audit by CMS.

In light of the clear intent of CMS to intimidate volunteers who serve on the Board of Directors of the NAPXP, I wish to thank the Committee for offering to protect my identity in this hearing. In spite of risks entailed in speaking out, I feel strongly as a citizen and small business owner that the only way to combat this abuse is to bring full light to this matter. And that cannot be done from behind a screen, even if the screen is there to protect me.

That an honest small businessman would need, might need such protection from his own government is unconscionable. When Members of Congress contact CMS regarding the data necessary to reach informed decisions regarding our industry, they are told, as you were told, Mr. Chairman, that it cannot be produced. In fact, it can and has.

This data demonstrates a policy failure that has been devastating to the health care delivery in rural America. After Congressman Phil Crane received this stunning information, CMS realized what it had produced, and attempted to retract it.

Now, in response to your request, Mr. Chairman, CMS claims that the same data produced last year is impossible to compile. How can CMS steadfastly hold that their policies are correct, when they also claim that they are unable to compile basic usage data?

As we raise awareness of our situation, CMS targets us with a fraud alert. The February 7 fraud alert was followed by a March 20 CMS request for comments on improving the health and safety standards survey process, specifically for portable x-ray services.

Obviously, looking for irregularities within our industry has become a very high priority for CMS in the wake of our discussions with this Committee and others.

While CMS aggressively seeks to uncover supposed fraud within the industry, they refuse to assist us in educating small business providers of our services, so that they might better serve the public and avoid improper activities. We have repeatedly requested either CMS speakers or responses to technical questions to assist us in complying with CMS regulations. Routinely, we are unable to get a speaker or answers to our questions.

Obviously, preventing improper billing or fraud by interacting with us is not a priority, while catching someone at it is.

Mr. Chairman, our role in health care delivery is relatively simple. We provide x-rays, EKGs, and other diagnostic services at the patient's bedside. We do so at a substantial savings to Medicare, over the alternative of transporting the patient to the hospital.

CMS would have you believe that doctors carry EKG devices with them to nursing homes, family members of patients transport their loved ones to other facilities, or nursing homes purchase the equipment and provide the trained staff to provide these services themselves.

We are fortunate to have two Members of Congress here who are also physicians today with us, Dr. Weldon and Dr. Christiansen. I ask these professionals, are the claims of CMS credible? Do they stand up to your personal experiences in the medical profession?

CMS offers no data to support these assumptions. In spite of the clear statutory requirements contained in the RFA, SBREFA, the APA, and the Social Security Act, CMS refuses to consider the impact upon our industry of their rulemaking, consult with us during the rulemaking process, or in any way evaluate industry costs prior to setting our reimbursement rates.

In his letter to you, Mr. Chairman, Mr. Scully states that the PEAC Committee is the appropriate body to review our industry costs, and the process is more efficient. We applied for a seat on that Committee and were denied.

Mr. Chairman, counsels for both the Legislative and Executive Branches are of the opinion that CMS is engaged in illegal rulemaking pertaining to this industry. While CMS has no effort or expense in seeking to uncover fraud within our industry, they refuse to obey federal rulemaking statute.

We know that small business providers will be prosecuted if they get caught in expanding, in the expanding CMS fraud net. I ask you, who will prosecute CMS? How can we be subject to penalties for improper billing, when the rulemaking that establishes the billing is illegal? When a federal agency refuses to obey the law, and then uses its might to punish the small businesses that dare to complain, where do they go for justice?

In closing, Mr. Chairman, I want to thank this Committee again. I would also like to especially thank the two physicians. Congresswoman Christiansen and your staff have been most helpful. I appreciate the time that Dr. Weldon has given. As I know, he does not sit on this Committee. And I would formally request that this matter be investigated by the Committee on Government Reform, and specifically the Subcommittee which Congressman Weldon chairs, Civil Service and Agency Organization, as he deems appropriate.

Thank you for your time. And I will be available for questions.

[Mr. Evans's statement may be found in appendix.]

Chairman MANZULLO. Thank you very much. Could you, if you would not mind, take the seat here on the end next to your props? And Matthew, could you put Mr. Scully's sign down there at the end, and replace the signs? It will be a little bit easier for you to testify with your props there.

Mr. EVANS. Do I have to sit beside him? [Laughter.]

Chairman MANZULLO. Okay. The next witness is a constituent of mine from Richmond, Illinois. Mary is the President and CEO, and probably chief manufacturer, of Merry Walker Corporation. And we look forward to your testimony, Mary.

STATEMENT OF MARY HARROUN, PRESIDENT, MERRY WALKER CORPORATION

Ms. HARROUN. Thank you very much, Mr. Chairman.

Chairman MANZULLO. Could you pull the mike a little bit closer to you?

Ms. HARROUN. And members of this distinguished Committee.

Back in 1990, I invented the Merry Walker after having spent 20 years in the nursing home industry watching my residents melt away under the guise of restraints and sitting in wheelchairs. Twelve years ago I invented a product known as the Merry Walker, which is a registered trademark, and is honored by being protected with two U.S. patents.

When I was in the nursing home business, industry, as a geriatric psychologist and licensed nursing home administrator, I looked around at my residents and I said, you all walked once, why aren't you walking any more? And they were sitting in wheelchairs at that time, with Posey belts. And now today, because of CMS, they are now still in wheelchairs, under the guise of chair alarms, which forbids them from standing because this horrible, screeching,

loud, buzzing noise occurs behind them every time they go to stand up.

Physical therapists have said it takes three weeks for an elderly person sitting in a wheelchair to never, ever walk again. That is intolerable.

My issue with CMS is the minimum data set, which is done on all 1.8 million residents in nursing homes, hospitals, and VA facilities. That is done upon entrance; it is maintained every three months. There are 500 questions that are posed to fill out this assessment, of which then CMS somewhere here in this area has a large database.

There are 500 questions. There are 17,000 nursing homes. And there are 1.8 million people suffering because of the MDS.

My issue started last summer. Actually, Merry Walker, we had some discussion back in 1994 as to whether it was a restraint. I discussed it with Lois Steinford, who was Chief of the Nursing Home Survey Process for HCFA. She has since retired. But she stated that Merry Walker is an enabler, and a piece of adaptive equipment very worthy of praise, and it does the job of getting elderly ambulatory, and keeping them ambulatory.

I did not pursue it any further. When the MDS was brought out in 1995, I got a copy of it on my desk, I read through the format of the assessment and saw no problems. It was not interfering with my product. I did not agree with it, but never mind.

Last summer I was at the Alzheimer Educational Conference in Chicago, and Mary Lucero, a geriatric psychologist, as I am also, of geriatric resources, gave a full-hour seminar on the benefits of the Merry Walker ambulation device. Many of her attendees of that seminar ended up coming up to my booth afterwards saying, 'We can't use the Merry Walker.' I am going, 'What? Why can't you use it?'

Ended up calling the North Carolina Public Health Department. And in my fax machine I received page 3158 of the MDS Users' Guide. I did not even know this was available, because I am not in that aspect of the field any more.

I read from this lovely publication, under 'Devices and Restraints. Intent to record the frequency over the last seven days which a resident was restrained by any of the devices listed below at any time during the day or night.' And we have a definition of a restraint, which is a mechanical device, equipment attached to or adjacent to the resident's body that the resident cannot easily remove, and that restricts freedom of movement or normal access to one's body.

We have full bedrails. We have other types of bedrails. We have trunk restraint and we have limb restraint. Then we get down to the fated clause of chair prevents rising. And I will read.

'Any type of chair with a locked lapboard or a chair that places a resident in a recumbent position that restricts rising, or a chair that is soft and low to the floor (that is, bean bag chair); includes lap cushions (that is, lap buddy, Merry Walkers).'

I obviously contested that immediately with CMS, and have had no result. We have received statements that I feel are untrue, citing regulations that do not exist. So I am here to appeal to you to intercede on behalf of the 1.8 million people, to allow them the pos-

sibility of getting out of wheelchairs, and saving Medicare billions of dollars against decubitus ulcers and unnecessary fractures.

Thank you.

Chairman MANZULLO. As part of your testimony, could you demonstrate how that latch works, and how it has been denominated as a restraint?

Ms. HARROUN. Anybody who normally walks with the assistance of one person is the candidate to use Merry Walker. Most of the people in wheelchairs are able to get up and walk in the Merry Walker.

This cross-bar, which seems to have CMS in a problem, I have to have this closed securely, because I have to hold onto it. And they are able to walk, walk, walk. When they get tired, they simply sit down.

Chairman MANZULLO. Explain the significance of the legal definition of restraint on the nursing homes, and why those machines are not in nursing homes. You can resume your chair and speak into the mike.

Ms. HARROUN. The objection that CMS has to the Merry Walker is the front latch mechanism. And they are claiming that cognitively-impaired people are unable to open that front gate.

Anybody with an Alzheimer-type dementia is totally impaired from doing anything in the abstract. They cannot open a doorknob, they cannot use the commode by themselves, they can hardly feed themselves, because those things are in the abstract.

Because the latch mechanism on the Merry Walker happens to be in the abstract is basically there for their safety. Merry Walker needs to be deemed an adaptive device, and that is what they are not doing.

[Ms. Harroun's statement may be found in appendix.]

Chairman MANZULLO. Thank you. Dr. Christian-Christensen?

Ms. CHRISTIAN-CHRISTENSEN. Thank you. I would like to first, submit some documents for the record. One of them is a letter that Congresswoman Nydia Velázquez and I wrote to Administrator Scully on the issue of the x-ray audit that took place on the day that they were testifying here. It was, this came out of the blue. It was something that they thought had been resolved, or at least was put on hold. And while the testifying was taking place, they were being audited.

In addition to that, they were meeting here that week, and they asked for some, for CMS to send some, a representative to explain some of the regulations to their membership. And they refused to go. So I wanted to submit that for the record.

And also some documentation from some of my own constituents on the problems that they have been having, and on which we want to meet with CMS.

Chairman MANZULLO. The documents will be received and be made part of the record without objection.

Ms. CHRISTIAN-CHRISTENSEN. I want to commend Ms. Harroun, is it?

Ms. HARROUN. Yes.

Ms. CHRISTIAN-CHRISTENSEN. On the wheelchair. In fact, if I could just tell a quick story about a person that, I had a constituent who was in the VA hospital who was in a wheelchair. And

we were able, with working with the American Legion, to get that person home, into an area where he could have assisted living. The wheelchair failed to come.

We were called and worked to get this wheelchair to come, get to the Virgin Islands from the VA in Puerto Rico. I thought it had been resolved. I was in a little restaurant one day, and this old man came in to me, walking. And he introduced himself. It was the same person. The wheelchair never came.

Ms. HARROUN. Good. Good.

Ms. CHRISTIAN-CHRISTENSEN. He was walking with a cane. So this is a really great invention, I guess I would call it. I hope we can work to get it approved.

I wanted to ask Mr. Sullivan a couple of questions. Your last statement said it is your hope and desire that the Office of Advocacy and CMS will develop a working relationship that will result in better communication and action on the issues that are of concern to the Committee.

I mean, how do we make that happen? This is not the first time that you have been here. We have gone through this over, you know, several times. How do we make that happen?

Mr. SULLIVAN. Congresswoman, we keep trying. We keep trying over and over again, to the extent that we need to write more letters that clarify their reluctance to comply with the Regulatory Flexibility Act. We will do that. To the extent that we work with OMB in a signed memorandum of understanding that clarifies exactly how agencies are supposed to comply with the Reg Flex Act, we will do that.

Ms. CHRISTIAN-CHRISTENSEN. Did you and OMB make any headway after your last meeting here?

Mr. SULLIVAN. Yes, we have, Congresswoman. We have actually signed a memorandum of understanding to share information that leads to a decision-making by OMB when it comes to rules.

So to the extent that we document non-compliance with the Regulatory Flexibility Act, we then make available that analysis, and a response or lack of response to that analysis to Dr. John Graham, when they make a decision on whether or not a regulation should move forward.

So the simple answer to your question is, we keep trying. And we try with the help of this Committee, and any other help that we can, to convince CMS that it is to their benefit to adequately consider the impact on small business.

Ms. CHRISTIAN-CHRISTENSEN. Are there any suits pending right now? I cannot remember from the last hearing. Are there any suits against CMS to which you have filed an amicus?

Mr. SULLIVAN. As to whether or not we have filed an amicus brief on pending suits, the answer is no. But there is still outstanding the court decision that orders CMS to do the regulatory analysis that is in my written statement. We will continue to try and work with this Committee to make sure that CMS does that regulatory analysis and complies with the court decision.

Ms. CHRISTIAN-CHRISTENSEN. Does anyone else want to add anything to how do we make them comply? Because it is getting very frustrating, Mr. Chairman.

Dr. NIELSEN. Mr. Chairman and Congresswoman Christian-Christensen, it was our intent, as we came here today, to be here testifying in the spirit which you mentioned at the beginning, Mr. Chairman. Our intent was that our testimony not be an attempt to accuse, or to malign, or to embarrass anyone; but rather, an opportunity for us to sit around the table, express the reality of what we face, and work toward some common conclusions and results.

In fairness to Mr. Scully and to his administration, much of what we are complaining about, or much of what we see as a problem, was inherited by him and by his administration. And we have had assurances from Secretary Thompson and from Mr. Scully that they intend to sit down with us and work with us on this.

And so my contribution would be that we continue to try to do that. If this is not the right venue, let's find another one. But we stand ready to meet whenever and wherever to openly discuss the reality of these situations, and find solutions for them. We did not intend in any way for this to be a confrontational situation.

Mr. EVANS. Thank you for letting us have this moment. I agree with the gentleman that spoke before me, that HCFA did inherit some of these problems. But I will tell you that the new CMS has effectively closed their ears. They do not, they do not want any conversation.

Before, they at least talked to us. They listened to us. And they may say yes occasionally, once in a blue moon; but they at least said no, and we knew where we stood.

It is out of control. It is completely out of control.

Ms. CHRISTIAN-CHRISTENSEN. Mr. Chairman, I know my time is up right now, but I get the sense that perhaps Mr. Scully, Secretary Thompson did not understand the complexity of the nature of HCFA and what they were going to have to deal with. You know, I really think it is out of control.

Chairman MANZULLO. Dr. Weldon.

Dr. WELDON. Thank you, Mr. Chairman. And I want to again thank you for providing me with the opportunity to join with your Committee and your colleagues on this very important hearing.

Mr. Evans, if you could just answer a few questions for me. I understand there have been several audits of your industry throughout the country. Representing your industry today, can you comment on the outcome of those audits in terms of the numbers or percentages of portable x-ray companies that have been found to be over billing, or double-billing, or engaging in any kind of fraud in the Medicare program?

Mr. EVANS. Sure. To give you statistics of the whole industry is a pretty tough thing to do, because obviously not all portable x-ray providers belong to our association. I can tell you that within our industry, we have done anything and everything to try to make sure that we are compliant. We have had conversations with CMS on how to be more compliant, how to avoid fraud.

I think that what is happening is that we do not order the x-rays, Doctor. We do not know who to bill, unless the skilled nursing facility, or SNF as they are called, tells us who to bill. The rules are so confusing that a lot of the time the finger gets pointed back at us.

I will tell you that I was personally audited recently, within the last few years. I came through, you know, clean as a whistle. In fact, they said there was a $29 problem, so to speak, and we came back and showed them that there, in fact, was not a $29 problem. There was not an issue there. But as far as statistics, I cannot tell you exactly.

Dr. WELDON. So you do not keep track of the number of audits for your members, and——

Mr. EVANS. No. We have——

Dr. WELDON. The reason I ask you the question is, Medicare, CMS has really not provided us any data to support the claim that would justify a fraud alert for your business. And so I was wondering if you had any information as to how much fraud is out there.

Mr. EVANS. I think that every, I think that every industry, be it, and I do not care what industry it is, I think that every industry has some dirt.

I can tell you that the President of our association was just recently audited, as I said in my testimony. His came back clean. And his was a federal audit, not a state audit.

Dr. WELDON. Now, I wanted to get into that a little bit with you. You implied in the opening comments that his audit was some kind of a reprisal from CMS?

Mr. EVANS. It sure appears that way to me. I have got to tell you, in my testimony my fear is, as far as I am concerned, well-founded. I have instructed my staff that if CMS walks in, or the state walks in, that I am out of town and they will have to come back. That they do not have all the records there to be able to go through it.

I am very fearful that they are going to come in and audit me. I am very fearful, not only for myself, but for the members who we represent.

Dr. WELDON. How are you typically reimbursed? If you get a call from a nursing home to go do an x-ray or EKG, do you bill through Part A or Part B? Either one?

Mr. EVANS. The skilled nursing facility has to instruct us. There is no way for us to go in and know whether this is a Part A patient, in other words a patient that has spent three days or more in the hospital and has been released back into that facility, and is still under the Part A care; or if it is a Part B patient, and the Part B patient is there under, has not been in the hospital and is there for just normal care.

We have no control over that. And I think that that is one of the reasons why this is so hard to track. That is one of the reasons why we have looked for exclusion from PPS.

It is my understanding that CMS has said we want to treat everybody the same within a group. We are not treated the same. We are in the physician's fee schedule, and we are the only people within the physician's fee schedule that are not excluded from PPS.

Dr. WELDON. Dr. Jones, as I understand it, CMS is scheduled to put through another 5-percent reduction for reimbursement, and then possibly another reduction after that.

Is that what you were alluding to when you showed those two maps? If these things progress onward, more and more providers

in your association would have to just start refusing to see Medicare patients? It just would not be profitable at all for them to see these people? Is that the concern you are raising?

Dr. JONES. Thank you very much for the opportunity to answer that question, Congressman Weldon.

The formula is so flawed that Mr. Scully was quoted himself, on the 2nd of February of '02 in The Milwaukee Journal, as saying that the formula is, quote-unquote, screwed up and exceedingly harsh. And if he is saying that as the head of the Agency, it shows that it really needs to be addressed.

The problem is that it is scheduled for 5.4 percent this year, 5.7 percent next year. And it is the formula that is tied to the GDP, and not tied to the expense of the office for seeing patients, as you know.

So the problem is, what we see occurring is that this negative rate of reimbursement, this negative growth will make it such a disincentive for our best and brightest to look at coming into health care and for those who are currently practicing, to continue to see the Medicare population, which is our most needy population, those that are elderly and those that are infirm.

And we just cannot afford to have that happen. We need to have this formula fixed. The regulators are saying it is beyond regulatory control. And if it is, then we need to now look at getting some help from Congress.

Dr. WELDON. It is in the statute in the '97 budget agreement, Congress has to fix it. Thank you, Mr. Chairman.

Mr. EVANS. Congressman Weldon, Mr. Chairman, may I make another statement?

I would just like to say that the 5.7-percent decrease that Dr. Jones spoke about translated to our industry as a roughly 12-percent decrease in revenue. If this other 5.4 percent goes into effect, we are gone. In fact, we have, we have providers in California that are already going by the wayside.

Added on this with the situation with the prospective payment system, and us being under that system, in October the skilled nursing facilities are taking a 17-percent cut in their revenues. They are paying us for Part A patients; they will no longer be able to afford to pay us.

While the situation with physicians is a critical situation, and I agree with it, we are about gone.

Chairman MANZULLO. Thank you. Go ahead, Dr. Nielsen.

Dr. NIELSEN. Mr. Chairman and Congressman Weldon, the extent of this goes far beyond that. It has not been too many weeks since the announcement of the expected decreases over the next five years were announced. And I do not remember the exact numbers, but it was approximately 5.5 percent two or three years in a row, and 2.8 at the end. And when you add those up, you are talking about a 20-point-something-percent reduction. And in a small business private practice, where overhead may be 50 percent, that is a 40-percent cut in pay.

It is not about physician pay, but physicians who have to pay out of pocket to treat patients will stop treating them. And although this is a map of primary care, we have regions of the country where specialists such as our head and neck surgeons, who have to pro-

vide very comprehensive care for head/neck surgery cases with long global periods and extensive follow-up, are unable to afford to do it. They simply stop providing the care.

And as a lot of insurance companies adopt Medicare fee schedules and global periods, it extends way beyond Medicare. Then it becomes your entire insured population. That cost shifts all of the specialty and tertiary care to regional medical centers and academic institutions, who can no longer bear the burden. And pretty soon we are going to start losing teaching institutions.

So the ramifications of this go far beyond primary care, and far beyond the kind of mapping that you see here that Dr. Jones presented.

Chairman MANZULLO. Thank you. Ms. Napolitano.

Ms. NAPOLITANO. Thank you, Mr. Chairman. I think we can probably spend weeks really getting complaints, if you will, on HCFA. And I come back from the state level, where we went through this ad nauseam.

The issue then, Mr. Chairman, is, will you set up a meeting with Secretary Thompson, and maybe get to the bottom of how can we work together? Not being punitive, not being aggressively charging anybody with dereliction of duty or whatever. But get to the point now. We are facing a critical state.

Chairman MANZULLO. We have remedies to take care of people who obstruct truth from coming forth, and that is the purpose of this Congressional hearing. We will pursue those avenues vigorously.

I think it would be a good idea for us to send a letter to Secretary Thompson, who is a marvelous man, and explain to him that somebody under his watch is not doing his job.

Ms. NAPOLITANO. Or explain why he is not doing his job to the satisfaction of this Committee.

But I think it goes beyond. I can tell you that some of my providers have been, especially home health care providers, nursing home providers, and some of my dentists are complaining to me about their not being able to treat patients. They are cutting down repeatedly because of, the statement has been because of the lack of reimbursement, and they have to keep their door open.

So you cannot blame them. And we are not really helping the people who need it the most, that will not have the access to this assistance. And whatever can be done, we are with you, Mr. Chairman. And I think the rest of the Committee understands the severity of the issue. It is not going to get better, and we need to act expediently as possible.

Thank you.

Chairman MANZULLO. Thank you. Let me put this into the record. The number of times that I can think of off the top of my head where we have had members of the Administration along with small businesspeople.

We had somebody from the VA along with a constituent of mine complaining about when the VA went into the laundry business. And that particular match, the VA came in, the shortest statement I have ever heard. They said as soon as we got your letter, take our word, as of June 30 last, the VA is out of the laundry business. We saved about 200 jobs in my district alone.

We have a match with somebody from the National Parks Service, and a camp owner from Denali in Alaska. And as a result of that, Denali National Park decided not to go into the hotel business. We saved about eight small businesses that had campgrounds outside.

We had a match with Mr. Barreto, who has been nothing but fabulous with the SBA, is doing a great job, and Dr. Graham from OMB. It was a pretty tense meeting. But it brought the parties together, along with the owner of Albany Travel, over the size standards. As a result of that hearing bringing the people together, new size standards were promulgated almost immediately. Albany got their $600,000 loan and were able to stay in business.

Again, Hector Barreto came in with people from the industry with regard to the subsidy rate. And our policy here is whenever anybody testifies from the Administration, if there is somebody with the witness that knows the answer better than they do, that individual just scoots up to the table, identify them self for the record, and answers the question.

Dr. Blanchard testified, it was about three weeks ago, extremely productive hearing, all going to the resolution of that issue.

We had a match with somebody from the Federal Prison Industries, with the lady from Ohio, dealing with electronic harnesses. And as a result of that, Federal Prison Industries went out of the business of making electronic harnesses and she got her contract.

We had a match with the Defense Logistic Agency when two Major Generals were here, and a lady from Phoenix, Arizona. As a result of that hearing, the importation of most of those black berets stopped. We got a $50 million set-aside for small businesses and helped save her business in Phoenix, Arizona.

We had a match with the National Park Service and the folks at West Yellowstone, Yellowstone, Montana. As a result of that valuable testimony, it went into the record on the impact on small businesses.

We had a match when I held a field hearing in Santa Fe, New Mexico, with the people who run the Los Alamos Lab, along with members of the six Pueblos, the Indian tribes, and others who were seeking contracts. As a result of that, one person who was complaining was put in charge of overseeing all contracts at Los Alamos, with an initial start of $50 million being set aside for small business involved in construction.

That is how we do business in this Committee. And I think for Mr. Scully to wield his arrogance, to think that he cannot sit down with these nice people. I mean, to me it just defies logic that a person can remain a part of the Administration and come here, and stiff a Congressional Committee, ignore a Congressional subpoena, when our only purpose here is to save the jobs of small businesspeople.

And it has always been within this spirit that we have worked on this issue. And I would say if Mr. Scully is somehow—he is missing an opportunity, I think, to redeem himself and the organization. Now what you have here is an antagonistic group of people.

I really think that Mr. Scully should resign. He should resign his office immediately. Anybody who does not take the time to meet with people, to take the input from the people most affected, is

doing a disservice to the seniors of this country, and to the poor who rely upon Medicare services. And the sooner he does that, the better. I mean, we need to get on with the tremendous problems that are affecting this Government.

It was in the last Administration where the Doctor Hulsebus, it was three brothers, from Rockford, Illinois were savagely and brutally attacked by HCFA that said they owed $250,000 in chiropractic overpayments as a result of extrapolation. We took on HCFA at that time, and brought them out to Rockford, had a meeting and found out that they did not even know what an x-ray was. They had no idea. How can you say that an adjustment by a chiropractor was not medically necessary when you did not look at the x-rays? As a result of that, that entire fine was lifted. It got down to eventually $1500. HCFA insisted on appealing the remaining $1500 on that, and they were persuaded not to do that, and to drop the appeal.

This is an agency that has, my understanding, 4,500 employees. I do not know what they do. They contract with 81 different companies, including Wisconsin Physician Service that does my area. They are some of the worst people, who know absolutely nothing about medical care. They have 81 different sets of regulations, 81 different sets of standards. Totally confusing the medical industry. Demoralizing people who spent years in college for the purpose of healing. And many of those are here in this room today.

I just think when I look upon the tremendous amount of sacrifice, and the witnesses here, and the time that you have put in for the practice of healing. You came here today to heal some of the wounds that have arisen because of the intransigence of the Health Care Financing Administration.

They are not here today. Perhaps at the next hearing we will have a new Administrator.

Mr. Davis, did you have any questions?

Mr. DAVIS. Yes, sir.

Thank you very much, Mr. Chairman. Let me apologize for not hearing the testimony, but I think I got a good drift of what has been taking place. Plus I think the fact that I have been associated with health care now for about 30 years, and have spent about 15 of those as a health planner, and represent a district that has 24 hospitals in it, four medical schools, and the biggest medical center complex in the country, as well as about 35 or 40 nursing homes and about 25 or 30 community health centers, I spend a great deal of my time listening to the woes of people who have interacted with HCFA. And also having some understanding of why HCFA was created in the first place, to try and handle, or get a handle on, what was called the spiraling runaway health care costs.

I kind of understand a little bit of what has taken place. And I agree with you, it is one of the most complex of all agencies probably within the Federal Government. And I guess the one question—and I have heard these arguments and discussions many, many times, as I am sure most of us have, and all of us probably have—what would your recommendations be to us in terms of what it is that you think we really can do, and need to do, to try to get a, a balance on this problem? That would be my question to the panel.

Ms. HARROUN. I am Mary Harroun, Congressman Davis. I live in your general area. I am a Chicago person.

I have before me a very ragged-tagged book of nursing home regulations. They are there. They were passed in 1990. If HCFA, CMS, would just mandate that their surveyors follow these regulations, providing the highest quality of care possible to our residents in long-term care. They are written. They do not follow them.

Mr. DAVIS. Follow the rules.

Dr. NIELSEN. Congressman Davis, one of the things that I recommended was passage of the Medicare Regulatory and Contracting Reform Act. And one of the most important provisions of that Act is a provision that engages us in compliance education.

Physicians want to be in compliance. Nobody wants to be audited, nobody wants to have their reputation ruined, or their office sacked, or their records reviewed. And we want education.

So to the degree that we have to deal with this extremely complex issue, as you mentioned, and we are going to have difficult regulations whose executive summaries run into the hundreds of pages, help us to educate ourselves so that we can comply. And let's reduce those burdens that are unnecessary.

We are being asked to bear the burdens financially for, for a provision of services that we think are good, but we do not have the resources to cover. If we are going to make those services necessary, then we have to provide the resources to cover them.

I come from a family of 10 children. And if one of us misbehaved, it was not my father's pattern to spank all of us just so that he made sure he got the right one in there somewhere. And that is the way physicians feel. If there is a problem, don't spank all of us. Let's find the problem, and let's weed it out.

Dr. JONES. And with all due respect, I am number nine of 12, and we all got spanked whether we needed it or not. [Laughter.]

But Mr. Davis, I appreciate the opportunity to offer you two suggestions, as a Committee.

I would like to ask your support for the legislation that was introduced by Representative Nancy Johnson, preserving patient access Preserving Patient Access to Physicians Act, H.R. 3882.

The good thing about that is it would affect the MedPAC recommendations and remove reimbursements for expenditures away from the GDP. To me, that is the reasonable way to do it.

Some people say it costs too much. My question is, can we afford not to do it? It is the right thing to do.

And it is interesting to me that CMS found a way to increase the reimbursement for Medicare Plus Choice. It seems as though they wanted to ensure that there was money there to make sure that everyone had an HMO, but not put money into physician reimbursement to make sure that everyone had a physician. There is a disconnect here for me. Your support in helping to make sure this happens, and getting Medicare to do all they can, getting CMS to do all they can from the regulatory component would help us tremendously.

Mr. EVANS. Congressman Davis, thank you for asking the question. My name is Zach Evans, and I am with the portable x-ray providers.

Our industry is 85 percent, 85 to 90 percent dependent on Medicare. We cannot turn Medicare patients away and look for other sources of payment.

Like I said before, we are, if we do not get a bill passed, and it is a bill which Congressman Phil Crane and Chairman Manzullo have sponsored. It is H.R. 3094, which will help fix our industry.

Is it a total fix? No, sir, it is not. Do I think that, that the things that we have mentioned here, all of us have mentioned here today, will help? I think they will. But I think it is going to take more than that in the long run. I think it is going to take an honest effort by Mr. Scully and his organization to respect this Committee and respect the small businesses that are out there. Because I do not see any respect today.

If that had been me, and I ignored a subpoena, I would be in the pokey right now.

Ms. HARROUN. That is right.

Mr. EVANS. Thank you.

Mr. DAVIS. Well, I thank you all very much. And Mr. Chairman, it seems to me—yes?

Mr. SULLIVAN. Mr. Congressman, I actually would like to answer how Congress can help come to a solution, in addition to having these hearings which are intended to be productive.

As far as the Office of Advocacy is concerned, we do need your help to help convince CMS that compliance with the Reg Flex Act is more than simply running a bunch of numbers. When CMS complies with the Reg Flex Act, and they consider their consequence on small business, they will learn what Dr. Weldon has already learned, and what he brought before this Committee. That is that if you consider the impact on transportation costs, and you consider what portable x-ray providers do, you actually save the Medicare system money.

Mr. DAVIS. Well, I thank all of you for your answers. And Mr. Chairman, it seems to me that you do a pretty good job of spanking. [Laughter.]

Chairman MANZULLO. Dr. Christensen.

Ms. CHRISTIAN-CHRISTENSEN. I am sorry that I did not get to this before, but this was something that was shared with us at one of our roundtables. And it shows you what happened to Medicare payments, which is down all the way at the bottom of this. And this is what, where practice costs are.

In actuality, what happens is that there is at least a $20 billion shortfall in the payments over just the last, since 1997. A shortfall of $20 billion over the last five years. The costs are going up, and the discrepancy is just really large.

And one of the problems with this is, and correct me if I am wrong, but whatever Medicare does, all of the other insurance companies follow.

Mr. EVANS. Very correct.

Ms. CHRISTIAN-CHRISTENSEN. So what we are seeing here is the beginning of a process of getting rid of small business health care providers. Because the other insurance companies are going to follow. There is just going to be no way for them to stay in business.

I know it sounds bad to hear that providers are not going to serve Medicare patients, but they just cannot. And it is going to get worse, because this is just the beginning.

Mr. Chairman, I feel like there is a war going on against small health care practitioners. I felt it before I came here, I feel it even more now. The references made by Dr. Jones about the HMOs versus the practitioner, but I feel like they are trying to get rid of all of us and let the big corporations, you know, continue to make the money. You know we cannot let that happen.

Chairman MANZULLO. I have a final question that is technical, Mary, so I am going to read it, if you do not mind.

'It seems clear that in a wheelchair muscles degenerate. But with the assistance of the Merry Walker, those same muscles are used and preserved.

'In the Sunday Washington Post, Mr. Scully announced that HCFA would begin rating nursing homes. The data to be used to rate nursing homes will come from the MDS, that is the minimum data set.'

This was originally a question for Mr. Scully, but since he is not here, I will ask you. I guess you are in his chair. Here is the question.

Since the Merry Walker is deemed to be a restraint and nursing homes are discouraged from using restraints, and are sometimes penalized for doing so, do you believe a nursing home would receive a poorer rating for using the Merry Walker than a nursing home that places residents in wheelchairs?

Ms. HARROUN. Yes, Mr. Chairman. In my research of this MDS wrongful tort suit describing the Merry Walker as a chair that prevents rising, I——

Chairman MANZULLO. They actually took your trademark name——

Ms. HARROUN. That is correct.

Chairman MANZULLO [continuing]. And took out the capitalization——

Ms. HARROUN. That is correct.

Chairman MANZULLO [continuing]. And used it as a generic name in their manual.

Ms. HARROUN. That is correct.

Chairman MANZULLO. Anybody else would have been sued for doing that.

Ms. HARROUN. Yes. And there is no way I can sue them. We have already pursued that. Because they made no money. You can only do a trademark lawsuit when there is money to be made.

Chairman MANZULLO. I just hope, I just hope people realize the significance of what they did to you. It is the same as if somebody took the name Xerox——

Ms. HARROUN. And put it with small letters, and 'do not use it,' basically.

Chairman MANZULLO. And they used your device, with Merry Walker spelled the same way, they did not put the trademark on it, or service mark, in small letters, and used it as an example of what they do not like.

Ms. HARROUN. Right.

Chairman MANZULLO. Okay.

Ms. NAPOLITANO. Mr. Chairman, isn't that defamation of a product?

Chairman MANZULLO. I do not know what it is. I think it is defamation of Congress that these guys do not show up.

Ms. HARROUN. Yes, exactly. The thing is, they have now come across, in their latest writings, which they—when I wrote to them the 1st of August, we have got two answers here coming forth. I will answer your question in a second.

Chairman MANZULLO. Go ahead.

Ms. HARROUN. I did write Tom Scully, Jeane Nitsch, Fred Gladden, and Steve Pelovitz. I copied them all on the same letter, showing them Merry Walker was a registered trademark, it was a patented product. And it is certainly not a chair that prevents rising. I mean, I went into that in detail.

They wrote back on the internet, on a question/answer on the internet stating that Merry Walker is not—they used the trademark. Do you want me to read that?

Chairman MANZULLO. That is all right, you can just——

Ms. HARROUN. All right, I will just say it. They said that Merry Walker, although it is not a chair that prevents standing, it is still a chair that restricts freedom of movement. That is, residents' access to steps—this is nursing home regulations—to the commode, to transferring to another chair, or into their bed. There are no regs on steps in nursing homes.

Chairman MANZULLO. Because there are no steps.

Ms. HARROUN. We have things called elevators in nursing homes. Yes, what a unique idea. And there is no such thing as transferring to a chair regulations, or to a commode, or to bed. That is why they are in the nursing home.

Chairman MANZULLO. So they made a reference to regulations that do not exist.

Ms. HARROUN. That do not exist, that is correct. And it was not my say-so. I did have a witness of an expert on these rules. And there are none.

Now, in answer to your question, I did contact all the MDS minimum data set coordinators of all the large nursing home chains. Marriott, Manor Care, all of them. There are like 20 of them. Got hold of all the MDS coordinators and asked them how they are able or not able to use the Merry Walker because of what the MDS has written.

None of them can use the Merry Walker. None of the large corporations handling the majority of our nursing home residents are allowed to use the Merry Walker because of the MDS.

Chairman MANZULLO. So because HCFA will not correct the miscategorization, a nursing home that allows seniors to deteriorate will fare better under Mr. Scully's rating than a nursing home that attempts to keep seniors active and healthy.

Ms. HARROUN. That is right. So Merry Walker will never be used in nursing homes under this new policy, because they will be cited and they will get negative ratings.

Chairman MANZULLO. Mary, a final question. How many of these have you manufactured and put into the market?

Ms. HARROUN. There is about 100 a month over the last 12 years.

Chairman MANZULLO. So that is, what, about 15,000? Would that be correct?

Ms. HARROUN. About. And there is 1.8 million people that could use them.

Chairman MANZULLO. Have you ever had a liability suit against you for this machine?

Ms. HARROUN. I have never. And I never even had a viable FDA med watch, in 12 years.

Chairman MANZULLO. Okay. This has been a very interesting hearing.

Let me say this. Mr. Scully's not showing up here, in my opinion, my wholehearted opinion, this is not indicative of the President's office. We have worked with numerous agencies. In fact, I was in China the first week of January as the Chairman of the American/Chinese Parliamentary Exchange.

And we sat down with Undersecretaries of Commerce, and state and national security councils, USTR's office. I mean, there was more than a briefing. It was, it was for the purpose of making sure that when I went there, we would present the same message. And I met with the President of China, an extraordinary hour-and-25-minute meeting.

But everything that we did, and the reason I bring that up, it was totally in concert with everything that we want to do with the Department of State, the National Security Council, the Department of Commerce and the USTR's office. It was done purposely, to make sure that they were not only notified of what they were doing, but they helped us set the agenda. Because I believe that the branches should work together.

And that is why I am very disappointed that we have this, this total disconnect that is going on. This Committee does not have the reputation for doing anything other than trying to solve, solve problems.

We will deal with Mr. Scully appropriately, swiftly, according to the rules. And I just want to thank you for coming long distances, paying your own way. Very impressive witnesses. I thank God that there are people like you that are out there, that are carrying the torch, especially to the two M.D.s that studied long and hard and continue to stay in the profession, even though it becomes more and more discouraging.

This Committee is adjourned—I am sorry, Mr. Davis?

Mr. DAVIS. Yes. Before you adjourn, I just want to commend you. I mean, very seriously. I mean, of course this Committee does not necessarily have jurisdiction over HCFA, and this is a serious—I mean, this is a gut-wrenching complex. I mean, it really is.

I mean, I see people come in my office and virtually cry. I have had nursing home operators and home health agencies; people who I am wondering if I am going to be able to keep them from cracking up before they leave.

I just want to commend you for this hearing, and for the depth of analysis of a problem and of an issue that we have been able to explore today. And, and pledge, also, support for your continuing effort as you attempt to deal with HCFA and the Administration, to try and help us move towards some resolution of a big problem facing an awful lot of people throughout the country.

So I commend you for that.

Chairman MANZULLO. Thank you, Congressman Davis. This Committee is adjourned.

[Whereupon, at 11:49 a.m., the Committee was adjourned.]

Congress of the United States

House of Representatives

107th Congress

Committee on Small Business

2301 Rayburn House Office Building

Washington, DC 20515-0515

Statement of Donald A. Manzullo
Chairman
Committee on Small Business
United States House of Representatives
Washington, DC
April 10, 2002

On March 19, the President stated that "every agency is required to analyze the impact of new regulations on small businesses before issuing them. That is an important law. The problem is it is often being ignored. The law is on the books; the regulators do not care that the law is on the books. From this day forward they will care that the law is on the books. We want to enforce the law." I concur with the President that the law must be enforced. This Committee will play its part in ensuring that the regulators comply with the law because it is important to small business.

This is the first hearing to ensure that they regulators will care that the law is on the books. The Health Care Financing Administration or HCFA and I will continue to refer to it as HCFA because I have not seen sufficient change to call it by its new name – CMS.

Today's hearing focuses on HCFA's compliance with the Regulatory Flexibility Act or RFA. In particular, the Committee will be examining HCFA's analysis, or more to the point – the lack of analysis – in implementing the physician fee schedule. HCFA's failure to comply with the RFA in developing the physician fee schedule is emblematic of

an endemic problem at HCFA – the regulators do not care that the RFA is on the books. From this day forward, HCFA will care that the RFA is on the books.

The Committee is not interested in excuses or crabbed interpretations by lawyers at HCFA to avoid compliance with the RFA. The Committee expects that HCFA, if it wants to demonstrate that it is a new agency, will comply with the RFA. HCFA should evaluate the costs of their regulations on small health care providers and examine alternatives that are less burdensome to our health care providers. For example, in developing the fee schedule for portable X-Ray providers, HCFA is required to consult with suppliers of radiologic services to obtain information on their costs. HCFA has not done so. Without this type of data, how can HCFA properly assess the costs of its regulations on small portable X-Ray providers? More importantly, how can HCFA correctly calculate a fee for portable X-Ray providers? HCFA cannot.

The Committee has examined the Medicare statute and concurs with the conclusions of Chairman Thomas and Subcommittee Chairwoman Johnson of the Ways and Means Committee that HCFA has sufficient regulatory discretion to alleviate the problems faced by the witnesses. If HCFA has regulatory discretion, then it has the ability under the RFA to examine alternatives that will reduce burdens on small health care providers. So this Committee will not tolerate the reflex response that Congress is forcing HCFA to do it that way. If HCFA does not change the way it does business, then this Congress, this Committee, Mr. Sullivan, the Chief Counsel for Advocacy, and Dr. Graham at the Office of Information and Regulatory Affairs will force HCFA to change its ways in order to fulfill the wishes of your boss, the President.

Before turning to the Ranking Member, the gentlelady from New York, Ms. Velázquez, I would like to welcome, as ex officio members to the Committee, my good friend Dr. Weldon.

DONNA M. CHRISTENSEN
DELEGATE, VIRGIN ISLANDS

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STATEMENT OF CONGRESSWOMAN DONNA M. CHRISTENSEN
BEFORE THE
HOUSE SMALL BUSINESS COMMITTEE HEARING ON
"CAN IMPROVED COMPLIANCE WITH THE REGULATORY FLEXIBILITY ACT
RESUSCITATE SMALL HEALTHCARE PROVIDERS?"

Wednesday, April 10, 2002

Thank you Chairman Manzullo and Ranking Member Velazquez for holding this hearing to discuss the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, compliance with the Regulatory Flexibility Act (RFA). Over the past two years, this committee has held numerous hearings on the issue of CMS lack of compliance with RFA and democratice roundtables have. Today's hearing, gives the members of this committee an opportunity to discuss with CMS the issues that were raised at previous hearings. One of these issues, which will be the focus of today's testimonies, is the Medicare Physician Payment Crisis. Effective January 1, 2002, Medicare payments for physician services were cut 5.4%. Under current law, CMS projects will continue steep payment cuts for 3 more years. Even before the 5.4% cut, there were press reports of access problems in a number of areas, including Denver, Atlanta, Pheonix, Albuquerque, Austin, and Maryland. Since January of 2002, reports of

access problems have appeared in West Virginia, South Dakota, Florida, Kansas, North Carolina, Wisconsin, Alabama, California, and Washington state. In my district, the U.S. Virgin Islands, where costs are very high, our Medicare reimbursement is far below 100%. This and other cutbacks in reimbursement to home care agencies and skilled nursing facilities has closed down our only home care service and severely threatened the latter facility.

Medicare cuts affect nearly 1 million health professionals, including medical doctors, nurses, podiatrists, physical therapists, optometrists, chiropractors and others. But more importantly, it is the patient that suffers. Emerging data and increasing anecdote about elderly patients unable to find doctors, and nurses because they have stopped taking new Medicare patients. The current method for determining the Medicare physician reimbursement is flawed and is counter productive to keeping healthcare providers in business. The combination of declining Gross Domestic Products and CMS error was the basis for the current cut in physician Medicare reimbursement. For this reason, I am a supporter of Representative Nancy Johnson's legislation to adopt Medicare Payment Advisory Commission recommendations to make annual updates that reflect increases in medical practice costs.

Another area of concern for small business healthcare providers is the expanding regulatory and paperwork burden. Small Business Administration statistics show that the per employee regulatory compliance cost to small firms is approximately 50% more than the cost to large firms. The actual dollar cost is up to $5,000 per employee in some small companies. Part of this regulatory and administrative burden has been created by CMS. CMS has imposed overwhelming regulatory burdens on health care providers – and

caused many physicians to reassess their commitments to patients under the Medicare system. Many in the health care field have expressed their dissatisfaction over CMS' coverage process - which result from the mountain of required health care forms each medical provider, must fill out. For example, after a doctor or other health care provider visits a Medicare patient, they are required to classify and accurately document their services in enough detail for CMS to determine what it should pay back to these providers. With an estimated 3 to 4 hours spent on filling out this paperwork, physicians often rush through these forms in order to ensure enough time is spent with their patients. Consequently, many health care providers either omit irrelevant data or forget to fill out the required checks on each form. The result – in many cases these omissions trigger an audit by CMS. Today, as we speak, a physician in my district, Dr. R.L. Bucher, is having difficulty obtaining reimbursement on claims for blood sugars done in his office. The reason for denial was " treatment was deemed by the payer to have been reentered in an inappropriate or invalid place of service." The place of service was the Dr.'s office. All the patients were clean. All the patients have diabetes. Dr. Bucher, as well as myself, cannot understand what is the problem. In a letter dated November 5, 2001, Dr. Bucher stated that he instructed his staff to stop billing Medicare for this service until the problem is resolve. He further stated, "All I'm getting is reams of paper and aggravation." I am confident that thousands of physicians across the country share this sentiment. Mr. Chairman, I would like to submit for the record a copy of Dr. Bucher's statement dated November 5, 2001. Secretary Scully, I would like to request you're the assistance and cooperation of your agency in resolving this matter.

I would like to this opportunity to recognize some of the witnesses that I have been in close contact with. Representatives from the National Association Portable X-Ray Providers have testified before this committee and their commitment to this issue has been steadfast. CMS lack of compliance with RFA has created serious problems for this industry. Portable X-Ray providers bring a very important medical service to the patient. These patients are primarily the aging who live in rural areas. A key component to providing this service is transportation. Yet, the portable EKG component and overall PPS have been exempted. Further, representatives of this industry have expressed that they are subject to unsubstantiated fraud alerts and audits. Most recently, during their meeting in Washington, CMS was invited to address Association of Medicare providers but CMS did not send a representative. I wrote a letter to Secretary Scully, signed by Congresswoman Velazquez, as well, regarding CMS non-response to the Association's invitation and the basis of an audit that was brought to the attention of members of this committee at a hearing on March 19, 2002. I would also like to take this opportunity to thank Dr. Warren A. Jones for accepting the committee's invitation to testify at this hearing.

I welcome all of the other panelists and I look forward to their testimony.

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Congress of the United States
House of Representatives

Congressman Mike Ross
Committee on Small Business Statement
"Can Improved Compliance with the Regulatory Flexibility Act Resuscitate Small Healthcare Providers?"
April 9, 2002

The Centers for Medicare and Medicaid Services (CMS) is one of the largest and most important federal government agencies. CMS has oversight of the country's most costly public health programs, Medicare and Medicaid. Yet the agency is too often the most irksome and dismissive of small business issues. Despite the pledge by Health and Human Services Secretary Tommy Thompson and CMS Administrator Tom Scully to make CMS more efficient and responsive to providers, the agency and its regulations have become no easier to navigate.

A prime example is the "Medicare-endorsed" prescription drug card. Why should Medicare (i.e., the federal government) financially and legislatively endorse an initiative that is already in practice by the private sector? Why would the federal government, specifically a "pro-business" Administration, continue to push a scheme that clearly harms pharmacists, which are predominantly independently owned small businesses?

In March, this Committee's Ranking Member, Representative Velazquez, hosted a health care regulations roundtable with pharmacists, physicians, nurses and other health care representatives. During the discussion, the officials [illegible], what I believe, are several opportunities for CMS to address concerns administratively, without the burdensome process of legislation and enduring months of Congressional back-and-forth. The simplest of these administrative solutions is CMS and/or HHS sponsoring training seminars about newly issued rules. Often during the course of a day a provider may not have time to call its intermediary or the intermediary may not fully understand the rule. A CMS or HHS sponsored training seminar would provide a uniform explanation of the rule and give providers a chance to talk face-to-face with a government official.

Hopefully, today's hearing, "Can Improved Compliance with the Regulatory Flexibility Act Resuscitate Small Healthcare Providers?," will be straight talk between Administrator Scully, the panelists, and Congress.

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Testimony of
The Honorable
Thomas M. Sullivan
Chief Counsel for Advocacy

U.S. House of Representatives
Committee on Small Business

Date:	*April 10, 2002*
Time:	*10:00 A.M.*
Location:	*2360 Rayburn House Office Building*
Topic:	*Can Improved CMS Compliance with the Regulatory Flexibility Act Resuscitate Small Healthcare Providers?*

Created by Congress in 1976, The Office of Advocacy of the U.S. Small Business Administration (SBA) is an independent voice for small business within the federal government. The Chief Counsel for Advocacy, who is appointed by the President and confirmed by the U.S. Senate, directs the office. The Chief Counsel advances the views, concerns, and interests of small business before Congress, the White House, federal agencies, federal courts, and state policy makers. Issues are identified through economic research, policy analyses, and small business outreach. The Chief Counsel's efforts are supported by offices in Washington, D.C., and by Regional Advocates. For more information on the Office of Advocacy, visit http://www.sba.gov/advo, or call (202) 205-6533.

Chairman Manzullo and Members of the Committee, good morning and thank you for the opportunity to appear before you today to discuss the issue of whether improved Centers for Medicare and Medicaid Services (CMS) compliance with the Regulatory Flexibility Act can be expected to resuscitate small healthcare providers.

For the last twenty-five years the Office of Advocacy has been monitoring federal agencies' compliance with the Regulatory Flexibility Act, commonly referred to as the RFA. The RFA requires federal agencies to determine whether a proposed rule will have a disproportionate effect on small entities, and, if so, to explore alternative regulatory solutions. As I testified before this committee on March 6, 2002, and as I indicated in our recently released annual report on RFA compliance, not all agencies comply fully with the RFA. Advocacy has historically had difficulty impressing upon some federal agencies the benefits that can by derived by complying with the provisions and spirit of the RFA. The benefits flow not only to small businesses, but also to the agencies themselves, as their compliance with the RFA helps to lessen legal challenges and legislative criticism of their regulations.

Your invitation to appear before this Committee today asked me to address the adequacy of CMS's compliance with the RFA. Advocacy appreciates the complicated public policy objectives undertaken by CMS and the enormous pressure the agency is under to promulgate regulations on payment schedules in a timely manner. We also appreciate the effect these regulations have on small healthcare providers, including the portable x-ray and EKG providers, ninety percent of whom are small entities as defined by SBA size standards.

It is our goal that CMS more fully consider the consequences of their regulatory actions on small employers prior to finalizing their rules. This is, after all, the primary tenet of the RFA.

Generally speaking, we believe that CMS should do a better job of following administrative procedures that require public notice and comment. CMS should also

consider less burdensome regulatory alternatives that would still allow the agency to meet its statutory requirements. Of particular concern is CMS's practice of promulgating direct final and interim final regulations. Procedurally this methodology allows the agency to bypass notice and comment requirements of the Administrative Procedure Act (APA) and the RFA. The APA does not afford an agency the latitude to issue direct final or interim final rules unless the agency, for good cause, finds that notice and public procedure thereon are impracticable, unnecessary or contrary to the public interest. 5 U.S.C. § 553(b)(3)(B). In one of our comment letters to CMS, Advocacy pointed out that in a 10-month period during 1998, CMS published twenty-four rules in the Federal Register. Of that total, fourteen of the rules were interim or direct final rules. We are concerned that by relying on direct final rulemaking, CMS is losing out on the benefit of public comment and the agency's ability to appreciate the rule's effect on small business is unfortunately minimized.

Two recent rulemakings serve to highlight Advocacy's ongoing concerns with CMS' lack of compliance with the RFA: The Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21; and the rule announcing Revisions to the Payment Policies and Five-Year Review of the Relative Value Units Under the Physicians Fee Schedule for Calendar Year 2002.

I. The Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21.

In July 1999, CMS's predecessor, the Health Care Financing Administration (HCFA) issued an interim final rule entitled, "Medicare and Medicaid Programs; Conditions of Participation: Patients' Rights." The rule contained standards for the use of patient restraints in hospitals. U.S. Representative Saxby Chambliss asked Advocacy to review the Patients' Rights rule to determine if HCFA had complied with the RFA. After reviewing the rule Advocacy concluded that the one-hour restriction on the use of restraints was particularly burdensome on rural hospitals primarily because it called for the treating physician to make a face to face assessment of the patient within one hour of

initiating restraint or seclusion. Advocacy commented that HCFA failed to analyze the impact of the one-hour provision in the rule and that no serious alternatives were considered. Interestingly, the rule became the subject of a lawsuit filed in the District Court of the District of Columbia. In September 2000, the court upheld the rule, but because the agency failed to comply with the RFA, the court remanded the rule back to the agency for the completion of a final regulatory flexibility analysis. The court's decision, with regard to the RFA requirement for agencies to describe their efforts to minimize their impact on small business, reads: "The Secretary [the named defendant was Donna Shalala, then Secretary of the Department of Health and Human Services] did not obtain data or analyze available data on the impact of the final rule on small entities, nor did she properly assess the impact the final rule would have on small entities." National Ass'n of Psychiatric Health Systems, et al., v. Donna Shalala, Secretary, Dep't of Health and Human Services, 120 F.Supp.2d 33, 42, (D.D.C. 2000). The court concluded that, " the fact of the matter is that she has totally failed to comply with section (5) of § 604(a) of the FRFA [§ 604 contains the elements of a Final Regulatory Flexibility Analysis (FRFA) under the RFA]. Id. at 44.

We continue to insist that CMS complete the regulatory analysis as ordered by the court, which still has not been done. Why do the analysis after the fact? Because it creates an institutional mechanism whereby CMS can produce regulatory analyses of the rules' impacts on small healthcare entities.

II. Revisions to the Payment Policies and Five-Year Review of the Relative Value Units Under the Physicians Fee Schedule for Calendar Year 2002.

Currently, Advocacy is experiencing similar problems getting CMS to address RFA compliance issues in a rulemaking that Advocacy believes will have a detrimental effect on the portable x-ray and EKG industry, the majority of which are small businesses. On November 1, 2001, CMS published the rule regarding Revisions to the Payment Policies and Five-Year Review of the Relative Value Units under the Physicians Fee Schedule for Calendar Year 2002. Portable x-ray and EKG providers transport x-ray and EKG machines to the patient's bedside so they do not have to be transported to a

hospital or facility for the studies. Because of the nature of the industry, the majority of the portable x-ray and EKG providers' billing is derived from Medicare. The rule would reduce, among other things, the transportation component of the portable x-ray service by 5.4%. As transportation costs make up approximately 80% of the portable x-ray industries' overhead, the 5.4% reduction in the physician fee schedule rate, in addition to other reductions, will likely devastate numerous portable x-ray businesses.

On three occasions since 1998, the Office of Advocacy has filed comments with the CMS concerning the agency's determination of payment policies as they applied to the portable x-ray and EKG industry. Advocacy suggested that because portable x-ray providers were consolidated with the other physician practice groups covered by the rule, CMS was running afoul of the legislative intent behind the RFA, to eliminate "one-size-fits-all regulations." We believed that pursuant to the RFA, CMS should have analyzed the impact on this industry separately. Only then would the agency have been in a position to decide whether to certify no impact under the RFA, or whether to perform further analysis. Advocacy suggested that the preparation of a flexibility analysis would allow CMS to determine the true extent to which the rule would impact the portable x-ray industry. Advocacy also opined that because CMS failed to prepare a proper regulatory flexibility analysis, the agency was not in a position to determine whether the cost of the regulation relative to the portable x-ray industry outweighed the benefits. For example, will it ultimately cost more money for CMS to transport patients to the hospital for the x-ray and EKG services? Will the public good will be adversely impacted if elderly patients, who currently rely on the services provided by the portable industry, have to be transported to the hospital for their studies, resulting in an increased risk of infection, or transportation injuries?

Conclusion

As I stated in my testimony before this Committee on March 6, 2002, Advocacy hopes that Secretary Tommy Thompson's recently announced plan to reform the regulatory process within his agency extends to CMS. We believe that one of the ways

CMS can implement Secretary Thompson's vision is to comply with the requirements of the RFA. Another way that CMS can reform the regulatory process is to issue proposed rules which should allow for the consideration of public comment, instead of going direct final and shutting out constructive input on the rules.

Recently, the President singled out the RFA in his Small Business Plan. In a speech before the country's top woman entrepreneurs, President Bush said, "I want to make sure people understand that we're going to do everything we can to clean up the regulatory burdens on small businesses, starting with this: Every agency -- already it's under current law -- but every agency is required to analyze the impact of new regulations on small businesses before issuing them. That's an important law. The problem is, it's oftentimes being ignored. The law is on the books; the regulators don't care that the law is on the books. From this day forward, they will care that the law is on the books."

Advocacy is working to implement the President's commitment towards full agency compliance with the RFA. We applaud this renewed emphasis toward government accountability to the small employer community. We at Advocacy have learned that when regulatory agencies involve our office in the pre-proposal stage of rule promulgation, compliance with the requirements of the RFA is improved. Advocacy has been aggressively attempting outreach with regulatory agencies in an effort to highlight the benefits of RFA compliance and early consultation with Advocacy during the pre-proposal stage of rule promulgation. We've found that this early consultation works. And we are willing to work with CMS on this early consultation process.

It is my hope and desire that the Office of Advocacy and CMS will develop a working relationship that will result in better communication and action on the issues that are of concern to this Committee.

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Statement of the

American Academy of Otolaryngology – Head and Neck Surgery

to the

Committee on Small Business
U.S. House of Representatives

on

"Can Improved CMS Compliance with the Regulatory Flexibility Act Resuscitate Small Healthcare Providers"

Presented by: David R. Nielsen, M.D.

April 10, 2002

Mr. Chairman and members of the Small Business Committee, I would like to thank you for this opportunity to discuss a few of the problems small healthcare providers face in attempting to navigate thousands of pages of regulations, guidelines and requirements issued by agencies such as the Center for Medicare and Medicaid Services (CMS), while at the same time trying to maintain the viability of their practices. Your dedication toward eliminating many of the burdensome restrictions will allow physicians across the country to concentrate on what they do best -- treat patients. On behalf of all physicians and the patients we serve, I want to thank you for your leadership.

I am Dr. David Nielsen, a practicing otolaryngologist at the Mayo Clinic in Scottsdale Arizona and the incoming Executive Vice President of the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS), which represents more than 10,000 otolaryngologists and head and neck surgeons across the country. Prior to my position at the Mayo Clinic Scottsdale, I worked for 13 years as a solo private practitioner, and two years in a small group practice. I can speak personally about the concerns faced by a small business attempting to remain in compliance with a host of regulations. I have served for eight years as the Speaker of the House of Delegates for the Arizona Medical Association and have participated in the many attempts to find solutions to the overwhelming regulatory burden that physicians face in private practice. At

one point in my solo practice I counted over 55 agencies or institutions with some form of daily oversight or regulatory control over my practice.

Physicians, like myself, share a common frustration with the barrage of burdensome Medicare regulations and guidelines and the constant struggle to remain compliant without forsaking time with our patients or our dedication to quality health care. We are especially grateful to Representatives Patrick Toomey (R-PA) and Shelley Berkley (D-NV) for their leadership in introducing the *Medicare Education and Regulatory Fairness Act* (H.R. 868), which would help alleviate many of the problems that stem from Medicare's regulatory and reporting requirements. To that end, we urge all House members to encourage their Senate colleagues to pass the *Medicare Regulatory and Contracting Reform Act* (H.R. 3391), which contains many similar provisions found in H.R. 868. Provisions in H.R. 3391 that are specifically helpful include educational programs for physicians on billing and coding changes and evaluation and management documentation guideline revisions.

We are also pleased that the House Small Business Committee has taken an active interest in ensuring that Federal agencies comply with the Regulatory Flexibility Act (Pub. L. 96-354) (RFA). Congress enacted the RFA in 1980 to protect small businesses by requiring Federal government agencies to take into consideration the burdens imposed on small businesses by the regulations they issue. Specifically, the RFA requires that each Federal agency perform, and make available to the public, an initial and a final "regulatory flexibility analysis" of any rule that will have a significant economic impact on small businesses. Among other things, the RFA states that in a regulatory flexibility analysis, a Federal agency must describe any significant alternative proposals that could achieve the rule's objectives at a lower cost to small entities, and explain why each alternative was rejected in favor of the final rule. These requirements were intended to deter Federal agencies from issuing rules capriciously, without having thoroughly considered the true effects on small businesses.

Most otolaryngologists, like other physicians, are considered small businesses for purposes of the RFA. Although many small businesses face high costs, physician practice costs are often even higher due to high rates of inflation in the costs of goods and labor required to sustain a physician's practice. Moreover, the vast majority of physicians depend on revenue from insurers, including Medicare and Medicaid that have declined in some cases and have not kept up with the rate of inflation in practice costs.

Against this backdrop of rising practice costs and falling reimbursement rates, Federal regulations often have a particularly dramatic and significant economic impact on physicians. Physicians are subject to a wide array of Federal regulations, including:

- Health Insurance Portability and Accountability Act (HIPAA) regulations on medical privacy and electronic transactions;
- Emergency Medical Treatment and Labor Act (EMTALA) regulations;
- Medicare and Medicaid fraud and abuse regulations, including the Stark physician self-referral laws, the Federal Anti-kickback Statute, and the False Claims Act;
- Clinical Laboratory Improvement Act (CLIA) regulations;
- Occupational Safety and Health Act (OSHA) regulations;

- Limited English Proficiency Guidance (LEP);
- Evaluation & Management Documentation Guidelines; and
- Federal health care program payment policy rules (e.g., the Medicare physician fee schedule).

Required to comply with these and numerous other unfunded regulatory mandates, physician practices face high practice expense costs associated with regulatory compliance. For example, the Limited English Proficiency Guidance, issued by the U.S. Department of Health and Human Services, requires physicians who receive payments from Medicaid to provide, at their own expense, trained and competent interpretation and translation services for all their limited English proficient patients. An otolaryngologist practicing in Kansas, for example, would pay $70 per hour plus transportation costs for a Russian interpreter, however Medicaid only reimburses the otolaryngologist $12 to $28 for an office visit. Such reimbursement clearly does not cover practice costs. In light of the already low level of Medicaid reimbursement, the LEP Guidance only adds insult to injury. The Academy acknowledges that the goals of such Departmental issuances are often laudable, however forcing small businesses to bear the burden of paying for an ever-growing crop of unfunded regulatory mandates threatens the financial viability of physician practices and may ultimately threaten patient access to care.

Although CMS does not directly promulgate all of the above-mentioned Federal regulations, CMS does regulate the Medicare program and, more specifically, the Medicare physician fee schedule. CMS has discretion over many aspects of physician payment, however it has not taken into account the high costs of regulatory compliance that physician practices face as a result of the mandates issued by HHS and other Federal agencies.

In the context of the Medicare physician fee schedule regulations, CMS could potentially take into account the high costs of compliance with various other Federal regulations through the Medicare Economic Index (MEI), which is a component of the physician fee schedule update formula. The formula for the MEI is not mandated by statute, but rather has been developed by CMS. Although CMS has included physician practice expense in the MEI, federal health care regulatory compliance costs are not explicitly taken into account because the measures are based on price data from across the economy. Prior to issuance of the 2002 Medicare Physician Fee Schedule, 66 Fed. Reg. 55246 (Nov. 1, 2001), many associations representing physicians submitted comments to CMS regarding the various federal health care regulatory compliance costs that CMS had failed to account for in the MEI.

Despite the RFA's requirements, and CMS's own admission that physicians are small businesses, CMS did not engage in a full regulatory flexibility analysis in the final rule publishing the 2002 Medicare Physician Fee Schedule, although CMS does make reference to the RFA in the rule. Specifically, CMS did not consider the increased costs physicians must bear to comply with federal health and safety regulations. Moreover, CMS has an obligation to respond to all comments submitted to the proposed rule pursuant to the Administrative Procedure Act. CMS's failure to perform an analysis of the costs of regulatory compliance under the RFA or to acknowledge comments calling for recognition of these costs within the structure of the MEI undermines the integrity of the regulatory process and compromises public participation in rulemaking. CMS should either explain why the MEI adequately reflects these costs or provide

some reason why these costs should not be accounted for in Medicare payments for physician services.

The RFA was designed to prevent Federal agencies from making decisions behind closed doors, without consideration of the public interest in general, and small businesses in particular. The RFA intends to make the regulatory decision-making process transparent, thereby giving small businesses the opportunity to have their considerations addressed publicly. By permitting CMS and other Federal agencies to ignore the RFA's requirement to explore possible lower cost alternatives and justify the rejection or adoption of such alternatives, we permit Federal agencies to ignore the interests of small businesses and physician practices in the regulatory process. Often, a Federal agency's failure to consider and address lower cost alternatives results in small businesses feeling forced to seek legislative relief, which serves only to burden Congress's already heavy workload.

While the RFA is designed to protect small business entities, a loophole exists that allows CMS and other agencies to issue a variety of requirements that fall below the radar screen of the RFA, thus leaving small businesses vulnerable to burdensome guidelines and responsible for the increased cost of compliance without the benefit of an impact analysis. Medicare has a variety of sub-regulatory policy issuances such as program memoranda, contractor letters, guidance documents and coverage decisions that, while not technically regulations, continually exacerbate the climate of fear in which physicians practice medicine. These types of issuances are not subject to RFA requirements.

One of the most onerous examples is the evaluation and management documentation guidelines (E&M) established by CMS. These guidelines require physicians to record certain documentation in a patient's medical records regarding the types of items and services provided. To ensure compliance, Medicare carriers use the documentation to validate a physician's Medicare claims. Because a physician's reimbursement is ultimately determined by the carrier's approval of a claim, physicians are forced to provide tedious documentation that may not be wholly pertinent to the patient's medical history or treatment regimen, but instead only included to comply with the regulatory requirements. Furthermore, Medicare carriers use the documentation to determine overpayment and to audit practices, placing additional pressure on physicians to fill a patient's chart with extraneous information rather than focusing on medically necessary descriptions.

Despite the importance placed on the E&M guidelines by the Medicare program and the fact that the requirements have a tremendous impact on the way physicians practice medicine on a day-to-day basis, the E&M guidelines have never been evaluated to determine their true impact on physician practices nor on patient and health outcomes. The cumbersome regulatory requirements compounded with rising practice costs and increasing medical liability premiums are forcing physicians to lay off staff, reduce services and turn away Medicare patients in an attempt to keep their practices afloat. Medicare patients in some communities and neighborhoods are unable to find a physician who can afford to treat them.

The overwhelming number of state and Federal regulations and the inherent cost of remaining current and compliant forces physicians to devote a greater amount of time and energy away

from their number one priority – providing quality health care to their patients. Therefore, we recommend that Congress direct CMS and other agencies to comply fully with the RFA in order to better protect small business entities, like physician practices, from onerous and costly regulations. Additionally, we recommend that Congress expand the RFA to cover sub-regulatory issuances to help ensure that small businesses are not unnecessarily burdened by a federal agency's requirements.

On behalf of the American Academy of Otolaryngology – Head and Neck Surgery, I would like to thank the committee for the opportunity to share our concerns regarding the challenges physician practices face as we struggle to comply with countless regulations and guidelines. We look forward to working with members of the committee and the Center for Medicare and Medicaid Services to help ensure small healthcare providers are adequately protected by the Regulatory Flexibility Act.

For more information, please contact Kristen Hedstrom in the Academy's Washington office at (703) 836-4444 or dgogoll@entnet.org.

STATEMENT of the American Academy of Family Physicians

Submitted to the Small Business Committee
U.S. House of Representatives

Concerning

The Medicare Fee Schedule Update

Presented By
Warren A. Jones, M.D.
President

April 10, 2002

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Statement of Warren A. Jones, M.D.
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Submitted to the Small Business Committee
U.S. House of Representatives

April 10, 2002

Mr. Chairman, Representative Christian-Christensen, and members of this Committee, thank you for this extraordinary opportunity to comment on how the small medical practices across the country, especially those of primary care family doctors, are affected by the precipitous decline in the Medicare reimbursement to physicians. We particularly appreciate your interest in CMS's implementation of the Medicare physician fee update as it relates to the Regulatory Flexibility Act. We would suggest that the solution to the problems created by the flawed formula that determines this update is enactment of the recommendations of the Medicare Payment Advisory Commission.

American Academy of Family Physicians

Let me first explain whom I represent. Founded in 1947, the American Academy of Family Physicians, which is the only medical specialty society devoted solely to primary care, is made up of more than 93,500 family physicians, family practice residents and medical students nationwide. We provide comprehensive, coordinated and continuing care to all members of the family and serve as the patient's advocate in the changing health care system. We are proud to include three Members of Congress, including the distinguished Representative from the Virgin Islands.

Mr. Chairman, for the purposes of this Committee it is important to point out that most of the members of AAFP practice in small groups and can be characterized as small businesses. Moreover, a recent study demonstrated that the presence of a family physician in a rural community is a substantial economic stimulus. That study by the Center for Health Policy Research of the Oklahoma State University Health Sciences Center found that, "on average, each family physician ... will generate (both direct and secondary) an estimated 50 full-time jobs and these jobs will generate over $1.1 million of income annually."

Medicare Physician Fee Update

Mr. Chairman and Members of the Committee, physicians and other health practitioners have experienced a sharp, 5.4-percent across-the-board reduction in their Medicare payments as of January 1. Although it is called the "Physician Fee Update," these cuts apply to all services and to more than one million health professionals, including therapists, advanced practice nurses, chiropractors and optometrists. Many of these providers practicing in their offices and clinics function as small businesses.

The Medicare Payment Advisory Commission (MedPAC) has called for the elimination of the current update formula and warned that cuts of the magnitude expected under this formula could raise concerns about the adequacy of payments and beneficiary access to care.

According to *The Milwaukee Journal Sentinel* (2/2/2002), the Administrator of the Centers for Medicare and Medicaid Services (CMS), Thomas A. Scully, admitted that the formula that produced the reduction is "screwed up and exceedingly harsh," and requires a Congressional fix. AAFP agrees with that assessment and joins in urging Congress to take immediate steps to "freeze and revise." That is, immediately freeze the conversion factor (payment rate) at the 2001 level and work to revise the update formula as recommended by MedPAC.

The *Preserving Patient Access to Physicians Act* (HR 3882), sponsored by Rep. Nancy Johnson, would do just that. It would codify the recommendations put forth by MedPAC by repealing the formula, which is based on the Gross Domestic Product (GDP), and replacing it with one that is more equitable and sensible. MedPAC recognizes, as does the AAFP, that there is no rational connection between the health care needs of the elderly and the nation's economic performance, as reflected in the GDP. If anything, in stressful economic times and circumstances, the health care needs of the elderly are exacerbated. Historical events including those following the terrorist attacks of last fall have demonstrated this. The American Academy of Family Physicians urges the Congress to take swift positive action on HR 3882, which would tie the reimbursement rate to the cost of healthcare rather than to national economic conditions. AAFP requests that each member of this committee cosponsor this important legislation.

Currently, Medicare officials are required to use a statutory formula to calculate physician conversion factor updates. The update formula, known as the sustainable growth rate (SGR), ties Part B spending to business cycles rather than patient needs or health services use. Despite 1999 legislation that attempted to reduce the volatility of formula updates, large and unpredictable payment swings with potential cuts of more than 5 percent a year still occur.

The cut experienced this year makes the fourth time in 11 years that Medicare physician payment rates have been reduced. During that time, physicians and other practitioners have been inundated with expensive new government regulations requiring physicians to provide interpreters, dedicate staff to documenting and monitoring compliance plans, and supply unnecessary and duplicative documentation. Yet, Medicare payments during the same 11 years have risen by an average of just 1.1 percent a year or 13 percent less than practice costs as measured by the government's own statisticians. And for the sake of comparison, it is instructive to note that during the same time, the Social Security Cost of Living Adjustment (COLA) increased by an average of 3.0 percent every year.

While Medicare reduced payments to health care providers by 5.4 percent this year, the government estimates that under the same formula, Medicare fees paid for each medical service will be reduced in each of the next three years, for a total decrease of 17 percent from 2002 to 2005. Under this estimate, payment rates in 2005 will be lower than the rate by which physicians and other providers were paid in 1993.

The Effects of the Flawed Formula on Small Practices

The gap between cost inflation and Medicare's payment updates is already starting to take its toll and a negative update could greatly exacerbate the situation. In the last year or so, access problems have been reported in Atlanta, Phoenix, Albuquerque, Annapolis, Denver, Austin, Spokane, northern California and Idaho. AAFP data from last year reveal that 17

percent of family physicians who responded to our practice survey are not accepting new Medicare fee-for-service patients. As Dr. Conrad Flick, vice president of the North Carolina Academy of Family Physicians, noted, "You figure out pretty quickly that if all you take is Medicare, you're going to lose money, and businesses can't afford to lose money" (*The Raleigh News & Observer*, 2/15/2002).

The effect of this sudden and drastic reduction in Medicare reimbursement rates is not isolated to Medicare patients. After all, most states peg Medicaid payments to Medicare rates, and many insurance companies incorporate Medicare's rates, as well.

Perhaps the most striking example of what this payment rate cut means is provided by the experience of Dr. Baretta Casey, which was described in the February issue of ***FP Report***:

> *Dr. Casey has done what the government wants many physicians to do: set up practice in an underserved area, taking care of many patients on Medicare and Medicaid. She came to medicine later in life than many do, as a wife with two children -- three by the time she graduated. She wanted to become a family doctor and practice in her Appalachian hometown of Pikeville, Kentucky.*
>
> *Her business background stood her in good stead. She bought an office building at an auction, rented out the top floor to offset the cost of her first-floor office, computerized her practice from the start and opened her doors as a solo practitioner eight years ago.*
>
> *Thanks to the booming practice and conservative living, Casey significantly paid down her $145,000 in student loans her first full year. But that was as good as it got. Ensuing years didn't get better. In fact, they got worse.*
>
> *On her computer Dr. Casey watched while medical expenses continued to grow but payment rates failed to keep pace. Dr. Casey says: "As a solo practitioner, I pay for everything. And the increase in expenses hasn't been the measly little percentage you hear forecasted by the government. I've tracked it on my computer. It has gone up 10 to 15 percent every year."*
>
> *"It took about six years, but at the six-year mark, expenses and income literally met in the middle," she says. "This past year, they crossed over. And now, I have to dip into my savings to cover the extra expense. I'm basically subsidizing my own practice out of a savings account."*
>
> *And now, in 2002, the worst blow of all -- the 5.4 percent cut in the Medicare conversion factor. "I've had to make some decisions," Dr. Casey says. "I won't take any new Medicare patients or any new patients with any insurance company that follows suit and drops payment." And ultimately, she says, "If things don't change, I probably couldn't stay in practice any more than two more years."*
>
> *Dr. Casey has a message for Washington:*
>
> *"If our reimbursement rates continue to go down and our expenses continue to go up," she says, "you will see an exodus of physicians out of rural areas like Moses out of Egypt. It's not because doctors don't care about their patients. They do, tremendously."*

"It's because nobody is going to continue in a field or in a business when they're losing 10 to 15 percent per year. The practice of medicine is like any other business: If you can't pay your bills, you can't survive."

Since this story was published, Dr. Casey, whose practice is 60 percent Medicare patients, reports that she has had to reduce one of her four employees from full time to part time. If Dr. Casey has to close her uneconomical practice, her departure will deeply affect her little town, which is in what the Health Research and Services Administration has defined as a "Health Professional Shortage Area." In other words, Dr. Casey is struggling to provide health care in a county that needs at least 15 more primary care physicians just to reach a minimally acceptable level of service. Without her, Medicare patients--in fact, everyone--in eastern Kentucky will find it even more difficult to find a physician or any other health care professional.

In a March 17 *New York Times* article by Robert Pear, entitled "Doctors Shunning Patients with Medicare," Dr. Mark H. Krotowski, a family doctor in a working-class neighborhood of Brooklyn, said: "My expenses go up and up and up every year. For the government to lower what it pays me when my expenses are rising - that doesn't make sense. It's an insult."

Dr. Krotowski said that about 25 percent of his current patients were on Medicare, but that he was not taking any new Medicare patients. "I love my elderly patients," Dr. Krotowski said. "But they are very sick. They need a lot of attention, a lot of medications and a lot of time. Medicare reimbursement has not kept up with inflation or the cost of providing care to the elderly."

In the same article, Dr. Stephen C. Albrecht, who practices with three other doctors in Olympia, Washington, said he stopped taking new Medicare patients about six months ago. "It impedes the economic viability of my practice to have a large Medicare population," Dr. Albrecht said. "When you own and run a small business, you have to make sure it's economically viable."

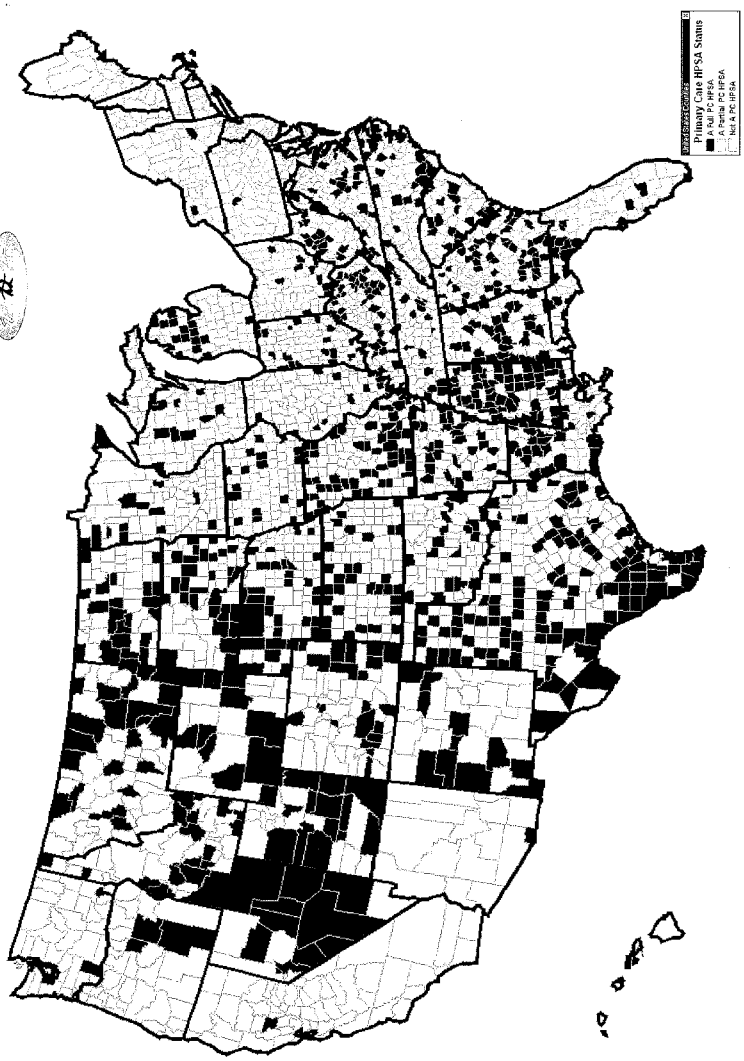
Dr. Deborah G. Haynes, a family physician in Wichita, Kansas, was quoted in the same article as saying that her seven-doctor group decided three months ago not to take new Medicare patients. "We hated to do it," Dr. Haynes said, "but we have a responsibility to pay our staff."

In addition, Dr. Conrad L. Flick, of Raleigh, North Carolina, said: "We don't take new Medicare patients. We want to, but as a business, we really can't afford to." In the past, Dr. Flick said, "private insurers used to subsidize our Medicare practice," but they are no longer willing to do so. "Private insurers have cut back their reimbursement, so there's less opportunity to use those payments to cover the losses on Medicare patients," he said.

Experience has already shown the danger of unrealistic payment rates in Medicaid, where twenty years of studies have consistently concluded that fee levels affect both access and outcomes. Medicare is not immune from similar problems as has been made abundantly clear by the continued exodus of Medicare+Choice plans from the program despite a guaranteed pay increase of at least 2 percent a year. About 85 percent of elderly and disabled Americans rely on fee-for-service Medicare. For these Americans, whose numbers are growing, there is no other option available.

Mr. Chairman, I am here today to deliver the message that the American Academy of Family Physicians strongly urges Congress to act now to immediately freeze this year's conversion factor at last year's rate. In addition, we urge Congress to act on and pass HR 3882, which would repeal the SGR and replace it with a more equitable and sensible formula, as MedPAC recommended. This bill also would increase the conversion factor for next year by a modest 2.5 percent. Your action will ensure that the small practices for which many physicians work can continue to provide Medicare patients, especially in underserved areas, with the care they depend on and deserve.

Thank you for the opportunity to speak with you and the members of this committee.



1999 distribution of counties with full or partial primary care health personnel shortage designation.

Source: The Robert Graham Center: Policy Studies in Family Practice and Primary Care

1999 distribution of counties with full or partial primary care health personnel shortage designation.

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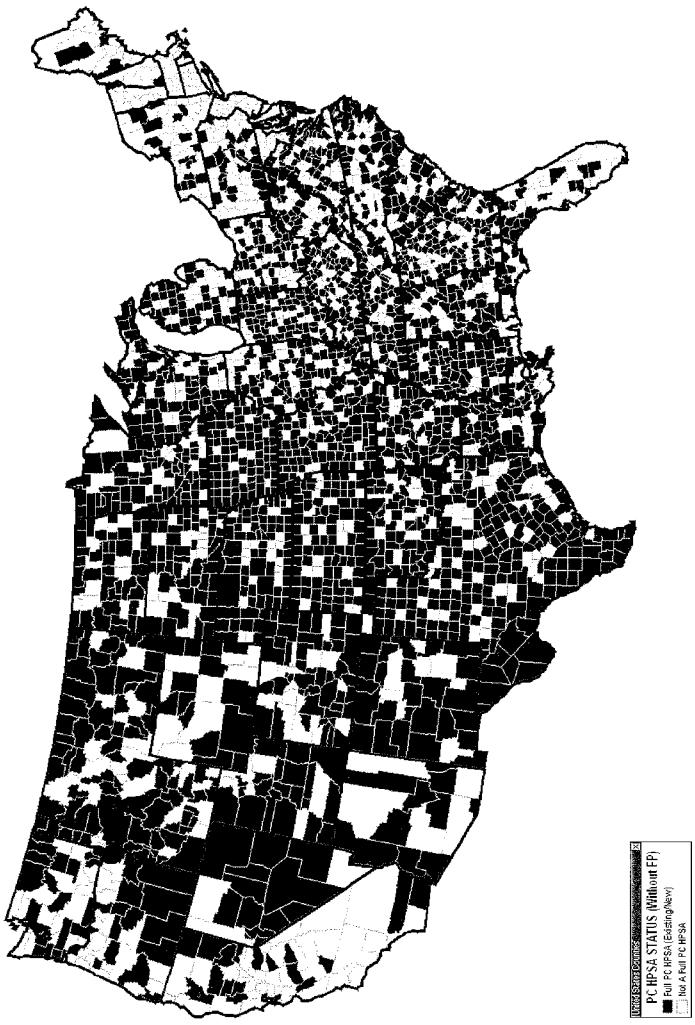

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Testimony of Zachary Evans, NAPXP
House Committee on Small Business
April 10, 2002

NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS

1333 Village Drive
St. Joseph, Missouri 64506

Mr. Chairman, Ranking Member Velazquez and distinguished committee members, my name is Zachary Evans. I currently serve as the Chairman of the Board for the National Association of Portable X-Ray Providers (NAPXP). Thank you for allowing me to come before you personally a second time. I also want to recognize Congressman Weldon, Chairman of the Government Reform Subcommittee on Civil Service and Agency Organization. I believe the proceedings here today will be of great interest to him. I want to thank him for his time and for offering his expertise as a physician to this committee.

Mr. Chairman, I appear before you today under a cloud of fear, fear of reprisal from CMS for speaking to this Committee. Fear of being punished by a federal agency that has targeted my industry and my colleagues for daring to tell the truth. This is no idle fear. Just five weeks ago, on March 6, 2002, our association testified before this Committee regarding CMS' illegal rulemaking against our industry. On March 5, the day before the hearing while John Cavalier of Youngstown, Ohio, the President of our association was here in Washington to meet with this Committee and hold our annual spring meeting, his small business was subjected to an unannounced "snap" audit by CMS. On that morning Mrs. Cavalier opened the door to find a CMS auditor who demanded access to all company files and records. As her husband was here in Washington seeking reasonable policy for the industry from CMS, she faced this frightening experience alone, without her husband or benefit of legal counsel. After many hours of searching, the auditor left, having found no violations. I offer the official documentation of this finding for the record. This audit was conducted in spite of another audit conducted in December of 2001, which also disclosed no violations. One might presume that the timing was intended to allow us a day to amend our statement to this Committee, but the auditor informed Mrs. Cavalier that the inspection was scheduled for the following day, the actual day of the hearing, but had been changed at the last moment.

In light of the clear intent of CMS to intimidate the volunteers who serve on the Board of Directors of the NAPXP into silence, I ask, in advance, for the assistance of this Committee if I am now singled out as a "troublemaker" and subjected to harassment from this agency run amok. I wish to thank the Committee for offering to protect my identity in this hearing. In spite of the risks entailed in speaking out, I feel strongly as a citizen and small business owner that the only

way to combat this abuse is to bring full light to the matter and that cannot be done from behind a screen, even if the screen is there to protect me.

That an honest small businessman might need such protection from his own government is unconscionable, but when CMS decides that it is not subject to laws enacted to protect small business and uses its powers to attempt to smear an industry that provides critical, cost-saving, medical services to the elderly, it is hardly surprising. Our industry has sought fairness from HCFA and now CMS for many years only to be told that we are too small to be considered. When Members of Congress contact CMS, requesting the data necessary to reach informed decisions regarding our industry, they are told, as you were told, Mr. Chairman, that it can't be produced. In fact it can and has. I include with my testimony, data regarding portable EKG services provided, by CMS, in response to Congressional inquiry last year. This data demonstrates a policy failure that has been devastating to health care delivery in rural America. After Congressman Phil Crane received this stunning information, CMS realized what it had produced and attempted to retract it. Now, in response to your request, Mr. Chairman, CMS claims that the same data produced last year is impossible to compile. In addition to the horrific implications to health delivery evidenced in the data, we discover that CMS is unable to simply name the fifty states of the Union. In this official response to a Member of Congress, the state of West Virginia does not exist. The sad irony of a federal agency attacking small businesses with audits of excruciating detail while they display incompetence of such magnitude is overshadowed only by their refusal to release data, which they possess, which is vital to any policy decision regarding this industry. How can CMS steadfastly hold that their policies are correct when they also claim that they are unable to compile basic usage data?

Our abuse at the hands of CMS is made all the more apparent when one contrasts the efforts undertaken by CMS to provide legitimate data or accurately assess the impact of our vanishing services upon the elderly, particularly those in rural areas, with those undertaken to find fraud within our industry. CMS' attempts to "kill the messenger" are obvious, while we can find no evidence of any attempt to determine true industry costs, patients served, Medicare savings realized through our services, or any other data which might prove embarrassing to an agency bent on our demise. As we raise the awareness of the Congress and the public regarding our situation, CMS targets us with a fraud alert, instructing carriers and fiscal intermediaries (FIs) to aggressively seek fraud within our industry. This fraud alert was released by CMS on February 7, 2002, along with several others, accompanied by a "Vulnerability Report" which provided data supporting the need for the alerts. We note that there is no supporting data in the *Vulnerability Report June 2001 through December 2001* to justify the fraud alert targeting our industry. This action was taken just as our efforts to bring attention to this matter were reaching a peak. The February 7 fraud alert was followed by a March 20, 2002 CMS *Federal Register* request for comments on improving the health and safety standards survey process specifically for portable x-ray services. Obviously, looking for irregularities within our industry has become a very high priority for CMS in the wake of our discussions with this Committee and others. While CMS aggressively seeks to uncover supposed fraud within the industry, they refuse to assist us in educating small business providers of our services so that they might better serve the

public and avoid improper activities. On October 18, 2001 Mr. Frank Camozzi of the San Francisco CMS Regional Office addressed our association at our request. However, when, at his suggestion, we forwarded further questions that Mr. Camozzi was not able to answer to Mr. Scully, we never received a response. I have attached our request including the questions to my testimony. Further, when we met in Washington on March 5-7, 2002, we requested speakers from CMS to address our membership. On January 29, 2002 we invited Mr. Scully, in writing, to join us. After repeated calls following our written request, Tom Grissom, Director of Medicare Management was scheduled to address us. Two days prior to our meeting, Mr. Grissom canceled and we were informed that no one would be available to address us. While we certainly understand the time constraints of CMS staff, it seems reasonable to request that someone speak with us, particularly in light of CMS' supposed concerns with rooting out fraud. I must note that we have been contacted repeatedly by CMS over the past two days with requests for information regarding who we invited and when. We have been told by CMS that they have no record of our written invitation to Mr. Scully or our repeated telephone conversations regarding speakers. I have attached a copy of our invitation to Mr. Scully to this testimony. Additionally, responding to our written requests for information would be appreciated. Obviously, preventing improper billing or fraud by interacting with us is not a priority, while catching someone at it is.

Mr. Chairman, in spite of the convoluted, often bizarre, statements from CMS regarding our industry, our role in healthcare delivery is relatively simple. We provide x-rays, EKGs and other diagnostic services at the patients' bedside. We do so at a substantial savings to Medicare over the alternative of transporting the patient to a hospital or other facility. We treat the patient in the comfort and convenience of their own room as opposed to the discomfort, disorientation and risk associated with transportation. By all available data, our services are less expensive to the system and preferred by the patient. CMS would have your believe that this is not true because; doctors carry EKG devices with them to nursing homes, family members of patients transport their loved ones to other facilities and nursing homes purchase the equipment and provide the trained staff necessary to provide these services themselves. We are fortunate to have two Members of Congress who are also physicians here with us today, Drs. Weldon and Christian-Christensen. I ask these professionals, are the claims of CMS credible? Do they stand up to your personal experiences in the medical profession? CMS offers no data to support these assumptions, yet stand by these myths in the face of hard data and common sense refuting them.

CMS' failure to adopt reasonable policies regarding our industry is not particularly surprising when one reviews the utter lack of industry input allowed in the process. In spite of clear statutory requirements contained in the Regulatory Flexibility Act (RFA), the Small Business Regulatory Enforcement Fairness Act (SBREFA) the Administrative Procedures Act (APA) and the Social Security Act (SSA), CMS refuses to consider the impact upon our industry of their rulemaking, consult with us during the rulemaking process or, in any way, evaluate industry costs prior to setting our reimbursement rates. In his March 12, 2002 letter to you, Mr. Chairman, Mr. Scully states that the existing Practice Expense Advisory Committee (PEAC) is the appropriate body to review our industry costs and that this process is more "efficient." I have

no doubt that Mr. Scully feels that this is "efficient," in that the NAPXP applied for a seat on the PEAC and was refused. I have attached a copy of the refusal letter to my testimony. Apparently Mr. Scully and CMS feel that it is "efficient" to have our cost data matters handled by a body that refuses our participation and has never requested data from the industry.

Mr. Chairman, Counsels for both the Legislative and Executive branches are of the opinion that CMS has engaged in illegal rulemaking pertaining to this industry. While CMS spares no effort or expense in seeking to uncover fraud within our industry, they refuse to obey federal rulemaking statute. We know that small business providers will be prosecuted if they get caught in the expanding CMS fraud net. I ask you, who will prosecute CMS? How can we be subjected to penalties for improper billing when the very rulemaking that establishes the billing is illegal? When a federal agency refuses to obey the law and then uses its might to punish the small businesses that dare to complain where do they go for justice? We have been told to sue the government. We have also been told to back away from this fight, that we are angering powerful people. While the anger is evident from the fraud alerts, audits and other acts of intimidation we have witnessed, we cannot allow this type of abuse to go unreported. Faced with the time and expense of filing suit against the government as small businesses we choose to speak out in the hope that someone will hear us and demand fairness. In the end, we have no choice. Our industry is dying and the patients we serve, and are ultimately accountable to, are those who stand to loose the most.

In closing, I want to again thank you Mr. Chairman, Congresswoman Velazquez and this committee for your attention to this important matter and offer what assistance you might need to address these issues. I would like to especially thank the two physicians present for their assistance in offering clarity to this issue. Congresswoman Christensen and her staff have been most helpful. I appreciate the time Dr. Weldon has given, as he does not sit on this committee. I would formally request that this matter be investigated by the Committee on Government Reform and, specifically, the Subcommittee which Congressman Weldon Chairs, Civil Service and Agency Organization, as he deems appropriate.

Thank you for your time and I am available for questions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 03/06/200
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36X0009830	A. BUILDING _____ B. WING _____	03/05/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAVALIER MOBILE X-RAY CO	7250 WEST BLVD YOUNGSTOWN, OH 44512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	INITIAL COMMENTS GR Cavalier Mobile Xray Co. is in compliance with 42CFR 486 Conditions of Participation for Portable X-ray at the time of the survey conducted on March 5, 2002.	H 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Halsey, Rains & Associates, L.L.C.

December 13, 2001

Mr. Tom Scully
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 314-G
Washington, DC 20201

Dear Mr. Scully:

On behalf of the National Association of Portable X-Ray Providers, we were pleased to have Mr. Frank Camozzi, of your San Francisco office, speak at our annual meeting in Las Vegas this past October.

Mr. Camozzi spoke to us about the changes taking place within CMS and more specifically he addressed a program memorandum of great concern to our industry (Program Memorandum Intermediaries Transmittal # A-01-119). His presentation was informative, although there were pending questions on a variety of issues relating to the industry, which he suggested we forward to the main office following his presentation.

The questions are attached. Should you or your staff have questions, please have them contact me. The response may be sent to my attention.

Thank you and we appreciate your efforts on behalf of the portable x-ray industry.

Regards,

Laurie D. Rains

Cc: John Cavalier, President, NAPXP

2111 Wilson Boulevard • Suite 600 • Arlington, VA 22201 • Phone (703) 351-5077 • FAX (703) 351-5827 • e-mail: hra@halseyrains.com

Halsey, Rains & Associates, L.L.C.

January 29, 2002

The Honorable Tom Scully
Administrator
The Centers for Medicare & Medicaid Services
The US Department of Health & Human Services
200 Independence Avenue, SW
Room 314-G
Washington, DC 20201

Dear Mr. Scully:

I am writing on behalf of the National Association of Portable X-Ray Providers (NAPXP) to invite you to address their membership at their spring meeting in Washington, DC, on March 6, 2002 from 1:00-2:00 at the George Hotel on Capitol Hill.

The NAPXP has been working closely for several months with your personal staff, specifically Jeff Flick, and regularly attending your "listening sessions". We are working on issues ranging from EKG transportation payment reimbursement to the need for necessary adjustments to the Physicians Fee Schedule. The membership would very much like the opportunity to hear your thoughts on these issues, and any others you think would be of interest and are relevant to the industry.

We hope that you are able to join us on the 6th of March. I will have Dottie Brown in my office contact Annetta Austin in your office as to your availability. Thank you and we hope you will attend.

Regards,

Laurie Rains

Laurie D. Rains

2111 Wilson Boulevard • Suite 600 • Arlington, VA 22201 • Phone (703) 351-5077 • FAX (703) 351-5827 • e-mail: hra@halseyrains.com

Packet Contents*

4/5/02 **Comparison/Industry Comment on Administrator Scully's Response to Chairman Manzullo.**

- NAPXP BOD side-by-side response to Scully letter created at request of Chairman Manzullo.

3/19/02 **Ranking Member Velazquez & Congresswoman Christensen joint letter to Administrator Scully regarding audit of NAPXP President.**

3/18/02 **San Antonio Business Journal article.**

- Article focusing on CMS's violation of the Regulatory Flexibility Act. Article includes comments by Tom Sullivan, Chief Advocate, SBA,and discusses legislation to revitalize portable x-ray industry.

3/15/02 **Letter to NAPXP President, John Cavalier, from Chairman Manzullo.**

- Chairman communicating to Mr. Cavalier that follow-up hearing has been postponed and mentioning Congressman Weldon and Congresswoman Christensen as being physicians who will bring their medical expertise and background to the upcoming hearing with Administrator Scully.

3/12/02 **Response letter to Chairman Manzullo from Administrator Scully.**

- Formal response from Administrator Scully notifying Chairman Manzullo that CMS will not accommodate him on any requests made on behalf of the portable x-ray industry.

2/20/02 **Chairman Manzullo letter to Administrator Scully.**

- Chairman Manzullo formally notifying CMS that he is aware they are in violation of RFA and have been since late 1998. Additionally, he requests specific remedies for the industry (many can be accomplished through Administrative action at CMS) and asks for support of his legislation, HR 3094.

2/28/02 **Inside Washington Publishers' *Inside CMS* article.**

- Coverage of the issue, specifically focused on Chairman Manzullo's communication with Administrator Scully dated 2/20/02.

2/25/02 **Medicare Compliance Alert Report**

- Document referencing CMS Vulnerability Report targeting the portable x-ray industry. The report issues a fraud alert on the industry with no supporting data to justify the alert. (Report can be provided to you with fraud alerts at your request.

1/17/02 **Inside Washington Publisher' *Inside CMS* article.**

- Article focusing on SBA Advocacy letter to Administrator Scully notifying him that CMS is again in violation of the RFA.

12/28/01 **US Small Business Administration's Office of Advocacy letter to Administrator Scully.**

- Formal comments filed notifying CMS of their RFA violation and recommending that CMS stay or withdraw the provisions of the final rule that relate to portable x-ray and EKG providers until a proper analysis of the rule's impacts can be prepared.

10/11/01 **HR 3094 (Crane/Manzullo)**

- Legislation would accomplished three things for the portable x-ray industry:
  - Makes portable EKG medically necessary like potable x-ray
  - Reinstates transportation component for portable EKG like portable x-ray
  - Removed the industry from PPS like all other entities under the Physician Fee Schedule

8/8/01 **Response letter to Congressman Crane from Administrator Scully.**

- Repeated old policy with no reference to contradictory nature of new data. Data attached was requested by the industry through specific questions, and overwhelmingly supports industry case. CMS did not review data before sending. Later stated as letter says "NO" and data says "YES", that data was clearly flawed. They asked Congressman Crane to regard this response as a mistake and stated new information would be provided. (None has been received to date.)

No date **Chart: Number of In-Nursing Facility EKGs Performed in 2000 by state.**

- We took the CMS chart and put it in a better format. Numbers are identical. Note: WVA is missing from CMS list.

6/8/01 **Congressman Crane's letter to Administrator Scully**

- Letter supporting the industry and asking specific questions of Administrator Scully to collect data on the industry. Additionally, he asks him to reinstate EKG administratively.

3/17/99 **Response letter to Norman Goldhecht from American Medical Association.**

- Denial to sit on PEAC as an industry representative. The portable x-ray industry does not have representation on the PEAC board that makes cost determinations for the Physician Fee Schedule. They do not consult with the industry, thus they are in violation of the medicare statute (Counsel to Small Business Committee and SBA Chief Advocate have reviewed in detail and believe to be the case.).

9/10/98 **US Small Business Administration's Office of Advocacy letter to Administrator Nancy-Ann DeParle**

- Comments by SBA Advocacy notifying HCFA/CMS that they are in violation of RFA.

** Documents are organized in descending order by date.*

Side by Side Comparision/Industry Comment to Administrator Scully's Letter to Chairman Manzullo Letter Dated March 12, 2002

Page 1, Paragraph 2

Mr. Scully states, "Medicare methods for the technical component depend on the statutory requirement for that place of service."

Response: One would assume that All providers have the statutory requirement to report the correct place of service. However, on page 2; paragraph 6, Mr. Scully states, "physicians may not accurately report the place of service". Would reporting the place of service inaccurately not constitute fraud, since it is a statutory requirement? Would this also be one of the reasons CMS cannot accurately give data on the EKG information we requested?

Mr. Scully states, "Medicare Part B does not make separate payments to either a portable EKG supplier or a physician for transportation of EKG equipment to a skilled nursing facility (SNF) since payment for transportation is not authorized by law."

Response: While transportation is not authorized by law, this understanding is a re-interpretation of CMS. Until 1997 and some subsequent years thereafter, CMS did in-fact pay for transportation of EKG equipment by portable suppliers. Physicians have never been paid for transportation of EKG equipment, they can however bill for other services to offset the transportation.

Page 1, Paragraph 4

Mr.Scully states, "During the time that a beneficiary is in a covered Part A stay, Medicare's per deim prospective payment system (PPS) to the SNF includes payments for EKGs and other diagnostic tests...Medicare has no billing data on the number of EKGs furnished to beneficiaries in Part a covered SNF stays"

Response: It is our understanding that the SNF still supplies Medicare with a billing form, to supply Medicare data of the diagnostic tests being performed on the beneficiary. Are we to conclude that non of the data being collected by Medicare on Part A covered stays is available for anyone to analyze? Additionally, if the data is not available for the number of EKGs performed on Part A beneficiaries then what is the difference of EKGs being billed under Part B now versus pre-PPS?

Page 2, Paragraph 3

Mr. Scully states that a SNF can supply the EKG to the beneficiary and receive payment.

Response: Our information suggests that *very few* SNF's have purchased or intend to purchase EKG equipment. The national average of 1.7 EKGs performed per SNF, per month does not warrant the individual SNF purchase of EKG equipment. Secondly, the turnover of staff and the liability associated with re-training and performing these tests further inhibits the SNF from making this purchase.

Page 2, Paragraph 4

Mr. Scully states, an EKG can be furnished by an outside supplier of services submit a bill to Medicare Part B and receive the same amount a physician would be paid for the same service.

Response: While it is true a supplier would be paid the same amount as the physician for the test, several factors have to be looked at before it is this cut and dried. The physician is not going to make a trip for the sole purpose of performing the EKG and if he is, he would also be billing for additional services granted him by the Medicare fee schedule and probably bill Medicare for other patients seen on this same trip. If a physician routinely performed EKGs at a rate of $15.00 to $20.00 per EKG on one patient, in one trip and was not able to bill for other services, this physician would not be in business very long.

Page 2, Paragraph 5

Mr. Scully states that physicians will bring the EKG unit into the SNF to perform the EKG, submit the bill with the "possibility" of using the wrong place of service code (because it doesn't affect payment) and thus leave Medicare with incorrect data of EKGs furnished to SNF beneficiaries.

Response: First, our information strongly suggests that no physician is carrying his $3,000.00 to $5000.00 EKG machine with him in his vehicle to perform EKGs on SNF patients at an average of $20.00 per test. If they were, would this not be a self referral problem? Secondly, Mr. Scully stated earlier in this letter that there is a statutory requirement for reporting the correct place of service. Would this not constitute fraud?

Page 2, Paragraph 6 and 7

Mr. Scully states in paragraph 6 that there is no apparent way to accurately determine the number of EKGs performed in a SNF setting, yet in paragraph 7 e is able to determine that 249 plus 2,211 EKGs were furnished to SNF patients. I do not understand how we can ask CMS one day how many EKGs were performed on SNF patients and the number is 249. Yet on another day we ask how many and suddenly the number is "accurately" counted at 2,211. It would appear that CMS does not know how many EKGs are performed on their own clientele.

Page 3, Paragraph 1

Mr. Scully states, "Medicare statute does not allow administrative flexibility to treat one type of person who furnishes the same service different from another person who furnishes the same service. In fact, the Medicare statue explicitly prohibits such differential treatment."

Response: Why then are portable x-ray and EKG providers not exempt from PPS? Additionally, if we as portable x-ray suppliers are the only entities that bill the Q0092 (set-up) and R0070 (transportation) codes does that not make us different? In other words, it would appear that CMS wants it both ways when it is good for them.

Mr. Scully states that "statue prohibits varying the physician fee schedule conversion factor..." . While we understand that, we are not asking that he violate the statute. What we are asking is for a variance on the R and Q codes which have no Relative Value Units assigned.

We will acknowledge that Mr. Scully is correct regarding satisfying the RFA requirements as they apply to the technical components, not however on the Q and R codes as we argued three years ago.

Page 3, Paragraph 2

If the carrier priced rates were not required to be reduced, then why were they reduced and why can't CMS tell the carriers to reinstate them.

Page 3, Paragraph 3

Please explain how temporary reimbursement rates would violate Medicare statute and the Administrative Procedures Act as you have eluded to in this paragraph.

Page 4, Paragraph 1

We have asked CMS to work with our industry in setting RVU's for the R and Q codes. Furthermore, we have asked to sit on some committees to accomplish this task. In the mid 90's our data was unanimously accepted by the committee only later to be discarded by HCFA.

The Basic Life Support ambulance percentages quoted by Mr. Scully are based on a one way trip with no mileage, additional services, or the actual examinations originally ordered performed. Furthermore, one would have to add Emergency Room, physician, diagnostic examination charges in order to compare apples to apples. Additionally, EMT wages are considerably less than Radiological Technologist.

Page 4, Paragraph 2

We asked to participate and sit on the PEAC committee but were turned down in writing.

Page 4, Paragraph 3

After reading this paragraph and the overall tone of this letter, it would appear to me that CMS sees no good in this industry. In fact it would appear to me that CMS does not want to work with this industry no matter what the savings are to the American taxpayer.

Washington, DC 20515

March 19, 2001

Mr. Thomas Scully
Administrator
Health Care Financing Administrator
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

Dear Administrator Scully:

On Wednesday, March 6, 2001, the House Committee on Small Business held a hearing on the Small Business Regulatory Enforcement Fairness Act (SBREFA). Mr. Norman Goldhecht, Regulatory Chairman for the National Association of Portable X-Ray Providers, testified on problems that the Portable X-Ray industry has had with the Center for Medicaid Service lack of compliance with the Regulatory Flexibility Act. This was the third time that Mr.Goldhect has come before the committee to provide insight on this matter. Some of the members of the committee were informed, off the record, that the president of the National Association of Portable X-Ray Providers was subject to an unexpected audit on the very same morning of the audit. The timing of the audit could possibly have given the impression that it was scheduled as a punitive measure for the Association testifying before the committee. We would like your personal assurance that this is not the case. In previous hearings on the topic of CMS compliance with SBREFA, the committee received testimony that physicians have been subject to unexpected audits that appeared to be in retribution to a their complaints about CMS. This has caused much concern and resulted in investigations to be conducted by the Chairman of the Committee, Congressman Donald Manzullo.

Additionally, the National Association of Portable X-Ray Providers met in Washington, D.C. this week. The members of the Small Business Committee were told that representatives from CMS were invited to participate but declined. This would have been a perfect opportunity for CMS to meet with the Association to discuss their concerns.

The above information that the Association shared with the members of the committee concerns us. We request that you look into this matter as soon as possible. It is our objective, as we hope is yours, to make federal regulations less burdensome on our nations small businesses. In reaching this objective, we hope that CMS will do what is possible to comply with SBREFA. Your assistance in this matter would be greatly appreciated.

Sincerely,

Congresswoman Nydia Velazquez
Ranking Member
House Committee on Small Business

Congresswoman Donna M. Christensen
Member
House Committee on Small Business

Business News from San Antonio

SAN ANTONIO BUSINESS JOURNAL
THE ESSENTIAL BUSINESS TOOL

March 18, 2002

Some ignore rules' small business impact

Kent Hoover Washington Bureau Chief

March 6 marked the third time that Norman Goldhecht appeared before the House Small Business Committee to describe how federal health regulators are putting portable X-ray providers out of business.

The previous time he testified, Goldhecht was owner of Diagnostic Health Systems of Lakewood, N.J. This time, however, Goldhecht testified as a former business owner. He recently sold his company after 16 years, he says, "largely because I felt that federal rule making was dooming our industry and that I could not longer afford to remain in business."

Agency Accountability Act

Provisions:

- Adds the Internal Revenue Service, the U.S. Forest Service, the National Marines Fisheries Service and the U.S. Fish and Wildlife Service to the list of agencies that must convene panels of small business representatives to review proposed regulations;
- Requires agencies to publish a summary of their analysis in cases where they decide a regulation will not have a significant impact on small businesses;
- Calls for the Small Business Administration's

Goldhecht says the Centers for Medicare & Medicare Services ignores the impact of its regulations on the small businesses that dominate the portable X-ray industry. The latest example, he says, is an 8 percent across-the-board cut in a reimbursement rate that already was so low that it was "driving many small businesses to halt services to rural areas and/or leave the industry."

Four years ago the Small Business Administration's Office of Advocacy advised CMS, then called the Health Care Financing Administration, that it had failed to prepare an adequate analysis of the impact its reimbursement rates would have on small businesses. In some cases, HCFA cut Medicare reimbursements for portable X-ray providers by 54 percent, says Thomas Sullivan, the SBA's chief counsel for advocacy.

HCFA ignored the SBA's Office of Advocacy four years ago, Sullivan says, and did so again in December, when it issued another cut in reimbursement rates for portable X-ray providers.

CMS and the Federal Communications Commission were cited by Sullivan as two agencies that "consistently ignore the requirements" of the Regulatory Flexibility Act, a 1980 law that requires agencies to consider the impact of their rules on

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Office of Advocacy to define what constitutes a significant impact on small businesses

- Bill number: S. 849
- Sponsor: Sen. Kit Bond, R-Mo.
- Status: Introduced in Senate

small businesses.

Criticism of CMS does not do much, however, to help portable X-ray providers, Goldhecht says.

"The SBA says we're right and CMS is wrong," he says. "That a few hundred thousand dollars over a few years to sue the government might force CMS to agree and do what they should have done in the first place, no more. The reality is, we won't be around to see the case through, because the rule making in questioning is bankrupting us."

Agencies face 'accountability time'

The House Small Business Committee wants to find a way to force agencies to comply with the Regulatory Flexibility Act.

Committee Chairman Donald Manzullo, R-Ill., says agencies like CMS use "interpretive gymnastics" to "avoid conducting the required analyses and identifying less burdensome alternatives."

Many agency officials resist "the concept that regulatory alternatives that are less burdensome on small businesses may in fact be equally effective in achieving public policy objectives," Sullivan says. "Other agencies simply haven't 'internalized' their RFA responsibilities and don't seem to view its requirements as germane to their mission."

Some agencies, however, are responsive to small-business concerns, Sullivan says. Input from the Office of Advocacy and small businesses resulted in changes to proposed regulations that saved businesses more than $16.4 billion over the past four years, he says.

"Let us know if they don't respond," Manzullo told Sullivan.

In these cases, agencies will face "accountability time" before his committee, Manzullo says.

Legislation eyed to close loopholes

Manzullo says his committee also will consider legislation "to remove the loopholes agencies have discovered" for not complying with the Regulatory Flexibility Act and a follow-up 1996 law, the Small Business Regulatory Enforcement Fairness Act.

SBREFA gives the courts jurisdiction to review agency compliance with the RFA, and requires the Environmental Protection Agency and the Occupational Safety and Health Administration to convene panels of small-business representatives to review regulations before they are published.

Before joining the Office of Advocacy this year, Sullivan was executive director of the NFIB Legal Foundation, where he used SBREFA to challenge government regulations that negatively impacted small businesses. In a few cases, courts have overturned regulations based

on SBREFA challenges -- "a significant incentive for agencies to do more in-depth small-business impact analyses," Sullivan says.

Another incentive, he says, is the Office of Advocacy's ability to file friend of the court briefs on behalf of small businesses challenging agency regulations.

Attorney David E. Frulla, who has filed four SBREFA cases challenging regulations, says Congress should instruct courts to defer to the Office of Advocacy on the question of whether regulations are subject to the RFA. This would cause agencies to give more weight to the office's comment letters before final regulations are issued, he says.

Frulla and small-business groups also support legislation, sponsored by Sen. Kit Bond, R-Mo., that would expand SBREFA's small-business panel requirements to the Internal Revenue Service and three other agencies.

Bond's bill also addresses a problem cited by the General Accounting Office: The RFA allows agencies to forego a small-business analysis on regulations that do not have a "significant economic impact" on a "substantial number of small entities," but it does not define what these terms mean. This lack of clarity allows agencies to avoid the law's requirements, GAO says. Bond's bill calls for the Office of Advocacy to define these terms.

DONALD A. MANZULLO, ILLINOIS
CHAIRMAN

NYDIA M. VELÁZQUEZ, NEW YORK

Congress of the United States

House of Representatives

107th Congress

Committee on Small Business

2361 Rayburn House Office Building

Washington, DC 20515–6315

March 15, 2002

Mr. John Cavalier
President
National Association of
Portable X-Ray Providers
7250 West Boulevard
Youngstown, OH 65203-3842

Dear Mr. Cavalier:

Pursuant to your inquiry, please be advised that the initial oversight hearing with CMS during the week of March 18th had to be rescheduled to April 10, 2002 because of scheduling difficulties. The specific hour is yet to be determined.

The witnesses will include: Tom Scully, HCFA/CMS Administrator and Tom Sullivan, Chief Counsel to the Small Business Administration Office of Advocacy. Congressman Dave Weldon, a physician, has been invited to participate, as well. Other witnesses who have been affected by HCFA/CMS actions will be invited to testify, as well.

As your association representative has testified before my committee, you are undoubtedly aware that Congresswoman Christian-Christensen is also a physician. As a member of the committee, she brings her medical expertise and background. I am confident that these two physicians will provide the committee with the necessary expertise to appropriately address this issue.

Attached is a copy of Tom Scully's response to my February letter concerning portable x-ray and EKGs. The letter raises more questions than answers and will be the subject of inquiry at the hearing.

I look forward to working with you on this matter.

Sincerely,

Donald A. Manzullo
Chairman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

MAR 12 2002

The Honorable Donald A. Manzullo
Chairman
Committee on Small Business
2561 Rayburn House Office Building
Washington, DC 20515-0515

Dear Chairman Manzullo:

Thank you for your letter regarding Medicare payment for transportation of portable EKG-and X-ray equipment. I have made it a major goal to make CMS into a responsive agency -- responsive to our beneficiaries and responsive to all of our stakeholders, such as providers of health care services including small businesses, and Members of Congress. I believe that most Members have found me and CMS to be extremely responsive.

An EKG service consists of two components: First, the taking of the test, the technical component, is done by a nurse or technician. Second, the professional interpretation of a test is done by a physician or other qualified clinician. By law, Medicare makes a separate Part B payment for the professional interpretation in all settings. In contrast, Medicare payment methods for the technical component depend on the statutory requirement for that place of service. Medicare Part B does not make a separate payment to either a portable EKG supplier or a physician for transportation of the EKG equipment to a skilled nursing facility (SNF) since payment for such transportation is not authorized by law.

In SNFs, EKGs are furnished to Medicare beneficiaries in a variety of ways depending on the statutory Medicare benefit and the provider who furnishes the service. Some of the confusion about this issue may be related the complexity of the statutory Medicare benefit for patients in a SNF. Let me try to clarify the situation.

The Medicare law has a very specific skilled nursing facility (SNF) benefit. Part A of Medicare will pay for 20 days in a SNF before coinsurance begins (for day 21 to 100). During the time that a beneficiary is in a covered Part A stay, Medicare's per diem prospective payment system (PPS) to the SNF includes payments for EKGs and other diagnostic tests. In this case, the SNF can not submit a separate bill for such a service to either Part A or Part B of Medicare. Since payment for the EKG is bundled into the SNF PPS rate, Medicare has no billing data on the number of EKGs furnished to beneficiaries in Part A covered SNF stays. We do know, however, that in 2000, Medicare paid for approximately 47 million Part A covered SNF days for beneficiaries.

Page – 2 The Honorable Donald A. Manzullo

The situation changes after a beneficiary uses up or "exhausts" their Medicare Part A benefit. At that point, Part A of Medicare no longer makes a per diem payment. However, Medicare will pay for certain services that would otherwise be covered for the beneficiary under Part B if they were not in a nursing facility. Thus, if a beneficiary who is in a SNF, and who is not covered under Part A, needs an EKG, then Medicare Part B would cover the EKG just like Part B would cover the EKG if the beneficiary received the EKG in a physician's office. That is, Medicare payment would be for both the technical component and the professional interpretation under the physician fee schedule.

The situation of a beneficiary in a SNF who has exhausted their Part A benefit is further complicated by the fact that a variety of providers can furnish an EKG to such a beneficiary and be reimbursed by Part B of Medicare.

First, an EKG can be furnished to a Medicare SNF beneficiary who has exhausted their Part A benefit by the SNF itself utilizing the SNF's own EKG machine. In this case, the SNF would be paid by Part B of Medicare (on a reasonable cost basis through December 31, 2001, and on a fee schedule basis after January 1, 2002).

Second, an EKG can be furnished by an outside supplier of services. In this case, the portable EKG supplier would submit a bill to Medicare Part B for the EKG test. Medicare would pay the same amount for the EKG to the portable supplier as Medicare would pay to a physician who furnishes the test.

Third, an EKG can be furnished by a physician who brings the machine to the facility. The physician would submit a bill to Part B of Medicare for the technical component (in addition to billing for the professional interpretation). However, since the place of service code does not affect payment, the physician may choose not to report the place of service as a SNF. Thus, data which considered only billings for SNF as the place of service would likely undercount EKGs furnished to Medicare SNF beneficiaries.

The data that you refer to represent only a portion of the total number of EKGs furnished to Medicare beneficiaries in SNFs. Because the SNF PPS pays a per diem amount and does not require providers to bill for each individual service they furnish, and because physicians may not accurately report the place of service for EKGs furnished in SNFs, our billing systems do not allow determination of the complete number of EKGs furnished to Medicare beneficiaries in SNFs.

I can assure you that the figure of 249 EKGs furnished to beneficiaries in Illinois does not represent the total. While we cannot get the total number, for the reasons cited in the previous paragraph, I can tell you that there were another 2,211 EKGs furnished to Medicare beneficiaries in Illinois in SNFs beyond their Part A stays by portable suppliers and physicians who billed Medicare using a different place of service code. Thus, there were at least 2,460 EKGs furnished

to Illinois SNF beneficiaries who had exhausted their Part A benefits and that does not count any that were furnished by SNFs.

Regarding physician payments, I have stated many times that the Medicare statute is extremely prescriptive and did not give me any administrative flexibility to have a different physician fee schedule update (-4.8 percent) and percent change in the physician fee schedule conversion factor (-5.4 percent) than the figures contained in our final rule published in the November 1, 2001 *Federal Register*. The Medicare statute does not allow administrative flexibility to treat one type of person who furnishes the same service differently from another person who furnishes the same service. In fact, the Medicare statute explicitly prohibits such differential treatment. One of the fundamental elements of the physician fee schedule since it was originally legislated is the statutory prohibition against variation in the amount of payment among different physician specialties for the same service. The Medicare statute specifically prohibits the Secretary from varying the physician fee schedule conversion factor or number of relative value units based on the specialty of the provider who furnishes the service. Whether an EKG or X-ray test is furnished by a physician, a portable supplier or and independent facility, the statute requires that the Medicare relative value, conversion factor and payment in an area to be the same. While the Regulatory Flexibility Act (RFA) may require consideration of alternatives, there are no alternatives to consider here. We believe that we have satisfied the RFA.

Medicare payment for portable X-ray comprises four separate payments: (1) for the X-ray test itself, (2) for set-up of portable X-ray equipment (code Q0092), (3) for transportation for the portable X-ray equipment, and (4) for a professional interpretation of the test. Medicare payment for the X-ray transportation is under the physician fee schedule, but the payment level is "carrier priced". This means that there is not a national relative value and payment amount, but rather, that each carrier sets up its own local pricing depending on its understanding of the local situation. In contrast to services paid under the fee schedule for which we establish relative values at the national level, and to which the 5.4 percent reduction in the conversion factor applied, we did not require that carrier priced services be reduced by 5.4 percent because that would have been inconsistent with the notion of the carrier setting the price based on their knowledge of the local situation. We cannot now tell carriers to freeze their rates for X-ray transportation as you requested.

You requested that we suspend the physician fee schedule rule as it applies to portable X-ray and EKG and that we establish temporary reimbursement rates for portable X-ray set-up and transportation based on figures from a study of industry cost data that you referenced. We do not believe that the Medicare statute authorizes us to suspend any portion of a final rule or establish temporary reimbursement rates outside of the normal regulatory process pursuant to the Administrative Procedure Act.

Your letter also requested that we establish Medicare reimbursement rates for portable EKG set-up based on industry cost data including a 20 percent profit margin. This too would be inconsistent with the statute. The statute requires that we establish relative values for each service which the represent the "relative" amount of the resources involved with furnishing a service, not the actual costs. In addition, the inclusion of a 20 percent profit margin for portable X-ray set-up and transportation would be inconsistent with the statutory requirement for establishment of relative values based on the relative resources involved with furnishing a service. I would note that the Medicare reimbursement rates you suggest for transportation ($140.96 during regular hours and $190.88 during after hours and weekends) would be 83 and 113 percent of the Medicare reimbursement rate for Basic Life Support ambulance services in our recently published final rule on ambulance services. Since an ambulance transports a sick patient, while a portable supplier transports a piece of equipment, the suggested rates seem generous.

You requested that we create a standing advisory panel with industry representation led by the National Association of Portable X-Ray Providers to determine accurate payment rates. We believe that the Practice Expense Advisory Committee (PEAC) of the American Medical Association's Relative Value Update Committee already serves to establish a forum wherein all physicians and providers may furnish cost information regarding all Medicare services paid under the physician fee schedule. Accordingly, like other physicians and providers, if the industry has data, information or studies on the resource inputs for these services, the industry should furnish such data to the PEAC and let this existing process work. The PEAC will then review the information and make a recommendation to CMS on this matter. Any changes in relative values would be done through Notice and Comment Rulemaking as part of our annual fee schedule regulation. I believe that using this existing process would be more efficient than setting up a separate advisory panel just for this issue.

Let me also comment on your request for support of H.R. 3094. After reviewing that bill, I have several concerns about it and believe that it would not be good public policy. H.R. 3094 would (1) unbundle EKGs, X-rays and mammograms from the SNF prospective payment rate and establish a separate Medicare payment for such services, and (2) restore Medicare payment for portable EKG transportation. I believe that the reasons I have previously indicated for opposing separate payment for EKG transportation continue to be valid. Medicare policy treats portable suppliers in the same manner as physicians or other suppliers in not making payment for EKG transportation. While unbundling these tests from the SNF prospective payment rate, the bill does not provide for any reduction in such rate. I believe that such an approach is not a desirable public policy for several reasons. First, it would result in a duplicate payment, paying the supplier directly and including payment for such service in the SNF PPS rate. This would inappropriately increase Medicare outlays. Second, it would not be a good precedent to remove inexpensive and relatively common items from the SNF PPS. It would not be long before supporters of many other services would want to be similarly treated and removed from the SNF PPS or one of Medicare's other prospective payment systems. This is contrary to the purpose of a PPS which is to provide a comprehensive payment for all services. Finally, H.R. 3094, might

even have unintended consequences that could adversely affect the portable supplier industry. Such an approach would encourage SNFs to set up suppliers which they own to furnish EKGs and X-rays to their own patients. Such an unintended consequence could have a significant negative impact on the current portable X-ray and supplier industry.

I hope that this addresses your concerns.

Sincerely,

Thomas A. Scully

Congress of the United States
House of Representatives
107th Congress
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515-6315

February 20, 2002

Hon. Thomas Scully
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Room 309-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Scully:

Last July, you testified before the House Small Business Committee that the "new" Centers for Medicare and Medicaid Services (CMS) was going to be run far differently than the former Health Care Finance Administration (HCFA). I distinctly remember stating on the record that until I noted any sincere changes of this organization that I would continue to refer to the agency you head as HCFA. I am very disappointed to state that in my opinion, your agency has changed in name only in the way it operates and how responsive it is to Congress.

As Chairman of the House Committee on Small Business, I write to you today and state unequivocally that I am strongly concerned about HCFA's failure to adhere to federal law as it pertains to the portable x-ray and EKG industry. In the opinion of my Senior Regulatory Counsel, who also serves as Administrative Law Counsel to the House of Representatives and of the Small Business Administration (SBA) Office of Advocacy, your office is in violation of the Regulatory Flexibility Act (RFA) relative to the rulemaking process as it applies to the portable x-ray and EKG industry and has been in violation for over three years. Specifically, the SBA notes the total lack of reasonable industry cost assessments as compared with the cost data utilized in all other portions of the rule in question.

The SBA Office of Advocacy twice informed *you* of these violations, first on September 10, 1998 and again, on December 28, 2001. To date your agency has failed to respond in any way to these serious indictments by the SBA. However, I noticed that your office did inform the publication *Inside CMS* (Vol. 5, No. 2 – January 17, 2002) that "the SBA comments will be forwarded to its policy department for consideration in next year's rule." HCFA's offer to consider obeying the law next year is not acceptable. HCFA (CMS) may not decide which laws to obey and which are simply inconvenient at the moment and may be put off for later consideration.

That said, I also wish to bring your attention to H.R. 3094, legislation introduced by Chairman Phil Crane and myself, to remedy past HCFA policy failures impacting this vital industry. It was brought to my attention that on December 11, 2001 you stated publicly that because neither Chairman Crane nor I personally "lobbied" you for support of this legislation that you were unconcerned about this legislation and, therefore, the issue.

Apparently Chairman Crane and I agree on this matter. On June 8, 2001, he wrote to you to ask for your assistance on a "very important matter." This matter was, of course, the concerns we share about the portable x-ray and EKG industry. In that letter, Chairman Crane expressly requested your support for legislation following upon a bill previously introduced by my predecessor, Chairman Jim Talent. Specifically, Chairman Crane requested certain data required by the Congress to properly address concerns voiced by the portable x-ray and EKG industry. On August 8, 2001 you finally responded to Chairman Crane – 9 weeks later! When you appeared before my committee on July 25, 2001, you testified verbally that the "new" CMS responded to all Congressional inquiries within 15 days. I am certain that my skepticism toward anything "new" over at your agency is understandable.

To make matters worse, the response that finally did arrive was unacceptable and displayed alarming signs of gross negligence in addressing congressional inquiries. Specifically, you cited the *nearly identical* position offered by the former Secretary of Health and Human Services, Donna Shalala, in 1998. In fact, it would appear that the language was lifted directly from *that* letter.

Additionally, the response to Chairman Crane's request for detailed data included numbers that seem to completely refute the position of both you and former-Secretary Shalala. Please review the data you included in the letter; it shows that the number of EKG services performed by portable x-ray and EKG service providers at SNFs has plummeted from 255,180 in 1995 (GAO\HEHS-98-82) to 56,178 in 2000. We both know that the nursing home population has risen from 1995 to 2000, so we can surmise that the dramatic decrease in procedures can be attributed to a failed policy, which has removed the in-room option from patients. More troubling are the specific state-by-state numbers, which clearly indicate a staggering loss of these services to rural areas. This policy has resulted in 15,080 procedures performed in New York in 2000, and 3 in Montana, 2 in North Dakota, 1 in Wyoming and 0 in Alaska. The data further shows that in my state of Illinois just 249 procedures were performed as contrasted with 2,936 in Connecticut despite the enormous population differences between the states.

The data also shows that approximately 80 percent of these procedures were performed by the portable x-ray and EKG industry, directly contradicting your statement in the very same letter that physicians "often" perform these procedures or that the SNF "often" owns the equipment and performs them themselves. Because the letter cites two separate events, which you state occur "often," but which your own data clearly shows occur no more than 20 percent of the time combined – relative to the 80 percent figure, I have to conclude that we define the term "often" much differently.

To provide some personal insight into these numbers, I'd like to relate my own experience with portable x-ray and EKG providers. When my mother resided in a nursing home in Illinois several years ago, she experienced pain and discomfort and was seen by a portable x-ray and EKG provider in the comfort of her room. The chest x-ray performed by that provider indicated that she had pneumonia and she was able to receive treatment swiftly and recovered. If my mother had to be transported to a hospital instead of being treated in her room it would have cost multiple times the cost of in-room service, plus the inconvenience to her because she had only one leg. I note with interest that your August 8, 2001 letter suggests that "a patient may be transported by family members or others" for these services. I speak from experience that your statement is too general and that it is not as simple as you make it out to be. Also, most people are not trained in the transport of elderly, infirm, amputees, particularly during a northern Illinois winter. Our nation's government, therefore, should not expect all people to act as surrogates for qualified healthcare professionals in the care of loved ones. In many cases, it is downright impossible, if not irresponsible, to do that.

Now that I have documented the reasons for my extreme dissatisfaction with HCFA/CMS regarding this matter, I strongly request the following from your agency:

1. Written support, based upon the data provided by your office, for H.R. 3094.
2. Immediately suspend the portion of the *Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physicians Fee Schedule for Calendar Year 2002; Final Rule, November 1, 2001*, pertaining to portable x-ray and EKG providers as requested by the SBA Office of Advocacy.
3. Set temporary reimbursement rates for portable x-ray in accordance with the industry cost data provided by the Center for Health Policy Studies (CHPS) report Cost Study of Transportation and Set-Up for Portable X-Ray Providers: Final Report May 2, 2001, including a 20% profit margin over costs identified in the report. Specifically, set-up (CPT Q0092) shall be reimbursed at $33.88 during regular hours and at $44.92 during after hours and on weekends, and transportation (CPT R0070) shall be reimbursed at $140.96 during regular hours and at $190.88 during after hours and on weekends.
4. Create a standing portable x-ray and EKG advisory panel tasked with determining accurate industry operating costs, as required by the RFA and referenced by the SBA. This panel will include reasonable industry representation led by the National Association of Portable X-Ray Providers (NAPXP). "Reasonable representation" will be determined by this Committee. This panel will utilize data compiled by the GAO, as instructed by me, in light of your failure to provide accurate data for this industry in the past.
5. Freeze the CPT Q0092 and CPT R0070 codes at the rates listed in #3 until such time as the findings of the panel described in #4 are reviewed and accepted by this Committee.
6. Appear before the House Small Business Committee along with the GAO to discuss the GAO findings and to explain your failure to provide credible internal data with which HCFA or the Congress might draft responsible policies.
7. Respond in writing and in detail to this correspondence within 15 days, per your statement before the Committee last July. Please be advised that if the response is simply a re-hashing of previous agency statements, I will have to seek other avenues to remedy this matter.

I trust that this letter makes very clear my intentions on this very important national health care issue – the portable x-ray and EKG industry.

Sincerely,

Donald A. Manzullo
Chairman
U.S. House Committee on Small Business

cc: The Hon. Tommy Thompson, Secretary of Health and Human Service
The Hon. Phil Crane, Chairman, House Ways & Means Subcommittee on Trade

Inside Washington Publishers'

Inside CMS

exclusive news on the most powerful agency in health care

Vol. 5, No. 5 - February 28, 2002

Graham Says His New Rx Drug Bill Will Include Lower Monthly Premium

A key Democratic senator announced yesterday (Feb. 27) that his revamped prescription drug legislation would cut premiums in half, compared to last year's bill.

Sen. Bob Graham (D-FL) made the announcement at a press conference of Senate Democrats on prescription drugs. Noting that the legislation he is currently working on is based on last year's version, Graham pointed to key changes in the legislation. The lawmaker noted that under the new bill, premiums would be cut in half, to about $25-$30 a month. Graham's bill last year called for $52 monthly premiums, which triggered concerns from consumer groups that many seniors could not

continued on page 6

AARP CALL FOR $700+ BILLION PUTS NEW SPARK IN Rx DRUG BENEFIT DEBATE

AARP's call this week for Congress to spend more than $700 billion on Medicare reforms centered on a prescription drug benefit has put a new spark in the prescription drug debate on Capitol Hill. The press by the nation's largest senior group for more than double what the congressional budget committees have set aside in the past for Medicare reform may bolster Democratic efforts to enact a comprehensive Medicare drug benefit reform bill prior to the fall elections, sources say.

As first reported Feb. 25 on *Inside CMS*' online news service

continued on page 10

Lawmaker calls for agency action

MANZULLO TAKES CMS TO TASK OVER PORTABLE X-RAY AND EKG INDUSTRY

House Small Business Committee Chairman Donald Manzullo (R-IL) is blasting CMS over its reimbursement policy for portable X-ray and EKG providers. Stating the policy has violated federal law for more than three years, the key House Republican is calling for a slew of agency actions to overhaul portable provider payments.

In a strongly worded Feb. 20 letter to CMS Administrator Tom Scully, Manzullo outlined his "extreme dissatisfaction" with CMS' handling of the

continued on next page

issue. He calls for the immediate suspension of current portable X-ray and EKG provider physician fee schedule payment rates, and the implementation of temporary portable X-ray reimbursements until an advisory panel is established to determine accurate industry operating costs.

The lawmaker's forceful request follows numerous complaints by industry stakeholders and the Small Business Administration's (SBA) Office of Advocacy, which has twice warned the agency since 1998 about its method of determining portable X-ray and EKG provider payments.

In its most recent warning, SBA's Office of the Chief Counsel for Advocacy stated the final 2002 Medicare physician fee schedule violates the Regulatory Flexibility Act (RFA), which requires government agencies to prepare a regulatory flexibility analysis to ensure regulations do not have a significant economic impact on small entities.

SBA's counsel told CMS the fee schedule could "significantly impact" the portable provider industry, and charged that CMS "failed to adequately assess" the industry's true operating costs (*Inside CMS*, Jan. 17, 2002). It remarked that CMS' RFA violation is "judicially reviewable."

"The SBA Office of Advocacy twice informed you [Scully] of these violations...," Manzullo's letter states. "To date your agency has failed to respond in any way to these serious indictments by the SBA."

Inside CMS reported Jan. 17 that SBA's comments would be forwarded to CMS' policy department for consideration in next year's physician fee schedule rule. In his letter to Scully, Manzullo says this is unacceptable. "HCFA (CMS) may not decide which laws to obey and which are simply inconvenient at the moment and may be put off for later consideration."

Expressing strong concern about CMS' "failure to adhere to federal law," Manzullo is calling for action. He has requested a CMS response within 15 days, warning, "Please be advised that if the response is simply a re-hashing of previous agency statements, I will have to seek other avenues to remedy this matter."

Manzullo noted that June 2001 efforts by Rep. Philip Crane (R-IL) to seek relevant data as well as Scully's support for his legislation on the issue yielded a response that mirrored prior agency correspondence. He says the response — that arrived nine weeks later — "was unacceptable and displayed alarming signs of gross negligence in addressing congressional inquiries.

"Specifically, you cited the nearly identical position offered by the former Secretary of Health and Human Services, Donna Shalala, in 1998. In fact, it would appear that the language was lifted directly from that letter."

In addition, Manzullo says the data cited in the eventual request "seem to completely refute the position of both you and former-Secretary Shalala." He is calling on Scully to review the data.

The portable industry asserts its reimbursements under the physician fee schedule are inadequate, fail to account for several factors, and lack an adequate process to determine accurate costs. As such, the industry is close to being lost, according to one industry source.

Like SBA's counsel, Manzullo is seeking an immediate suspension of CMS' final 2002 physician fee schedule relating to the portable industry. CMS published its Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units under the 2002 Physician Fee Schedule on Nov. 1, 2001.

The House Small Business Committee chairman is requesting CMS to set temporary portable X-ray reimbursement rates based on cost data in a Center for Health Policy Studies report, including a 20 percent profit margin. He is also calling for the establishment of a portable X-ray and EKG advisory panel led by industry representatives to determine accurate industry operating costs.

"This panel will utilize data compiled by the [General Accounting Office], as instructed by me, in light of your failure to provide accurate data for this industry in the past," the lawmaker states.

The new, temporary rates would be in place until the panel's findings are reviewed and approved by the Small Business Committee, Manzullo instructs. He has also strongly requested the agency appear before the committee "to explain your failure to provide credible internal data with which HCFA or the Congress might draft responsible policies."

The portable industry, headed by the National Association of Portable X-Ray Providers, has long pushed CMS to address its reimbursement concerns. It maintains that rates under the physician fee schedule are inadequate, and do not account for increasing transportation costs, treatment time and mileage.

The industry is seeking to discuss actual costs and determine codes and accurate payments with CMS. It is also pushing for exemption from the prospective payment system,

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Inside CMS is published every other Thursday by Inside Washington Publishers, P.O. Box 7167, Ben Franklin Station, Washington, DC 20044. Subscription rates: $595 per year in U.S. and Canada; $645 per year elsewhere (air mail).

as granted to physicians, and hopes to work with CMS to discuss modifications or alternative payment methods.

The portable X-ray and EKG provider issue is scheduled to be discussed at a March 6 House Small Business Committee hearing to discuss federal agency compliance with RFA and the Small Business Regulatory Enforcement Fairness Act of 1996. A representative of the industry is expected to testify about CMS' RFA compliance as it relates to portable x-ray and EKG providers. — *Lorraine Bennett*

FINANCE COMMITTEE CALLS ON GAO TO EXAMINE M+C FEE-FOR-SERVICE PLAN

Citing possible financial disparities between fee-for-service and Medicare+Choice (M+C), the Senate Finance Committee is calling for an examination of how the M+C program's only private fee-for-service (PFFS) plan is operating, according to a congressional document obtained by *Inside CMS*.

Senate Finance Committee Chairman Max Baucus (D-MT) and Ranking Member Chuck Grassley (R-IA) have directed the General Accounting Office (GAO) to study how the Sterling Life Insurance Company PFFS plan is working, assess its payment rates, and the plan's effects on beneficiaries, providers and the Medicare program.

Sterling is the M+C program's first and only PFFS option. PFFS plans were authorized under the Balanced Budget Act of 1997 to provide a coordinated care alternative for Medicare beneficiaries. Sterling has operated since July 2000, and is now available in about 25 states, providing the only alternative to traditional Medicare for about one-in-six beneficiaries, according to Baucus and Grassley's Feb. 13 letter to GAO (available on *InsideHealthPolicy.com;* see page 5 for details).

However, the lawmakers state, "several important concerns have been raised with respect to Sterling, especially its impact on the federal budget." A Senate source says there has been some concern that the PFFS plan is locating in parts of the country where M+C payment rates are higher than fee-for-service.

The Medicare Payment Advisory Commission (MedPAC) last year raised concerns about the "divergence between the M+C payment rates and Medicare spending in the Fee-For-Service (FFS) sector." It noted that a PFFS plan "has entered disproportionately into floor counties."

Floor counties receive higher M+C payments in a bid to entice HMOs to enter traditionally lower-paid locations, predominately rural areas. According to MedPAC, M+C payments in floor counties are 119 percent higher than Medicare fee-for-service spending before being adjusted for risk.

Another Senate source stressed that the senators' request is aimed at finding out how the program is working, and if it is a potential model for coordinated care. "If we're looking at alternative designs for [M+C], especially for rural America, we need to know we're doing it right," the source says.

Baucus and Grassley have requested GAO to study what areas Sterling plans are located, its enrollee size, and examine its benefit package make-up, premium, coinsurance co-payment fees versus those charged by traditional FFS, Medigap and local M+C plans in the same area.

Additionally, they are seeking information on beneficiary satisfaction with the PFFS plan, if providers are willing to take Sterling enrollees, and they are enquiring how Medicare per capita payments to Sterling compare to traditional fee-for-service program's per capita spending for beneficiaries with demographic characteristics similar to Sterling enrollees.

Lawmakers say delay of coverage appeals provisions is 'unacceptable'
WAYS AND MEANS COMMITTEE DEMANDS CMS ACTION ON BIPA PROVISIONS

Republicans and Democrats on the House Ways and Means Committee are demanding that CMS implement the coverage and appeals reforms that were included in the Benefits Improvement and Protection Act of 2000 (BIPA). In a strongly worded letter to the Bush administration, committee leaders say that CMS' delay "is unacceptable."

House Ways and Means Committee Chairman Bill Thomas (R-CA) has been extremely frustrated that the Bush administration has not implemented Section 521 and 522 of BIPA. Late last September, CMS said the new appeals mechanism called for in BIPA should not be implemented without a formal notice and comment rulemaking (*Inside CMS*, Oct. 11, 2001, p18). CMS then sought cover from Congress for its decision by asking lawmakers to include a one-year delay of the BIPA provisions to the CMS reform bill that eventually passed the House. But Thomas refused CMS' request.

The Feb. 12 letter (available on *InsideHealthPolicy.com*, see page 5 for details) to HHS Secretary Tommy Thompson and CMS Administrator Tom Scully is signed by Reps. Thomas, Charles Rangel (D-NY), Nancy Johnson (R-CT) and Pete Stark (D-CA). The lawmakers state, "We do not support extensions to the statutory deadlines because we have not lost sight of why these changes were made to the Medicare system....In sum, the timeframe is not discretionary and we expect CMS to proceed with implementation of the law."

BIPA called for the appeals reforms to be implemented Oct. 1 of this year and coverage appeals to be implemented Oct. 1, 2001.

Some say the letter from Ways and Means has been long overdue because CMS started to hint it would not implement the coverage and appeals provisions last summer. But throughout 2001, Thomas seemed reluctant to publicly criticize the Bush administration's health care policies.

While it took Thomas a while to publicly criticize CMS for its reluctance to implement Section 521 and 522

of BIPA, CMS observers praise the Ways and Means Committee chairman for not letting party politics prevent him from criticizing the agency for refusing to meet this statutory requirement.

In its new budget request, CMS said it would not address BIPA appeals provisions until after fiscal year 2003 (*Inside CMS*, Feb. 14, p5). This budget statement triggered the Ways and Means Committee to write the letter.

The lawmakers state, "We are deeply concerned that the President's budget provides no funding in FY 2003 to implement the coverage and appeals reforms required by [BIPA]....If no administrative funding is provided, [CMS] cannot begin until 2004 the process for contracting for Qualified Independent Contractors, who are critical to achieving a faster, more independent appeals process. This is unacceptable."

The letter notes that if an appeal goes through the Departmental Appeals Board level, the process takes an average of 1,214 days. "It seems no exaggeration," the letter says, "as beneficiary advocates state, that some beneficiaries are dead before their appeals are decided. In addition, the number of claims that are overturned at the Administrative Law Judge level...is staggering — 81 percent of home health appeals were overturned in 1996 and 79 percent of Durable Medical Equipment appeals were reversed in 1997."

It is not clear what the next step will be. The House Ways and Means Committee could urge appropriators to give CMS funds to implement Section 521 and 522 of BIPA but this would not ensure agency compliance with the law.

Sources say CMS will implement Section S22 later this year. This regulation's target date is June 28, sources say.

An agency official said CMS has received the letter and is preparing a response.

Over the last several months, health care experts have been critical of Thomas' silence on CMS' reluctance to implement the coverage appeals part of BIPA. During the Clinton administration, Thomas repeatedly blasted CMS (then HCFA) for failing to meet statutory deadlines. Thomas went so far to say that the Clinton administration used the Y2K bug as an excuse not to implement parts of the law it did not support.

JOHNSON VOWS TO MAKE PHYSICIAN PAYMENT REFORM A PRIORITY THIS YEAR

A key House Republican will make reforms to the law deciding on physician payment rates a legislative priority this year, arguing that this year's cuts are not fair and could result in loss of access for Medicare beneficiaries.

Rep. Nancy Johnson (R-CT), chairman of the Ways and Means subcommittee on health said Feb. 18 in a statement that through this year's 5.4 percent cut for physician payments, in addition to anticipated future cuts, "we are shortchanging our physicians, threatening both access to care and quality of care for our seniors as more doctors are forced to pull out of [Medicare] or over-schedule."

Johnson announced she would make the reform of statutes determining Medicare's physician payment rates "one of her top legislative priorities this year."

There are some provider groups that are concerned about House Ways and Means Committee Bill Thomas' (R-CA) commitment to this issue. Late last year, Ways and Means Republicans sent a letter to Thomas urging him to fix the physician payment update (*Inside CMS*, Dec. 20, 2001, p1).

Johnson's statement on physician payment reform was posted on her personal website, not the Ways and Means Committee site. However, sources say the Ways and Means Committee is committed to fixing the reimbursement system.

CMS Administrator Tom Scully discussed physician payments at a Feb. 14 hearing of the Energy and Commerce health subcommittee, suggesting that Congress consider a short-term fix rather than the long-term remedy proposed by Medicare Payment Advisory Commission (see related story). The CMS official argued that it would be easier and cheaper to do a short-term fix and noted that this strategy would also allow the physician payment formula to adjust itself as the economy picks up.

Sources say Energy and Commerce health subcommittee Chairman Michael Bilirakis (R-FL) is attempting to convince the Budget Committee to finance changes to the physician payment rates (see related story). A Ways and Means Committee source said that Johnson is also involved in the call for additional funding for a physician payment adjustment.

NAHC takes its case to Capitol Hill
HOME HEALTH GROUP OBJECTS TO SCULLY'S STANCE ON 15 PERCENT CUT

A key industry group has met with top congressional officials to strongly refute the Bush administration's recent comments on the looming 15 percent cut to home health. CMS Administrator Tom Scully recently suggested that the cut should not be eliminated because of 40 percent growth in the industry but the National Association for Home Care (NAHC) says these statements are off base.

Scrambling to respond to Scully's claims, NAHC has met with officials from the House Ways and Means Committee and is planning to meet with representatives from the Senate Finance Committee as well as the House Energy and Commerce Committee. The battle between the Bush administration and the home health industry could be fierce as Congress grapples over whether to eliminate the cut, which is scheduled to go into effect Oct. 1.

Many lawmakers want the cut to be eliminated. In a Feb. 15 letter (available on *InsideHealthPolicy.com;* see page 5 for details) to the House Budget Committee, 113 members say they want the budget resolution to provide for the complete elimination of the cut. Among those who

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Issue Date: February 25, 2002 Vol. 14 No. 8

CMS issues fraud hit list to carriers, FIs

Todd Leeuwenburgh
Monday, February 25, 2002

Millions in improper payments have flowed out of Medicare, and CMS knows where to go to get them back. In an internal report from CMS's program integrity office to carriers and fiscal intermediaries (FIs), the agency identifies fraud problems it wants to look at and suggests ways to clean them up. The carriers and FIs are under orders to step up data mining and pull more provider charts to weed out fraudulent providers.

In the "Vulnerability Report June 2001 through December 2001," CMS directs its regional offices, carriers and FIs to "target and intervene ... and mitigate the identified vulnerabilities." In the Feb. 7 report, Tim Hill, CMS director of program integrity, and deputy Elizabeth Cusick target the following problems:

- Hospital transfers reported as discharges, which has been the subject of a national initiative for three years (MCA 9/21/98, 7/3/00). CMS will instruct and work with FIs as they recover $233 million in improper payments that badly billed transfers have cost Medicare.
- Double billing of Part B services that should be covered under the Part A skilled nursing facility (SNF) global payment. Hill and Cusick direct the carriers and FIs to recover $47.6 million they say was overpaid this way.
- Chiropractic care. Providers are breaking utilization caps and billing for unauthorized maintenance treatments, according to a June 2001 OIG inspection report Hill and Cusick refer to. Medicare pays only for treatment that has a rehabilitative purpose, not for comfort or maintenance. All Medicare payers must employ edits to detect patients getting consecutive months of non-rehabilitative therapy, the memo states.
- Mobile x-ray services improperly billing for non-x-ray procedures that cannot be billed separately; billing for transportation and set-up costs several times, when in fact multiple beneficiaries are at the same location (such "gang visits" might occur at nursing facilities). To bill properly, the service would bill set-up/transportation once and each individual x-ray separately.
- Upcoding and billing for services not rendered. For instance, billing for pulmonary stress tests (CPT 94620) when the charts show only pulse oximetry testing was performed (CPT 94760, 94761); and billing for physical exams (CPT 99272) when they were not performed.

First Coast Service Options, Medicare contractor for Florida and Connecticut, will follow up on the CMS directives with a "combination of progressive corrective actions," says Patricia Ainsley,

First Coast's vice president for program safeguards.

First Coast will comb through years of claims looking for "aberrances," she says. Providers found to have billed targeted codes heavily will have to show their records. If those records do not substantiate the billing, the providers will be singled out for education, repayment or referral to enforcement agencies, she says.

In the year ending Sept. 30, 2001, First Coast recovered $523 million in improper billing through medical record reviews, Medicare cost report audits and working with other insurers to find instances where Medicare was not the primary payer, but was billed as such, Ainsley says. First Coast referred 92 cases to law enforcement in 2001, and the enforcers accepted 70% of those, she says. The carrier recovered money administratively in the remaining 30%.

Categories: Government Enforcement Initiatives

Inside CMS

exclusive news on the most powerful agency in health care

CMS rebuked for ignoring policy advice

Vol. 5, No. 2 • January 17, 2002

SBA CLAIMS CMS POLICY ON PORTABLE X-RAY, EKG PAYMENTS VIOLATES RFA

CMS' physician fee schedule for portable x-ray and EKG providers violates federal rulemaking protections for small businesses, claims watchdog the Small Business Administration (SBA), which has admonished the agency for ignoring its policy warnings on the issue.

In a Dec. 28 letter to CMS Administrator Tom Scully, SBA's Office of the Chief Counsel for Advocacy advises CMS to "immediately suspend" its final 2002 physician fee schedule rule relating to portable x-ray and EKG providers. SBA warns that the final rule could "significantly impact" the portable provider industry.

Asserting CMS "failed to adequately assess" this industry's true operating costs, SBA's counsel says the agency's final policy violates the Regulatory Flexibility Act (RFA), which requires government agencies to prepare a regulatory flexibility analysis to ensure regulations do not have a significant economic impact on small entities.

"CMS clearly violated the RFA when it failed to prepare a flexibility analysis, or certify that the rulemaking would not have a significant impact on a substantial number of small entities," the SBA letter states. CMS published its Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units under the 2002 Physician Fee Schedule on Nov. 1, 2001.

It is not the first time SBA has warned CMS about its portable provider policy. Since 1998 SBA's Office of Advocacy has twice sent comments expressing concern about CMS' method of determining industry payments. It advised the agency that its payment adjustments would affect a "substantial number" of small entity portable x-ray and EKG providers.

"By failing to comply with the provisions of the RFA, the CMS has voluntarily decided not to address the specific and significant issues raised by Advocacy," the chief counsel says.

SBA criticizes the agency's methodology for determining portable x-ray and EKG provider payment rates and policy. It laments that the agency has again "simply lumped" the portable industry in with every physician practice groups.

This approach is in "direct conflict" with the RFA, SBA claims, as it prevents CMS from "reasonably" analyzing the rule's economic impact on portable providers. SBA is urging CMS to stay or withdraw the rule as it applies to the portable industry until an impact analysis is completed. The agency should also consider alternatives such as exempting the industry from the rule, the chief counsel advises.

SBA's strongly worded letter intensifies a three-year industry campaign, spearheaded by the National Association of Portable X-Ray Providers, to have its reimbursement complaints addressed by CMS. It asserts reimbursements under the physician fee schedule are inadequate, and fail to reflect escalating transportation costs, treatment time and mileage. Of additional concern, is CMS' lack of reimbursement for EKG transportation costs, the industry laments.

While not opposed to being grouped with all physicians, the industry wants identical treatment — such as direct input with CMS to discuss actual costs and determine codes and accurate payments. It is also pushing for exemption from the prospective payment system, as granted to physicians, and hopes to work with CMS to discuss modifications or alternative payment methods.

Frustrated by the inaction, an industry representative says CMS has been dragging its feet. "[Our industry is] so little. We're not on the radar screen. It just hasn't been a high enough priority."

The source says the industry, which services only Medicare, is close to being lost, adding that service — particularly in rural areas — is declining. "Some small providers are drowning." If the industry is lost, beneficiaries would have to be taken to hospital for x-ray and EKG treatment — at four times the cost, the industry source asserts.

Thrilled with the strength of SBA's comments, the industry plans to renew congressional efforts for a solution. It has support from both the House and Senate Small Business Committees, and is working closely with the House Ways and Means Committee. The industry source indicates the Senate may also introduce companion legislation to Rep. Phil Crane's (R-IL) bill on the issue.

The industry is also taking SBA's remarks that CMS' RFA violation is "judicially reviewable" "under advisement," the source says.

SBA says CMS failed to explain how it chose the method it used to assess portable industry costs, and "appears to have disregarded" the pricing recommendations of the Clinical Practice Expert Panel. An impact analysis, it says, would allow CMS to "disclose the factual basis for its payment schedule" compared with the actual cost of providing portable x-ray and EKG services.

CMS says the SBA comments will be forwarded to its policy department for consideration in next year's rule. (The SBA letter is available on *IWP Extra*, see page 3 for details).

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, DC 20416

OFFICE OF THE CHIEF COUNSEL FOR ADVOCACY

December 28, 2001

Hon. Thomas Scully
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Room 309-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002

Dear Administrator Scully:

The Office of the Chief Counsel for Advocacy of the U.S. Small Business Administration was created in 1976 to represent the views and interests of small businesses in Federal policy making activities.[1] The Chief Counsel participates in rulemakings and other agency actions when he/she deems it necessary to ensure proper representation of small business interests. In addition to these responsibilities, the Chief Counsel monitors agencies' compliance with the Regulatory Flexibility Act (RFA), and works with Federal agencies to ensure that their rulemakings demonstrate an analysis of the impacts that their decisions will have on small businesses.[2]

On November 1, 2001, the Centers for Medicare and Medicaid Services (CMS) filed a final rule in the *Federal Register* concerning Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002.[3] This comment letter is meant to inform the CMS that the final rule has the potential to significantly impact the portable x-ray and EKG provider industry.

[1] Pub. L. No. 94-305 (1976)(codified as amended at 15 U.S.C. §§ 634a-g, 637).
[2] Pub. L. No. 96-354, 94 Stat. 1164 (1981) (to be codified as amended at 5 U.S.C. §§ 601-612).
[3] 66 Fed. Reg. 552451 (November 1, 2001).

On two occasions since 1998, The Office of Advocacy has filed comments with the CMS concerning the agency's approach with respect to the determination of payment policies and adjustments to the Relative Value Units (RVU) under the Physician Fee Schedule as it directly applied to portable x-ray and EKG providers.[4] The November 1, 2001, final rule is illustrative of the fact that CMS has yet to address the specific and significant concerns raised by Advocacy in its prior comment letters. In Advocacy's opinion the CMS should immediately suspend those portions of the rule that are specifically directed at portable x-ray and EKG providers and/or consider exempting them for the following reasons:

The final rule is violative of the RFA.

The final rule does not contain a section on the RFA. Congress established the RFA because Federal agencies tend to promulgate "one-size-fits-all" regulations without considering the adverse consequences for competition, innovation, and productivity. By requiring that each agency review its regulations to ensure that small businesses are not disproportionately or unnecessarily burdened, Congress intended to increase agency awareness and understanding of the impact of regulations on small business, to require that agencies communicate and explain their findings to the public, and to provide regulatory relief to small entities where appropriate. Advocacy believes that CMS's final rule is a textbook example of the situation Congress intended to address when creating the RFA.

Whenever the RFA applies, a Federal agency must either prepare a regulatory flexibility analysis or certify (with a factual basis) that the rule will not have a "significant economic impact on a substantial number of small entities." CMS clearly violated the RFA when it failed to prepare a flexibility analysis, or certify that the rulemaking would not have a significant impact on a substantial number of small entities.

Advocacy has argued in previous comment letters on this issue that many of the affected portable x-ray and EKG providers are likely to be small entities; and that a substantial number of those businesses will be affected by CMS's decision to adjust payments under the Physician Fee Schedule. In this rule, just as CMS has done with past rulemaking regarding the Physician Fee Schedule payments to portable x-ray and EKG providers, CMS simply lumped the portable x-ray and EKG providers in with every physician practice group. This methodology is in direct conflict with the regulatory flexibility analysis requirement of the RFA as it prevents CMS from reasonably analyzing whether its actions are likely to have a significant economic impact on a substantial number of

[4] See the Chief Counsel for Advocacy's comment letters addressed to the Honorable Nancy-Ann Min DeParle, then the Administrator of the Health Care Financing Administration of the U.S. Department of Health and Human Services, dated September 10, 1998, and November 18, 1998.

portable x-ray and EKG providers. As noted by Advocacy in its September 10, 1998, comment letter,

> "'Substantial number' in the context of the instant rulemaking means the number of portable x-ray and EKG providers that will be affected by the regulation. 'Substantial number' is a relative term and does not mean the number of portable x-ray and EKG providers affected in relation to the number of physicians affected. Therefore an analysis of the impact on physicians, such as the one provided in the rule, is irrelevant. The term 'substantial number' does not even mean the number of portable x-ray and EKG providers affected in relation to portable x-ray and EKG providers not affected. 'Substantial number' refers to the proportion of portable x-ray EKG providers that currently receive a separate transportation payment and will have to comply with the new requirements."

Advocacy believes that the CMS should prepare a final regulatory flexibility analysis concerning the portable x-ray and EKG providers in connection with this rule as it will aide the CMS in understanding the true impacts that the rule will have on these industries. Further, a impact analysis will help identify alternatives to the rule that may result in lessening the impact of the rule on portable x-ray and EKG providers.

By failing to comply with the provisions of the RFA, the CMS has voluntarily decided not to address the specific and significant issues raised by Advocacy in its prior comment letters and the comments identified by industry.

A final regulatory impact analysis may reveal that the costs of the final regulation relative to portable providers outweigh the benefits. The Federal budget and Medicare potentially will suffer economic consequences if the portable industry is lost. It will ultimately cost Medicare more money to transport patients to the hospital for x-ray and EKG services. Such services a currently provided by portable x-ray and EKG providers at the patient's home, or at the health care facility. Further, the public good will be adversely impacted if elderly patients, who currently rely on the services provided by the portable industry, are required to be transported to the hospital for their studies, resulting in an increased rate of infection, and transportation injuries.

Heretofore, the CMS has failed to adequately assess the true operating costs of the portable x-ray and EKG provider industry. The CMS appears to have disregarded the pricing recommendations of the Clinical Practice Expert Panel without providing the public with a transparent way of determining the method used by the CMS in assessing industry costs. Further, the portable x-ray and EKG industry has suffered unpredictability with respect to gasoline prices that will further detrimentally affect the industry's anticipated revenue. Upon information provided by industry, Advocacy has

been told that portable companies have recently had difficulty obtaining financing based on anticipated revenue cuts caused by the provisions contained in the final rule. Lastly, regulations and requirements of skilled nursing facilities already impose cost burdens on the portable industry. Additional cost burdens imposed by the CMS in this rule amount to a regulatory "piling-on." Again, Advocacy believes that a regulatory impact analysis would allow the CMS to disclose the factual basis for its payment schedule as compared with the costs incurred by industry to provide the portable x-ray and EKG services. The regulatory impact analysis would also allow the CMS to assess any potential alternatives to the rule that would lessen the rule's impact on these small entities.

In conclusion, Advocacy believes that the CMS should stay or withdraw the provisions of the final rule that relate to portable x-ray and EKG providers until a proper analysis of the rule's impacts can be prepared. The CMS should consider reasonable alternatives to the rulemaking for portable providers including, but not limited to, exemption of the portable x-ray and EKG providers.

CMS should be aware that a violation of the RFA is judicially reviewable under section 611(a)(1) of the RFA. If CMS is sued by aggrieved or adversely affected small entities, the court may remand all or part of the rule for further analysis by the agency or impose other applicable legal remedies.

Sincerely,

Susan Walthall
Acting Chief Counsel for Advocacy

Linwood L. Rayford, III
Assistant Chief Counsel for Advocacy

HR 3094 IH

107th CONGRESS

1st Session

H. R. 3094

To amend title XVIII of the Social Security Act to exclude services of certain providers from the skilled nursing facility prospective payment system, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

October 11, 2001

Mr. CRANE (for himself and Mr. MANZULLO) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to exclude services of certain providers from the skilled nursing facility prospective payment system, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MEDICARE REIMBURSEMENT FOR TRANSPORTATION OF PORTABLE MEDICAL EQUIPMENT.

(a) EXCLUSION FROM PAYMENT UNDER THE SNF PROSPECTIVE PAYMENT SYSTEM OF SERVICES OF CERTAIN PROVIDERS AND TRANSPORTATION COSTS FOR PORTABLE MEDICAL EQUIPMENT- Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy (e)(2)(A)(ii)) is amended--

(1) by inserting after `anesthetist,' the following: `portable electrocardiograms, portable x-rays, portable mammograms,'; and

(2) by striking `only with respect to services furnished during 1998'.

(b) INCLUSION OF COSTS FOR TRANSPORTATION OF EKG EQUIPMENT AS REASONABLE AND NECESSARY-

(1) IN GENERAL- Section 1861(s)(2) of such Act (42 U.S.C. 1395x(s)(2)) is amended--

(A) by striking `and' at the end of subparagraph (U);

(B) by adding `and' at the end of subparagraph (V); and

(C) by inserting after subparagraph (V), the following new subparagraph:

`(W) the transportation costs of electrocardiogram equipment for electrocardiogram test services;'.

(2) CONFORMING AMENDMENT- Section 4559(a) of the Balanced Budget Act of 1997 is amended by striking `Effective only for electrocardiogram tests furnished during 1998, the' and inserting `The'.

(c) EFFECTIVE DATE- The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply to items and services furnished on or after that date.

END

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

AUG - 8 2001

The Honorable Philip M. Crane
House of Representatives
Washington, DC 20515-1308

Dear Mr. Crane:

Thank you for your letter regarding Medicare payment for transportation costs associated with electrocardiogram (EKG) services furnished by portable x-ray suppliers. Specifically, you requested that the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, resume payment for EKG transportation costs. Alternatively, you requested certain data concerning EKG services and portable x-ray suppliers.

When the Medicare physician fee schedule was implemented in 1992, separate payments were generally not made for travel or transportation associated with furnishing covered services, except for portable x-ray and portable EKG services. After reviewing the law more carefully, we adopted a proposal that distinguished portable EKG from portable x-ray services and discontinued separate payments for the transportation of EKG equipment effective January 1, 1997. In responding to concerns similar to those raised by the industry, we indicated that the portrayal of portable EKG and ambulance transportation as the only methods of delivery for this service was not an accurate description of normal, acceptable medical practice.

In the final rule, we stated we believed that, in an age when EKG tracings can be sent via telephone, there are more efficient ways to furnish this service. We noted that EKG equipment is lightweight and is often carried into nursing facilities by physicians; it does not need to be transported by van. In addition, nursing facilities often have this equipment and staff to perform such tests on the premises. In some cases, the results of the test may be sent by telephone to the interpreting cardiologist or other physician.

Finally, in nonemergency situations, a patient may be transported by family members or others to his/her physician's office or other medical facility to receive an EKG in the same way s/he receives other diagnostic and therapeutic services for which Medicare does not make separate transportation payments. Lastly, we stated that the use of an ambulance to transport a beneficiary to the hospital simply for the purpose of receiving an EKG is inappropriate.

Further, we believe that, in the case of severe, potentially life-threatening cardiac problems, a patient would be transported by ambulance to the hospital—instead of waiting for the arrival of a van with portable equipment. Patients requiring ambulance transportation will exhibit symptoms and signs that require medical evaluation and treatment by a physician that would make an EKG alone medically inappropriate. We do not believe in an acute situation, e.g., chest pain, a physician would typically wait for results of the EKG (which could take hours) before transporting the patient to an acute care facility or coming to see the patient. An emergency situation would be best addressed by immediate transportation to an acute facility or by an immediate visit by a physician.

Pursuant to the publication of the final rule on November 22, 1996, Medicare carriers would make separate payments for the transportation of diagnostic equipment only in the case of x-ray and diagnostic mammography procedures as set forth in the law. We note, however, that section 4559 of the Balanced Budget Act of 1997 (BBA) restored the EKG transportation payments for 1998 and required the Secretary of Health and Human Services to issue a recommendation to Congress as to whether Medicare should make separate payments under Part B for the transportation of equipment used to performed EKGs. The BBA provision required the Secretary to take into account a study conducted by the Comptroller General of the United States in making such a recommendation.

For the following reasons, CMS believes that Medicare payment for transporting ultrasound or EKG equipment is not warranted:

- The General Accounting Office was unable to recommend a specific course of action regarding the restoration or elimination of separate Medicare transportation payments for portable EKG services in its report of May 1998;
- The Secretary's recommendation to Congress on this matter was forwarded in January 1999;
- The Secretary's report stated that the policy not to pay separately for transporting EKG equipment beginning in 1997 was the correct one;
- The report also stated that no new information has been presented to CMS since the publication of the final rule in 1996 that would cause the Secretary to recommend reinstatement of the transportation payment for EKG services; and
- Because the BBA restored payments only for 1998, the code for transportation of EKG equipment is not payable under the Medicare physician fee schedule beginning 1999.

As noted above, CMS is not reinstating the separate transportation payment for portable EKG equipment. Therefore, CMS is providing below the data that you requested. The answers to your questions reflect global service data from calendar year 2000 for Common Procedural Terminology codes 93000 and 93005:

Question 1: What is the number of EKGs performed in SNFs?

Response: 56,178 services

Question 2: What is the number of EKGs performed in SNFs by portable x-ray suppliers?

Response: 44,784 services

Question 3: What other providers performed EKGs in SNFs?

Response: General Practice, General Surgery, Cardiovascular Disease, Family Practice, Internal Medicine, Neurology, OB-Gynecology, Psychiatry, Pulmonary Disease, Radiology, Geriatrics, Nephrology, Endocrinology, Nurse Practitioner, Portable x-ray Supplier, Independent Laboratory, Clinic or Other Group Practice, Preventive Medicine, Other Nonphysician Supplier, Medical Oncology, Emergency Medicine, Independent Diagnostic Testing Facility, and Physicians Assistant

Question 4: How many EKGs are performed in SNFs in each state?

Response: Appendix A displays a chart of the number and cost of EKGs performed in SNFs for each state.

I hope that this information is helpful.

Sincerely,

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

Enclosure

CMS EKG Data submitted to Congressman Phil Crane on August 8, 2001

COST # OF EKGs IN SNF PER STATE

APPENDIX A

Locality Name	Allowed Charges	Allowed Services
ALABAMA	$ 22,480	981
ALASKA	$ -	-
ARIZONA	$ 7,501	284
ARKANSAS	$ 189	8
CALIFORNIA	$ 93,863	3,161
COLORADO	$ 1,803	81
CONNECTICUT	$ 75,398	2,936
DC + MD/VA SUBURBS	$ 39,732	1,244
DELAWARE	$ 9,236	381
FLORIDA	$ 77,119	3,309
GEORGIA	$ 8,583	313
HAWAII	$ 33	1
IDAHO	$ 701	31
ILLINOIS	$ 5,875	249
INDIANA	$ 17,408	696
IOWA	$ 212	9
KANSAS	$ 2,674	108
KENTUCKY	$ 2,387	98
LOUISIANA	$ 334	21
MAINE	$ 3,715	152
MARYLAND	$ 44,004	1,518
MASSACHUSETTS	$ 65,411	2,567
MICHIGAN	$ 77,858	3,927
MINNESOTA	$ 19,453	803
MISSISSIPPI	$ 791	38
MISSOURI	$ 25,493	1,119
MONTANA	$ 58	3
NEBRASKA	$ 1,190	53
NEVADA	$ 5,270	285
NEW HAMPSHIRE	$ 8,034	274
NEW JERSEY	$ 83,970	3,573
NEW MEXICO	$ 2,123	82
NEW YORK	$ 438,147	15,080
NORTH CAROLINA	$ 11,310	527
NORTH DAKOTA	$ 31	2
OHIO	$ 1	1
OKLAHOMA	$ 1,139	65
OREGON	$ 5,676	229
PENNSYLVANIA	$ 130,107	5,537
RHODE ISLAND	$ 33,436	1,384
SOUTH CAROLINA	$ 11,020	681
SOUTH DAKOTA	$ 176	7
TENNESSEE	$ 1,093	59
TEXAS	$ 23,952	1,192
UTAH	$ 1,816	104
VERMONT	$ 1,619	58
VIRGINIA	$ 3,551	139
WASHINGTON	$ 15,761	657
WISCONSIN	$ 24,699	1,298
WYOMING	$ 26	1
	$ 1,426,163	56,178

Number of In-Nursing Facility EKGs Performed in 2000 By State

1. New York--15,080
2. Pennsylvania--5,537
3. Michigan--3,927
4. New Jersey--3,573
5. Florida--3,309
6. California--3,161
7. Connecticut--2,936
8. Massachusetts--2,567
9. Texas--1,192
10. Maryland--1,518 *
11. Rhode Island--1,384
12. Wisconsin--1,298
13. DC + MD/VA Suburbs--1,244
14. Missouri--1,119
15. Alabama--981
16. Minnesota--803
17. Indiana--696
18. South Carolina--681
19. Washington--657
20. North Carolina--527
21. Delaware--381
22. Georgia--313
23. Nevada--285
24. Arizona--284
25. New Hampshire--274
26. Illinois-- 249
27. Oregon--229
28. Maine --152
29. Virginia--139 *
30. Kansas--108
31. Utah--104
32. Kentucky--98
33. New Mexico--82
34. Colorado--81
35. Oklahoma--65
36. Tennessee--59
37. Vermont--58
38. Nebraska--53
39. Mississippi--38
40. Idaho--31
41. Louisiana--21
42. Iowa--9
43. Arkansas--8
44. South Dakota--7
45. Montana--3
46. North Dakota--2
47. Hawaii--1
48. Ohio--1
49. Wyoming--1
50. Alaska--0

Note:

1. CMS did not provide data on WVA.
2. * Does not include DC Suburbs.

MEMBER OF CONGRESS
8TH DISTRICT OF ILLINOIS

COMMITTEE ON
WAYS AND MEANS
(VICE CHAIRMAN)
SUBCOMMITTEE ON
TRADE
(CHAIRMAN)
SUBCOMMITTEE ON
HEALTH

JOINT COMMITTEE ON
TAXATION

Congress of the United States
House of Representatives
Washington, DC 20515–1308

OFFICES:
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SUITE C
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June 8, 2001

Tom Scully, Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Tom:

I am writing to seek your assistance in a very important matter relating to the portable x-ray industry. During the 106th Congress, I sponsored legislation with Congressman James Talent (R-MO) to assist this Medicare-dependant industry, primarily consisting of small businesses serving our nations frail and elderly. That legislation would have done three things. First, exempt the industry from the prospective payment system; second, exempt small business from consolidated billing by rerouting the payment structure; and third, reinstate the transportation payment for EKG. Unfortunately, that legislation was not included in the final Medicare giveback package.

Today, I am writing to specifically address the issue of portable EKGs and am requesting that you consider reinstating the transportation payment for portable EKGs. This service is vital, cost-effective and in the best interest of our elderly population. By way of background, I offer the following history. Under section 4559 of the Balanced Budget Act of 1997 (BBA'97), Medicare carriers were allowed one additional year of payments for EKG transportation services under Part B. The legislation required the Secretary of Health and Human Services (HHS) to comment on the future of such payments, taking into account a study conducted by the Comptroller General of the United States and other relevant information.

The May 1998 GAO report to Congress titled *Medicare: Impact of Changing Transportation Policy for Portable Equipment is Uncertain (GAO/HEHS-98-92)* was exactly that, unclear in its findings. The GAO's estimate of the financial effect of the revised policy ranged from a savings of $11 million to a cost of $9.6 million. The report goes so far as to state that the best way to evaluate the results is to implement the policy and see what happens. In her comments to the Congress, the Secretary recommended that the Health Care Financing Administration (HCFA) not pay separately for transporting equipment to perform the EKGs in the beneficiary's place of residence, including nursing homes and other facilities.

We have now seen the effect of this cessation of reimbursement policies for portable EKGs --providers of these services, predominantly small businesses, are being hurt financially; some are refusing to provide this vital service and some are even shutting their doors. As a result, the elderly and infirm are being forced to endure transport by ambulance to a hospital. Not only is the bedside service preferable to the patients and their families, it is less costly than having individuals transported by ambulance to a local hospital for the same procedure.

I have written a letter to Chairman Nancy Johnson (R-CT) expressing my concern over the difficulties facing this industry and I am hopeful that you will consider administratively reinstating the payment for portable EKGs. Should you find you are not able to do this, I would ask that your agency gather relevant data so that I may proceed through legislative remedies. I want to ensure that the Congress has the most recent data on this industry if a legislative remedy is necessary.

The essential data could best be gathered by answering the questions below:

1. What is the number of EKGs performed in place of service 31?
2. Of these EKGs, what is the total performed by Specialty 63?
3. What providers are performing the remaining EKGs? Labs? Doctors?
4. How many EKGs are performed in each state?

The following information is provided for your reference, if necessary.

- Code 31 is the code for a Skilled Nursing Facility.
- Specialty 63 is the code for portable x-ray.
- 93000 is the Global code for EKG.
- 93005 is the Technical code for EKG.

Thank you for your immediate attention to this matter and I look forward to your response.

Sincerely,

Philip M. Crane, M.C.

PMC/smr

cc: The Honorable Nancy Johnson, Chairman, Subcommittee on Health, Committee on Ways and Means

American Medical Association
Physicians dedicated to the health of America

AMA/Specialty Society RVS Update Process
515 North State Street
Chicago, Illinois 60610
312 464-4736
312 464-5849 Fax

March 17, 1999

Mr. Norman Goldhecht
Regulatory Chairman
National Association of Portable X-Ray Providers
1333 Village Drive
St. Joseph, Missouri 64506

Dear Mr. Goldhecht,

Thank you for your letter of January 13, 1999 requesting a seat on the Practice Expense Advisory Committee (PEAC). The PEAC discussed the need for additional representation during the PEAC meeting held on February 4, 1999. While organizations such as the National Association of Portable X-Ray Providers may be able to contribute a unique perspective to the PEAC's review of the Clinical Practice Expense Panel data, the PEAC members decided that it would be premature at this time to add additional PEAC advisors.

Since the PEAC has only met once, and has not determined its specific needs, the PEAC decided that it should first identify the universe of potential groups that could potentially become PEAC advisors, and then possibly select additional representatives based on specific PEAC requirements.

Thank you for your interest in the PEAC, and I invite you to attend and observe future PEAC meetings.

Sincerely,

Eugene S Ogrod MD

Eugene Ogrod, MD

SBA

Office of Advocacy

Office of Interagency Affairs

September 10, 1998

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
Attn: HCFA-1006-P, P.O. Box 26688

Baltimore, MD 21207-0488

Re: Regulatory flexibility analysis of the proposed rule revising the payment policies for portable x-ray providers under the physician fee schedule for calendar year 1999; 63 Fed. Reg. 30,818 (June 5, 1998).

Dear Administrator DeParle:

On June 5, 1998, the Health Care Financing Administration (HCFA) published a proposed rule revising the Medicare Part B payment policies for the 1999 physician fee schedule. The proposed rule seeks to implement certain provisions of the Balanced Budget Act of 1997 and other changes. Among those changes is a new methodology for establishing relative value units (RVU) for portable x-ray/EKG set-up and transportation based on average allowed charge data. The proposal seeks to nationalize transportation and will result in severe cuts in Medicare payments for portable x-ray/EKG suppliers.

The Office of the Chief Counsel for Advocacy of the U.S. Small Business Administration was created in 1976 to represent the views and interests of small business in federal policy making activities.(1) The Chief Counsel participates in rulemakings when he deems it necessary to ensure proper representation of small business interests. In addition to these responsibilities the Chief Counsel monitors compliance with the Regulatory Flexibility Act (RFA), and works with federal agencies to ensure that their rulemaking demonstrate an analysis of the impact that their decisions will have on small businesses.

Portable X-Ray/EKG Services

Portable x-ray/EKG suppliers are technologists who operate "on-call" at all times, and transport x-rays and EKGs to sick, elderly and/or frail patients—most of whom reside in nursing homes (on a short or long term basis), and some of whom still reside in their homes. Most EKG and x-ray services are performed in doctor's offices and hospitals, however, the portable service allows sick and elderly patients access to

x-ray and EKG equipment without moving the patient and risking further injury or aggravation of their already frail condition. In addition, the portable service is less expensive for the Medicare system than sending patients to the hospital by ambulance for the same services. According to industry statistics and a GAO report, the portable services cost Medicare significantly less than it costs to transport a patient in an ambulance for a hospital x-ray(2)

Medicare has traditionally paid portable x-ray/EKG suppliers in three components: 1) the technical component which involves administering the diagnostic test; 2) the set-up component which involves setting up the equipment and preparing/positioning the patient; and 3) the transportation component which involves driving the equipment to and from nursing homes or private homes. Medicare covers 85% of these portable services. In the past, Medicare permitted the portable equipment suppliers to receive a separate locality-based transportation payment in addition to the fee for the actual test. The separate transportation payment was eliminated for ultrasound services as of January 1, 1996; and the payment for EKG services was eliminated effective January 1, 1997, but then temporarily restored by the Balanced Budget Act of 1997.

Impact Assessment: GAO Report

GAO prepared a May 1998 report on changing the transportation policy for portable equipment in response to a request by The Honorable Bill Archer, Chairman of the Ways and Means Committee, U.S. House of Representatives.(3) GAO attempted to address how HCFA's change would affect Medicare beneficiaries and program costs. Specifically, GAO analyzed: 1) the Medicare recipients, places of service, and providers who might be affected most; 2) the number of services that would be affected by the changed policy; and 3) the effect on Medicare's program costs. The report was inconclusive with regard to costs and savings because GAO could not determine if mobile providers would continue to supply services as a result of eliminating the transportation payments. In fact, GAO estimated the effect of a revised payment policy would range from a savings of $11 million to a cost of $9.7 million for EKG tests and a savings of $400,000 to a cost of $125,000 for ultrasound tests. The savings would only be realized if homebound beneficiaries and nursing home residents did not travel outside in Medicare-paid ambulances to receive the tests.

Whether or not mobile providers will continue to supply service is definitely an important question—but, not the only question. Neither HCFA nor GAO have adequately addressed the impact on the industry. HCFA failed to address the issue at all in its rulemaking—only referring to the changed payment in one line of a 108-page chart in the *Federal Register*. In other words, there was no discussion in the proposed rulemaking about the impact on the portable x-ray/EKG industry. GAO shed some insight into how the industry might be impacted, but stopped short of acknowledging that this highly unique and specialized industry will be significantly impacted—regardless of Medicare savings, regardless of how many portable x-ray/EKG providers do not currently receive a separate transportation payment, and regardless of how frequently the service is currently used. In determining impact, the

focus of an analysis should not stop with making an assessment of whether suppliers will no longer provide the service or go out of business. In determining impact, there should also be an analysis of lost profits and ability to maintain competitive pricing in a regional market.

If the transportation component is removed or severely reduced, there will obviously be an impact. The Office of Advocacy has anecdotal information from one business in the industry indicating that the transportation component is the most expensive of the three components. Generally, the business owner would be reimbursed a total of $98.99 for a typical chest x-ray (inclusive of all three components). Of that amount, $70.00 goes toward the transportation component. Under the current proposal, this business owner claims that his total payment would drop to $54.48 (which represents an overall reduction of about 45%). This business owner may be able to stay in business, but at what cost? By any standards, a 45% reduction is significant.

The Regulatory Flexibility Act

When an agency determines that there is likely to be a significant economic impact on a substantial number of small entities, the agency must prepare an initial regulatory flexibility analysis (IRFA) pursuant to section 603 of the RFA. "Significant economic impact" certainly applies and was discussed in the preceding paragraphs. "Substantial number" in the context of the instant rulemaking means the number of portable x-ray/EKG providers that will be affected by the regulation. "Substantial number" is a relative term and does not mean the number of portable x-ray/EKG providers affected in relation to the number of physicians affected. Therefore, an analysis of the impact on physicians, such as the one provided by HCFA, is irrelevant. The term "substantial number" does not even mean the number of portable x-ray/EKG providers affected in relation to portable x-ray/EKG providers not affected. "Substantial number" refers to the proportion of portable x-ray/EKG providers that currently receive a separate transportation payment and will have to comply with the new requirements. Since it is more likely than not that the majority of the firms in the portable x-ray/EKG industry are "small,"(4) a substantial number of small businesses in that industry will likely be affected.

An IRFA is really a tool that agencies can use to help minimize the burden on small entities while maintaining the integrity of a regulatory scheme. The ideal is not to force agencies to abandon their regulatory objectives, but to help agencies refine those objectives and eliminate unnecessary burden on the affected industry. Once the determination has been made that a rule will have a significant economic impact on a substantial number of small entities, a careful analysis should follow. Section 603 of the RFA dictates that an IRFA must contain (among other things): a description of, and where feasible, an estimate of the number of small entities to which the proposed rule will apply; a description of the projected reporting, recordkeeping and other compliance requirements of the proposed rule, including an estimate of the classes of small entities which will be subject to the requirement; and a description of any significant alternatives to the proposed rule which accomplish the stated objectives of applicable statutes and which minimize any significant economic impacts of the proposed rule on small entities.(5) These and other elements are conspicuously

missing from HCFA's analysis with regard to portable x-ray/EKG providers.

An IRFA may have revealed that: 1) the costs of the regulation relative to portable providers outweigh the benefits (e.g., the savings to Medicare versus the chilling effect on competition); 2) portable providers simply cannot be analyzed with the same criteria as physician-operated radiology offices, and therefore, should be exempt from the instant rulemaking; or 3) other new regulations/requirements like the skilled nursing facility (SNF) prospective payment system for Part A patients and the consolidated billing requirements for Part B patients already impose cost burdens on portable providers that should be considered in calculating the reimbursement amount. It is not apparent from the proposed rule that HCFA considered these or any other options.

Conclusion/Recommendation

The Office of Advocacy recommends that HCFA publish a supplemental analysis detailing and analyzing the impact of the proposed rule on portable x-ray/EKG providers. It may not be sufficient for HCFA to publish such an analysis in the final rule because at least one court has ruled that it is impossible to have a valid or sufficient final regulatory flexibility analysis without the benefit of public notice and comment on the IRFA in a proposed rule.(6) HCFA should also give serious consideration to removing or exempting these providers from the instant rulemaking and publishing a separate rule with more relevant criteria as the basis of its reimbursement calculation.

The Office of Advocacy is prepared to assist you and your staff in your efforts to comply with the Regulatory Flexibility Act. Please do not hesitate to contact us at 202-205-6532.

Sincerely,

Jere W. Glover
Chief Counsel for Advocacy

Shawne Carter McGibbon
Asst. Chief Counsel for Advocacy

ENDNOTES

1. Regulatory Flexibility Act, 5 U.S.C. § 601, as amended by the Small Business Regulatory Enforcement Fairness Act, Pub. L. No. 104-121, 110 Stat. 866 (1996).

2. *See,* Center for Health Policy Studies, Analysis of the Costs and Reimbursement for Portable X-Ray Services (June 1995)(portable x-ray procedures cost Medicare one-third to one-fifth what it costs to transport the patient in an ambulance for a hospital x-ray.); *See also* GAO, Medicare: Impact of Changing Transportation Policy for Portable Equipment Is Uncertain (GAO/HEHS-98-82) (May 1998).

3. GAO, *Supra* note 2, at 2.

4. According to SBA's definition of a "small business," a small portable x-ray/EKG provider is one with annual receipts of $5 million or less. *See* 13 C.F.R. § 121.201. Medicare outlays for EKGs and ultrasound services in 1995 totaled $12 million and $8 million respectively. *See* GAO, *supra* note 2, at 2. Medicare typically pays for about 85% of these services. Based on this information, it is probably safe to assume that most providers in this industry category are small.

5. *See* 5 U.S.C. § 603(b-c).

6. *See Southern Offshore Fishing Association. v. Daley*, 995 F. Supp. 1411 (M.D. Fla. 1998).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEMORANDUM

DATE: February 7, 2002

TO: All Regional Administrators and Medicare Contractors

FROM: Director
Program Integrity Group
Office of Financial Management

Deputy Director for Contractor Management
Center for Medicare Management

SUBJECT: Vulnerability Report

Attached is the Program Integrity Group's Vulnerability Report, June 2001 through December 2001. The purpose of this report is to share, in composite form, information on Program Integrity vulnerabilities that were identified through a variety of audits/reports.

We expect the contractors to consider the content of the report, in conjunction with the Centers for Medicare & Medicaid Services' Program contractor budget requirements, manual instructions, and their own data analysis of program integrity activities to target and intervene as appropriate and to mitigate vulnerabilities identified.

Please review this report and make comments. E-mail your comments to Fraud@cms.hhs.gov

/s/
Timothy Hill

/s/
Elizabeth Cusick

Attachments

cc:
Associate Regional Administrators
for Financial Management Regions, I, II, III, V, VIII, IX, X
Associate Regional Administrator
for Health Plans and Providers, Region VII
Associate Regional Administrators
for Financial Management and Program Initiatives, Regions IV & VI
CCMOs
Carol Plum, CMM

ATTACHMENTS:

OFFICE OF INSPECTOR GENERAL (OIG)

1.

SUBJECT:

Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under Part A Skilled Nursing Facility Prospective Payment System A-01-00-00538, June, 2001.

VULNERABILITY:

$47.6 million in improper payments made by Medicare Part B to suppliers for services that were already included in the PPS payment that Part A made to the SNF for a covered day. Medicare is paying twice for the same service, once to the SNF under Part A prospective payment and again to an outside supplier under Part B.

RECOMMENDATIONS:

Continue to work with OIG to identify and recover potential improper payments made in subsequent years.

Direct the Medicare contractors to reemphasize education to the Part B suppliers regarding the SNF PPS consolidated billing provision.

Monitor the Medicare contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for further analysis.

CMS Response:

CMS concurred with each of the recommendations. CMS is developing a strategy to (1) identify mistaken payments (2) establish methodologies that allow Medicare contractors to effectively and efficiently recover overpayments.

2.

SUBJECT:

Medicare Inpatient Prospective Payment System Transfer Incorrectly Reported as Discharges, A-06-00-00041, November, 2001

VULNERABILITY:

Over 153,000 claims for incorrectly reported PPS transfer. The potential overpayments related to these transfers totaled nearly $233 million.

RECOMMENDATIONS:

Issue instructions to and work with the FIs to initiate the collection of the overpayments.

Issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (1) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital (2) is a reimbursement policy applied after the say is determined to be medically necessary (3) applies unless the hospital substantiates an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer.

Instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

CMS RESPONSE:

CMS concurred with the recommendations.

3.

SUBJECT:

Chiropractic Care: Controls Used by Medicare, Medicaid, and other Payers, OEI-04-97-00490, June 2001.

VULNERABILITY:

Medicare, Medicaid, and private insurers rely on utilization caps, x-rays, physicians referrals, copayments, and pre and post review, in varying degrees, to control utilization of chiropractic benefits. Utilization caps are the most widely used, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments.

RECOMMENDATIONS:

CMS should develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments by (1) requiring chiropractic physicians to use modifiers to distinguish the categories of the spinal joint problems (2) require all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

CMS RESPONSE:

CMS concurred with the recommendations.

4.

SUBJECT:

Medicare Reimbursement Check Forgery, MIR No 01-0006, October, 2001

VULNERABILITY:

A review of documents at several MRI facilities in the greater New York City Metropolitan revealed a number of Medicare checks had been forged. The original reimbursement checks were then requested from the Medicare carrier in order to identify the true signatory of the forged endorsements through hand writing analysis. When the Medicare carrier went to its banking institution to retrieve the original checks, the banking officials informed the carrier that they had destroyed the checks after 30 days. These were checks that the carrier had originally submitted to the bank and identified as possibly being part of an alleged fraud scheme as evidenced by the questionable endorsements. The bank, nevertheless, destroyed the checks after 30 days without prior authorization. By destroying these checks, the bank essentially destroyed *prima facie* evidence. Without the original checks, handwriting analysis cannot be conducted.

RECOMMENDATIONS:

Medicare contractors should first notify the appropriate Office of Investigations upon claim of forgery.

Medicare contractors should be aware of the internal banking policies of their financial institutions relative to allegations of forgery. Banks that destroy their original checks prevent any appropriate hand writing analysis, as original documents are necessary for comparison purposes.

Contractors should seek to establish an agreement with their respective financial institutions requiring that all checks submitted on allegations of forgery be returned intact.

Those financial institutions that maintain a policy of destroying original evidence when a claim of forgery is made, should be reconsidered as banking institutions.

CMS RESPONSE:

CMS concurred with the recommendations.

1.

DATE:

September 2001

ACTIVITY:

Providers are billing the Medicare Program for Procuren which is **not covered.**

2.

DATE:

September 2001

ACTIVITY:

Hospitals are receiving improper payments for non-covered Low Osmolar Contrast Material (LOCM) by intentionally using incorrect revenue codes and leaving off HCPCS codes in order to bypass the system edits. These edits would normally result in a claim denial.

3.

DATE:

October 5, 2001

ACTIVITY:

Individuals under the guise of performing HIPPA compliance audits, approached a medical group requesting access to the provider's computer and database. The individuals refused to produce identification. Access was denied by the provider's billing manager. Providers should never allow **ANY** individuals access to their computers, medical records, billing information, etc., who fail to produce identification and proper documentation from the auditing entity.

4.

DATE:

October 19, 2001

ACTIVITY:

Mobile x-ray providers are improperly billing Medicare by (1) billing for non x-ray procedures (which are not separately reimbursable)
(2) billing Medicare for transportation of x-ray equipment and personnel per beneficiary, when multiple beneficiaries are in the same location
(3) billing set-up codes (Q0092) multiple times for single x-ray procedures. Claims that are billed for a single chest x-ray (71010) are billed with three, and sometimes four, set-up codes.

5.

DATE:

October 29, 2001

ACTIVITY:

AdminaStar (ASF) has received information regarding two stolen Medicare numbers. The mother of a Medicare beneficiary contacted the OIG Hotline indicating that her son received a benefit notice showing that a hospital billed Medicare for a blood draw, a drug screening and for an x-ray of the spine. The beneficiary's mother stated that her son lost his wallet and she believes someone found the wallet and is using his Medicare card.

Another beneficiary contacted Administar Federal's office regarding a Medicare summary notice she received for services provided in California. The beneficiary resided in Indiana. She indicated that these were not her services and her name and Medicare number had also been used in Florida and New Mexico over the past year. A review of HIMR for her HIC# revealed billings to other contractors for the time period in question.

6.

DATE:

October 29, 2001

ACTIVITY:

The United Government Services (UGS) provided information regarding a potential program vulnerability discovered by them pursuant to CMS publication 83, Chapter 1, Section 3.2. Results of a UGS data analysis study on inpatient hospital claims for potential up-coding by a provider with an aberrant DRG reimbursement pattern. DRG 40 is a surgical DRG that represents Extraocular Procedures Except Orbit Age >17. One surgical procedure 10.91 (subconjunctival injection) was consistently seen on the claims with the primary procedure code of 14.49 (vitrectomy with scleral buckling). DRG 40 is the only DRG with this procedure code. It appeared that this procedure code was responsible for the higher DRG assignment. The provider was using this code in order to obtain higher reimbursement.

Part B does not allow additional payment to be made to the surgeon for a procedure that is considered routine and usual and is part of the primary procedure. A separate billing of the subconjunctival injection would be considered unbundling of the primary procedure. The higher weighed DRG 40 is assigned when the procedure 10.91 is placed in the surgical procedure code field of the claim.

7.

DATE:

October 29, 2001

ACTIVITY:

A former Independent Physiological Laboratory (IPL) was billing for pulmonary stress tests (94620) when allegedly performing pulse oximetries, singe (94760) or multiple determination with exercise (94761), mailing the oximeter to the beneficiary's home, and also billing two consecutive dates for one nocturnal oximetry service (94762).

8.

DATE:

October 29, 2001

ACTIVITY

A company is upcoding and billing for services not rendered. They are billing for pulmonary stress tests (CPT 94620) when the medical record documentation indicates only pulse oximery testing (CPT 94760, 94761) was performed. In addition, they are billing for confirmatory consultations (CPT 99272) when the medical review documentation indicated a physician did not perform the required physical exams on patients.

APPENDIX I

Final OIG Report: Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part a Skilled Nursing Facility Prospective Payment System, A-01-00-00538

APPENDIX II

Final OIG Report: Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported as Discharges, A-06-00-00041

APPENDIX III

Final OIG Report: Chiropractic Care - Controls Used by Medicare, Medicaid and Other Payers, OEI-04-97-00490

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Memorandum

Date JUN - 5

From Michael F. Mangano
Acting Inspector General

Subject Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System (A-01-00-00538)

To Thomas Scully
Administrator
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's (OIG) final report entitled, "Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System." We identified a potential $47.6 million in improper payments made by Medicare for Calendar Year 1999 for services covered by the consolidated billing provision of the skilled nursing facility (SNF) prospective payment system (PPS).

This review determined that the Medicare program is paying twice for the same service--once to the SNF under the Medicare Part A PPS and again to an outside supplier under Medicare Part B. These improper payments occurred because Medicare edits have not been established to detect and prevent supplier claims noncompliant with the consolidated billing provision. Our recommendations to the Health Care Financing Administration (HCFA) include: establish payment edits within the common working file; continue to work with OIG to identify and recover improper payments made subsequent to the implementation of the consolidated billing provision; direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the consolidated billing provision; and monitor the contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis. In response to our draft report, HCFA concurred with our recommendations.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-00-00538 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF POTENTIAL IMPROPER PAYMENTS MADE BY MEDICARE PART B FOR SERVICES COVERED UNDER THE PART A SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM

JUNE 2001
A-01-00-00538

EXECUTIVE SUMMARY

BACKGROUND

Under the consolidated billing provision of the prospective payment system (PPS) for skilled nursing facilities (SNF), the SNF is responsible for billing Medicare for virtually all of the services rendered to its residents in a Medicare Part A stay. As a result, outside suppliers of services to SNF residents must now bill the SNF rather than the Medicare program. This review was performed as a follow-up action to our report (A-01-99-00531) dated March 2000 which found the Medicare program was paying twice for the same service--once to the SNF under the Part A PPS and again to an outside supplier under Medicare Part B.

OBJECTIVE

The objective of our review was to determine the extent of improper payments made by Medicare Part B to outside suppliers for services already included in the Medicare Part A prospective payment to the SNF. The period covered by our review is Calendar Year (CY) 1999. To accomplish our objective, we performed a nationwide computer match, using the Health Care Financing Administration's (HCFA) National Claims History file, to identify improper payments made by Part B to suppliers.

SUMMARY OF FINDINGS

Based on our nationwide computer match, we identified a potential $47.6 million in improper payments made by Medicare Part B to suppliers for services that were already included in the PPS payment that Part A made to the SNF for a covered stay. We also found instances where suppliers billed and were paid by both the SNF and Part B. We found the following types of services most vulnerable:

Type of Service	Potential Nationwide Improper Payments (in millions)
Outpatient Hospital Department	$15.8
Ambulance	$12.8
Laboratory	$9.4
Radiology	$5.9
Durable Medical Equipment	$3.7
Total	$47.6

CAUSE AND RECOMMENDATIONS

The results of our review show that some suppliers are still not fully cognizant of the consolidated billing provision and, as a result, continue to improperly bill Medicare contractors. Medicare improper payments continue to occur because HCFA has not yet established edits within the common working file (CWF) and contractors' claims processing systems to detect improperly billed claims and prevent payments.

We recommend HCFA establish payment edits within the CWF and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision. The Office of Inspector General (OIG) will assist HCFA with this initiative as necessary. Pending the implementation of payment edits, we recommend HCFA adopt these interim remedies:

- Continue to work with OIG to identify and recover improper payments made subsequent to the implementation of the consolidated billing provision.

- Direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the SNF PPS consolidated billing provision.

- Monitor the Medicare contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis. The OIG will provide HCFA with detailed claims information to assist in the recovery process.

In response to our draft report, HCFA concurred with each of the recommendations. The HCFA indicated that it will be finalizing implementation of an automated process in the near future. In the interim, HCFA is developing a strategy to 1) identify mistaken payments and 2) establish methodologies that allow Medicare contractors to effectively recover overpayments. Furthermore, HCFA recently completed a training conference for contractors to discuss the consolidated billing policy and to provide information on upcoming systems changes designed to prevent duplicate billing. In addition, HCFA instructed contractors to provide training to ensure their providers/suppliers understand program requirements and billing procedures. Lastly, HCFA will direct the applicable Medicare contractors to recover the potential $47.6 million in overpayments.

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INTRODUCTION

BACKGROUND

The Balanced Budget Act (BBA) of 1997 requires implementation of a Medicare SNF PPS for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are no longer paid in accordance with the reasonable cost-based system but rather through per diem prospective case-mix adjusted payment rates applicable to all covered SNF services. These payment rates cover virtually all costs of furnishing skilled nursing services (that is, routine, ancillary, and capital-related costs).

The BBA also set forth a consolidated billing requirement applicable to all SNFs providing Medicare services. Under consolidated billing, the SNF is responsible for billing Medicare for most of the services rendered to its residents in a Medicare Part A stay.[1] The SNFs are no longer able to unbundle services to an outside supplier that can submit a separate bill directly to the Medicare Part B carrier. Instead, the SNF must furnish the services either directly or under arrangements with outside suppliers. The outside supplier must then bill the SNF for the services rendered.

Section 1888(e)(2)(A)(ii) of the Social Security Act excludes certain services from the consolidated billing requirement. These include several types of practitioner services that are exempt and thus, are still to be billed separately to the Part B carrier. Emergency and intensive services provided to a SNF resident in an outpatient hospital department (OPD) are also excluded from consolidated billing and are billed by the hospital to the fiscal intermediary (FI). Other services not subject to the consolidated billing provision include dialysis services and supplies, hospice care related to a beneficiary's terminal condition, and ambulance transportation to the SNF for the initial admission or from the SNF following a final discharge, or to and from OPDs for the purpose of receiving excluded emergency or intensive type services. The Balanced Budget Refinement Act of 1999 expanded the list of excluded services to include ambulance services furnished in conjunction with dialysis services, certain chemotherapy and radioisotope services, and certain prosthetics.

On March 27, 2000, we issued a final report to HCFA entitled, "Review of Compliance with the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities (A-01-99-00531)." In this pilot review that led to our current report on this issue, we found that for over one-third of SNF PPS claims that we reviewed, Medicare paid twice for the

[1]Medicare Part A helps pay for up to 100 days of skilled care in a SNF during a benefit period. After that time, the beneficiary is no longer eligible for the Medicare Part A benefits but remains eligible for Medicare Part B benefits. The Part A benefit period begins the first day a beneficiary receives a Medicare-covered service as an inpatient in a Medicare certified hospital and ends when the beneficiary has been out of a hospital or other facility that mainly provided skilled nursing or rehabilitation services for 60 days in a row.

same service--once to the SNF under the Part A PPS and again to an outside supplier under Part B. Improper payments occurred because the Part B suppliers billed Medicare directly and Medicare edits have not been established to detect and prevent these types of improper claims. Also, some suppliers are not fully cognizant of the consolidated billing provision and, as a result, improperly billed FIs and carriers. Pending the implementation of program edits, HCFA concurred with our recommendation to jointly develop a computer application with OIG to identify and recover overpayments made to suppliers during CY 1999.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine the extent of improper payments made by Medicare Part B to outside suppliers for services already included in the Medicare Part A prospective payment to the SNF. The period covered by our review is CY 1999. We limited consideration of the internal control structure to the payment controls in place within the CWF and selected Medicare contractors Part A and Part B claims processing systems to ensure compliance with the consolidated billing requirement. The objective of our review did not require an understanding or assessment of the complete internal control structure at HCFA or its contractors.

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- performed a nationwide computer match, using HCFA's National Claims History file, of all SNF PPS stays with discharges in CY 1999 to Part B services rendered by suppliers to SNF residents to identify payments made by Part B to suppliers for services subject to consolidated billing (see APPENDIX D for our computer match methodology);[2]
- reviewed a judgmental sample of 65 claims for SNF PPS stays submitted by 3 free-standing SNFs and 3 hospital-based SNFs, and 71 associated Part B services rendered by suppliers during the selected SNF stays to validate the results of our computer match for CY 1999;
- reviewed the CWF Part B, outpatient, and Durable Medical Equipment Regional Carrier (DMERC) summary records and detail claim history to confirm that

[2]Our nationwide computer match included payments to 14,136 SNFs. Of this number, 701 were not under the PPS as of January 1, 1999. These non-PPS SNFs all became PPS during CY 1999 as their cost reporting date passed. Since we could not identify a cost reporting period for non-PPS SNFs prior to January 1, 1999, we could not eliminate the payments that occurred prior to their conversion to PPS.

Medicare made separate payments to suppliers for services that were already reimbursed to the SNF through the PPS;

- met with representatives of the selected SNFs to discuss the sampled claims, to obtain additional documentary evidence of noncompliance with consolidated billing, and to identify issues to facilitate revisions to our computer match; and

- discussed the results of our review with HCFA central office.

In completing our review of the sample, we established a reasonable assurance on the authenticity and accuracy of the data. Our audit was not directed toward assessing the completeness of the file from which the data was obtained.

The three FIs that processed the judgmental sample of SNF claims selected for our review included United HealthCare Insurance Company, Associated Hospital Service of Maine, and Blue Cross and Blue Shield of Alabama. The claims for the Part B services rendered during the selected SNF stays were processed by National Heritage Insurance Company, United HealthCare Insurance Company, Anthem Insurance Companies, Empire Medicare Services, and Associated Hospital Service of Maine.

We conducted our review from April 2000 to October 2000 at the Region I, Office of Audit Services in Boston, Massachusetts and at selected SNFs in Connecticut and Massachusetts.

The HCFA's written comments to our draft report are appended in their entirety to this report (see APPENDIX E) and are summarized on page 8.

FINDINGS AND RECOMMENDATIONS

As part of the SNF PPS, the consolidated billing provision represents a relatively new payment policy designed to curb excessive Medicare expenditures. Accordingly, we acknowledge HCFA's efforts toward the development of implementing regulations and guidelines. However, the results of our review show that some suppliers are still not fully cognizant of the consolidated billing provision and continue to improperly bill Medicare contractors. Based on our nationwide computer match, we identified a potential $47.6 million in improper payments made by Medicare Part B to suppliers for services that were already included in the PPS payment that Part A made to the SNF for a covered stay. As a result, the Medicare program is paying twice for the same service--once to the SNF under the Part A prospective payment and again to an outside supplier under Part B. We also found instances where suppliers billed and were paid by both the SNF and Part B. Medicare improper payments continue to occur because HCFA has not yet established edits within the CWF and contractors' claims processing systems to detect improperly billed claims and prevent payments.

We designed several computer applications, utilizing HCFA's claims payment data, to identify potential improper payments made by Part B to suppliers during CY 1999 for services covered under the consolidated billing provision. *It is important to note that the potential $47.6 million in improper payments developed through the computer match is an amount which represents actual provider-specific overpayments, not an amount based on a statistical projection of sample results.* As a means of validating the results of the computer match, we judgmentally selected three free-standing and three hospital-based SNFs located in Connecticut and Massachusetts, respectively. For these SNFs, we reviewed a judgmentally selected sample of 65 claims for beneficiary SNF stays and 71 associated nonphysician Part B supplier services rendered during those stays in order to:

- substantiate our results and continue to revise the parameters of the computer applications as necessary to obtain a population of potentially improper claims;
- identify additional control weaknesses contributing to supplier noncompliance with the consolidated billing provision; and
- determine whether some suppliers are billing both the SNF and Medicare.

Based on detailed claims analysis and subsequent discussions with the SNFs, suppliers, and HCFA, we determined that 27 of the 71 Part B supplier services were not subject to the consolidated billing provision. Accordingly, we revised the parameters of our computer applications to reflect the results of our validation work in order to provide HCFA and OIG with the best measure of potential improper payments.

We did not extend our audit work beyond the sample because, in our professional judgment, the results obtained from additional audit work would not have produced different results. We base this conclusion on the results of our judgmental sample and the results of our pilot review (A-01-99-00531).

POTENTIAL IMPROPER PAYMENTS BY SERVICE

Medicare Part B made improper payments for services rendered by outside suppliers to beneficiaries in a covered Medicare Part A SNF stay. The suppliers incorrectly billed Part B for the services instead of the SNFs. The services were already reimbursed to the SNFs through the Part A PPS. Based on the results of our nationwide computer match and subsequent field work to validate the match, we found the following types of services most vulnerable to improper payments: OPD, ambulance, laboratory, radiology, and durable medical equipment (DME) (see Figure 1).

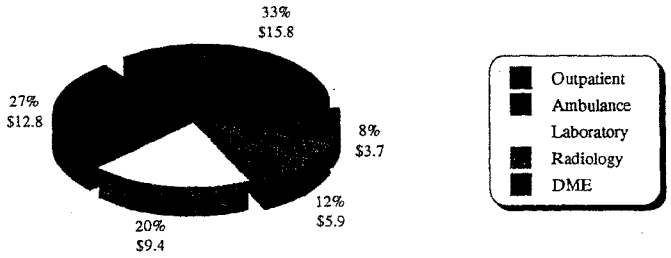

Figure 1 - Potential Nationwide Part B Improper Payments for CY 1999 (in millions)

OUTPATIENT HOSPITAL DEPARTMENT

When a SNF resident receives outpatient services at a hospital, the SNF retains the overall financial responsibility for essentially the entire package of care furnished during the outpatient visit other than the small number of exceptionally intensive services (i.e., MRI, CT scans, and cardiac catheterization) that lie well beyond the scope of care that SNFs would normally furnish, as well as emergency and end stage renal disease (ESRD) services. Through our computer application, we identified $15.8 million in potentially improper payments made by Medicare to OPDs for services that should have been billed to SNFs. If the OPDs billed correctly, the SNFs should have paid the OPDs for these services through the SNFs' Part A prospective payment. The most prevalent types of potential errors found in the OPD setting were diagnostic clinical laboratory and diagnostic radiology services. We also found instances of OPDs billing the FI for minor ambulatory surgical center procedures.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on August 27, 1999 and discharged on September 30, 1999. On September 11, 1999, an OPD performed clinical laboratory services for the beneficiary and billed the Medicare FI. Our validation work indicated this was a routine diagnostic procedure for which the OPD should have billed the SNF rather than Medicare.

AMBULANCE

The consolidated billing provision requires that ambulance suppliers bill the SNF for any services furnished to a SNF resident during a covered Part A stay, except for trips that occur at the beginning or end of the SNF stay, or for transportation to an OPD for the purpose of receiving excluded emergency or intensive type services.

Our match identified $12.8 million in potentially improper payments made to suppliers by Part B for non-emergency ambulance transportation costs that should have been paid by SNFs.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on February 25, 1999 and discharged on March 22, 1999. On March 4, 1999, the beneficiary was transported by ambulance to a free-standing MRI center. The ambulance supplier billed Part B instead of the SNF and was paid $455. The MRIs and the associated ambulance transportation are only excluded from consolidated billing when performed at an OPD.

LABORATORY

Laboratory services furnished to a SNF resident during a covered Part A stay must be billed to the SNF unless the services meet the requirements for payment under the physician fee schedule. Our match identified $9.4 million in potentially improper payments inappropriately billed by laboratory service suppliers to Part B instead of the SNF. We also found instances where suppliers billed both Part B and the SNF. We have referred one supplier to our Office of Investigations for further review.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on April 21, 1999 and discharged on April 30, 1999. On April 26, 1999, a laboratory test was performed by an independent laboratory. The laboratory billed both the SNF and Part B.

RADIOLOGY

Under consolidated billing, only the professional component of a diagnostic test (representing the interpretation that the physician performs personally) is billed separately as a physician service, while the technical component representing the diagnostic test itself, must be billed to the SNF. We identified $5.9 million in potentially improper payments inappropriately billed by radiology

service suppliers to Part B instead of the SNF. The potentially improper payment amount represents the technical component of the radiology service. We found:

- Some free-standing MRI centers are billing Part B for the technical component of MRIs instead of billing the SNF. The technical component of MRI procedures performed at free-standing MRI centers is not excluded from consolidated billing. Conversely, MRI procedures are considered intensive services and excluded from the consolidated billing provision only when performed in an OPD.

- Some physicians are billing Part B for both the technical component and the professional component of the radiology procedure. This billing practice is known as global billing and is not allowed under the SNF PPS consolidated billing provision. Physicians should bill the SNF for the technical component of the procedure and Part B for the professional component.

- Some portable radiology suppliers are billing Part B instead of the SNF for the technical component of portable radiology services rendered to a beneficiary while in the SNF.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on December 26, 1998 and discharged on January 21, 1999. On January 4, 1999, an MRI was performed at a free-standing MRI center. The technical component of the MRI was incorrectly billed to Part B instead of the SNF. As a result, Medicare overpaid the supplier $396.

DURABLE MEDICAL EQUIPMENT

The DME suppliers must bill the SNF when items are furnished to a SNF resident during a covered Part A stay. Our match identified $3.7 million in potentially improper payments inappropriately billed by DME suppliers to the DMERC instead of the SNF for supplies delivered to the SNF.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on November 23, 1998 and discharged on March 3, 1999. During the SNF stay, a DME supplier delivered enteral nutrition to the SNF location several times for this beneficiary. The supplier should have billed the SNF. Instead, the supplier billed the DMERC and was overpaid $1,644.

CONCLUSION AND RECOMMENDATIONS

The results of our review show that some suppliers are still not fully cognizant of the consolidated billing provision and, as a result, continue to improperly bill Medicare contractors. Medicare improper payments continue to occur because HCFA has not yet established edits within the CWF and contractors' claims processing systems to detect improperly billed claims and prevent payments.

We recommend HCFA establish payment edits within the CWF and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision. The OIG will assist HCFA with this initiative as necessary. Pending the implementation of payment edits, we recommend HCFA adopt these interim remedies:

- Continue to work with OIG to identify and recover potential improper payments made in subsequent years.
- Direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the SNF PPS consolidated billing provision.
- Monitor the Medicare contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis. The OIG will provide HCFA with detailed claims information to assist in the recovery process.

HCFA COMMENTS

In response to our draft report, HCFA concurred with each of the recommendations. The HCFA indicated that it will be finalizing implementation of an automated process in the near future. However, the complexity of the systems changes needed to automate the consolidated billing policy makes implementation of an automated system difficult at this time without creating an unacceptable level of risk. In the interim, HCFA is developing a strategy to 1) identify mistaken payments and 2) establish methodologies that allow Medicare contractors to effectively and efficiently recover overpayments. Furthermore, HCFA recently completed a training conference

for contractors to discuss the consolidated billing policy and to provide information on upcoming systems changes designed to prevent duplicate billing. In addition, HCFA instructed contractors to provide training to ensure their providers/suppliers understand program requirements and billing procedures. Lastly, HCFA will direct the applicable Medicare contractors to recover the potential $47.6 million in overpayments. The HCFA also provided technical comments which we have addressed below.

ADDITIONAL OIG COMMENTS

The HCFA concurred with the OIG methodology for matching SNF PPS and Part B claims, however, it suggested two minor clarifications in the methodology section. Regarding HCFA's first technical comment, as discussed in Footnote 2 on page 2 of the report, we acknowledge that 701 of the 14,136 SNFs were not under the PPS as of January 1, 1999. Subsequently, all 701 of the SNFs became PPS during the initial months of CY 1999. Although we were unable to eliminate from our match the payments that occurred prior to their conversion to PPS, we believe the amounts are not material. With regard to HCFA's second technical comment, we excluded from our match all laboratory and radiology services which may have been associated with the excluded outpatient intensive or emergency service, including those services provided by an independent laboratory or radiology center.

APPENDICES

SUMMARY BY FISCAL INTERMEDIARY
Potential Improper Payments

	Fiscal Intermediary	Amount
00010	Blue Cross and Blue Shield of Alabama	$105,804
00020	Arkansas Blue Cross and Blue Shield	$151,912
00030	Blue Cross and Blue Shield of Arizona, Inc.	$88,528
00040	Blue Cross of California	$670,613
00060	Anthem Insurance Companies - Connecticut	$174,381
00090	Blue Cross and Blue Shield of Florida, Inc.	$1,129,562
00101	Blue Cross and Blue Shield of Georgia, Inc.	$164,704
00130	Anthem Insurance Companies - Indiana	$441,646
00131	Anthem Insurance Companies - Illinois	$626,459
00140	Wellmark, Inc. - Iowa	$158,393
00150	Blue Cross and Blue Shield of Kansas, Inc.	$146,918
00160	Anthem Insurance Companies - Kentucky	$163,655
00180	Associated Hospital Service of Maine - Maine	$195,699
00181	Associated Hospital Service of Maine - Massachusetts	$636,980
00190	Blue Cross and Blue Shield of Maryland, Inc.	$703,658
00220	Noridian Mutual Insurance Company - Minnesota	$152,257
00230	Blue Cross and Blue Shield of Mississippi	$296,453
00250	Blue Cross and Blue Shield of Montana, Inc.	$103,542
00260	Blue Cross and Blue Shield of Nebraska	$50,970
00270	Blue Cross and Blue Shield of New Hampshire	$102,262
00280	Horizon Blue Cross and Blue Shield of New Jersey, Inc.	$303,797
00308	Empire Medicare Services	$860,791
00310	Blue Cross and Blue Shield of North Carolina	$225,173
00320	Noridian Mutual Insurance Company - North Dakota	$131,348
00332	Anthem Insurance Companies - Ohio	$696,517
00340	Blue Cross and Blue Shield of Oklahoma	$128,492
00350	Blue Cross Blue Shield of Oregon	$234,676
00363	Veritus Medicare Services - Pennsylvania	$815,357
00370	Blue Cross and Blue Shield of Rhode Island	$69,360
00380	Palmetto Government Benefits Administrators	$131,673
00390	Riverbend Government Benefits Administrators	$1,035,913
00400	Trailblazers Health Enterprises, LLC	$988,197

	Fiscal Intermediary	Amount
00410	Regence Blue Cross and Blue Shield of Utah	$88,649
00423	United Government Services - Virginia	$309,438
00430	Premera Blue Cross	$334,145
00450	United Government Services - Wisconsin	$548,599
00452	United Government Services - Michigan	$453,658
00453	United Government Services - West Virginia	$117,572
00460	Blue Cross and Blue Shield of Wyoming	$22,639
00468	Cooperativa De Seguros De Vida De Puerto Rico	$1,765
17120	Blue Cross of California	$2,740
50333	United HealthCare Insurance Company	$172,830
52280	Mutual of Omaha Insurance Company	$1,890,885
Total		$15,828,610

SUMMARY BY CARRIER
Potential Improper Payments

	Carrier	Ambulance	Laboratory	Radiology
00510	Blue Cross and Blue Shield of Alabama	$239,357	$148,939	$106,153
00511	Blue Cross and Blue Shield of Alabama - Georgia	$333,105	$174,413	$129,866
00520	Arkansas Blue Cross and Blue Shield - Arkansas	$91,322	$58,713	$21,673
00521	Arkansas Blue Cross and Blue Shield - New Mexico	$7,143	$14,498	$20,468
00522	Arkansas Blue Cross and Blue Shield - Oklahoma	$36,876	$95,514	$55,867
00523	Arkansas Blue Cross and Blue Shield - Eastern Missouri	$84,370	$150,152	$74,362
00528	Arkansas Blue Cross and Blue Shield - Louisiana	$82,924	$50,731	$46,904
00590	Blue Cross and Blue Shield of Florida, Inc.	$371,998	$892,782	$677,693
00630	AdminaStar Federal, Inc. - Indiana	$176,001	$222,081	$110,720
00650	Blue Cross and Blue Shield of Kansas, Inc. - Kansas	$10,305	$26,145	$23,125
00655	Blue Cross and Blue Shield of Kansas, Inc. - Nebraska	$10,438	$32,928	$14,967
00660	AdminaStar Federal, Inc. - Kentucky	$181,836	$148,596	$36,926
00740	Blue Cross and Blue Shield of Kansas, Inc. - Western Missouri	$42,797	$108,471	$27,234
00751	Blue Cross and Blue Shield of Montana, Inc.	$4,473	$6,106	$9,371
00801	Blue Cross and Blue Shield of Western New York, Inc.	$131,423	$107,579	$109,437
00803	Empire Medicare Services - New York	$617,650	$561,267	$273,870
00805	Empire Medicare Services - New Jersey	$559,805	$386,774	$249,656
00820	Noridian Mutual Insurance Co.- North Dakota	$5,487	$30,749	$21,211
00824	Noridian Mutual Insurance Co. - Colorado	$14,784	$78,283	$33,031
00825	Noridian Mutual Insurance Co. - Wyoming	$3,854	$7,305	$6,507
00826	Noridian Mutual Insurance Co. - Iowa	$15,067	$22,108	$21,924

	Carrier	Ambulance	Laboratory	Radiology
00831	Noridian Mutual Insurance Co. - Alaska	$0	$1,257	$219
00832	Noridian Mutual Insurance Co. - Arizona	$37,359	$201,758	$101,962
00833	Noridian Mutual Insurance Co. - Hawaii	$3,460	$8,643	$1,198
00834	Noridian Mutual Insurance Co. - Nevada	$8,143	$81,926	$34,770
00835	Noridian Mutual Insurance Co. - Oregon	$20,170	$65,008	$35,070
00836	Noridian Mutual Insurance Co. - Washington	$93,695	$146,573	$125,654
00860	Xact Medicare Svcs - New Jersey	$83,306	$73,594	$13,022
00865	Xact Medicare Svcs - Pennsylvania	$1,153,803	$599,206	$350,648
00870	Blue Cross and Blue Shield of Rhode Island	$82,737	$56,043	$23,713
00880	Blue Cross and Blue Shield of South Carolina	$337,364	$44,747	$52,586
00900	Trailblazer's Health Enterprises, LLC - Texas	$1,743,752	$962,355	$338,402
00901	Trailblazer's Health Enterprises, LLC - Maryland	$200,091	$124,546	$126,625
00902	Trailblazer's Health Enterprises, LLC - Delaware	$13,489	$8,780	$28,569
00903	Trailblazer's Health Enterprises, LLC - District of Columbia	$9,401	$143,146	$90,970
00910	Regence Blue Cross and Blue Shield of Utah	$11,738	$52,097	$40,829
00951	Wisconsin Physicians Service Insurance Corp.- Wisconsin	$107,463	$102,461	$86,156
00952	Wisconsin Physicians Service Insurance Corp.- Illinois	$800,463	$678,702	$240,218
00953	Wisconsin Physicians Service Insurance Corp.- Michigan	$369,815	$256,000	$257,921
00973	Triple-S, Inc. - Puerto Rico	$10,146	$8,975	$615
00974	Triple-S, Inc. - Virgin Islands	$192	$709	$0
02050	Transamerica Occidental Life Insurance Co. - California	$771,385	$462,923	$187,624
05130	Connecticut General Life Insurance Co. - Idaho	$4,705	$21,563	$15,660
05440	Connecticut General Life Insurance Co. - Tennessee	$348,027	$99,031	$120,902
05535	Connecticut General Life Insurance Co.- North Carolina	$303,318	$223,117	$137,256

	Carrier	Ambulance	Laboratory	Radiology
10072	United HealthCare Insurance Co. - Railroad Retirement Board	$138,188	$155,207	$93,613
10230	United HealthCare Insurance Company - Connecticut	$548,908	$184,825	$220,603
10240	United HealthCare Insurance Company - Minnesota	$24,168	$50,602	$72,487
10250	United HealthCare Insurance Company - Mississippi	$42,413	$34,592	$17,699
10490	United HealthCare Insurance Company - Virginia	$123,667	$70,463	$84,537
14330	Group Health Inc. - New York	$16,332	$36,243	$35,025
16360	Nationwide Mutual Insurance Co. - Ohio	$651,851	$533,669	$276,239
16510	Nationwide Mutual Insurance Co. - West Virginia	$98,789	$16,908	$26,706
31140	National Heritage Insurance Company - California	$288,227	$264,045	$156,103
31142	National Heritage Insurance Company - Maine	$147,989	$16,542	$36,952
31143	National Heritage Insurance Company - Massachusetts	$1,116,735	$273,306	$340,611
31144	National Heritage Insurance Company - New Hampshire	$33,817	$60,423	$10,708
31145	National Heritage Insurance Company - Vermont	$19,761	$4,031	$2,484
Total		$12,785,882	$9,448,150	$5,855,321

APPENDIX C

SUMMARY BY DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER
Potential Improper Payments

DMERC		Amount
00635	AdminaStar Federal, Inc.	$769,789
00885	Blue Cross and Blue Shield of South Carolina	$1,481,546
05655	Connecticut General Life Insurance Co.	$781,191
10555	United HealthCare Insurance Co.	$683,195
Total		$3,715,721

COMPUTER APPLICATIONS FOLLOWED IN THE IDENTIFICATION OF POTENTIALLY IMPROPER PAYMENTS FOR CY 1999

We performed a nationwide computer match, using HCFA's National Claims History file, of all SNF PPS stays with discharges in CY 1999 to Part B services rendered by suppliers to SNF residents to identify payments made by Part B to suppliers for services subject to consolidated billing. Of these Part B services, outpatient hospital, ambulance, diagnostic laboratory, radiology (diagnostic, therapeutic, and mammography), and DME were found to be the most vulnerable to noncompliance with consolidated billing. Home health agency services, all other nonphysician Part B services (i.e., therapies, vaccines), and DME claims submitted to other than the DMERCs were not found to represent significant areas of noncompliance.

The population was further refined as follows:

Skilled Nursing Facility Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file
- ✓ Limited population to claims with Date of Admission and Date of Discharge during CY 1999
- ✓ Eliminated claims involving hospital swing beds (Type of Bill 18X)
- ✓ Eliminated $0 paid claims

Outpatient Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated claims with at least one intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims with emergency room revenue center codes 0450 through 0459
- ✓ Eliminated claims with cast room revenue center codes 0700 and 0709
- ✓ Eliminated ESRD claims as identified with revenue center codes 0820 through 0859
- ✓ Eliminated $0 paid claims
- ✓ Eliminated services that were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Laboratory Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated services that have physician involvement
  - ✓ A HCPCS modifier of 26 (professional component); or
  - ✓ Listed in the Carrier Manual, section 15020 as having significant physician involvement for both professional and technical component; or
  - ✓ Subject to the physician fee schedule and has a value greater than zero under the physicians' work RVU.
- ✓ Eliminated services which match an outpatient ESRD claim
- ✓ Eliminated services which match an outpatient emergency room claim
- ✓ Eliminated services which match an outpatient intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Radiology Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated services that have physician involvement
- ✓ Eliminated services which match an outpatient emergency room claim
- ✓ Eliminated services which match an outpatient intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Ambulance Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated services which match an outpatient ESRD claim

- ✓ Eliminated services which match an outpatient emergency room claim - subtracted 1 day from the From Date of Service of the outpatient service to capture "close to midnight" emergencies
- ✓ Eliminated services which match an outpatient intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated services which match outpatient cast room services
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Durable Medical Equipment Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated any purchases with a Place of Service indicating "home"
- ✓ Eliminated any rentals and maintenance/service (HCPC modifiers RR and MS, respectively) with a From Date of Service prior to the Date of SNF Admission
- ✓ Eliminated other DME, prosthetics, orthotics, or vision, with Place of Service indicating "home"
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: APR - 2 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: *Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System* (A-01-00-00538)

We appreciate the opportunity to review the above-mentioned OIG draft report concerning the identification of a potential $47.6 million in improper payments made by Medicare for calendar year 1999 for services covered by the consolidated billing provision of the skilled nursing facility (SNF) prospective payment system (PPS). We believe the report provides an important contribution to our efforts to maintain the financial integrity of the Medicare program.

The Health Care Financing Administration (HCFA) detects instances of inappropriate payment on a limited, non-automated, post-payment basis using our program safeguard contractors (PSCs). However, we will be finalizing implementation of an automated process in the near future. The complexity of the systems changes needed to automate the consolidated billing policy, when combined with other necessary critical systems changes, make implementation of an automated system difficult at this time without creating an unacceptable level of risk. In addition to these systems changes, we are in the process of implementing critical systems changes enacted in the Benefits Improvement and Protection Act of 2000 and the Health Insurance Portability and Accountability Act of 1996. While we are dedicated to further refining automation of our consolidated billing systems, we must also protect the integrity of the existing systems by continuing with the aforementioned post-payment pilot strategy until the new systems are operational.

OIG Recommendation

HCFA should establish payment edits within the Common Working File (CWF) and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision. The OIG will assist HCFA with this initiative as necessary. Pending the implementation of payment edits, we recommend HCFA adopt interim remedies (recommendations 2-4).

Page 2- Michael F. Mangano

HCFA Response
We concur. HCFA has made meaningful progress towards implementing automated processes for identifying potentially inappropriate payments and recovery of overpayments without unduly burdening providers or exceeding available Medicare contractor resources. However, significant changes in the CWF and within each Medicare contractor's system are necessary to fully automate these processes. Since the scope of these changes necessitates an incremental deployment strategy, we are proceeding accordingly. As we move forward, knowledge gained through interim strategies, such as recovery activities currently underway, will be incorporated into the new systems to refine the edit criteria and enhance the success of the automated processes.

OIG Recommendation
HCFA should continue to work with the OIG to identify and recover improper payments made subsequent to the implementation of the consolidated billing provision. The OIG will provide HCFA with detailed claims information to assist in the recovery process.

HCFA Response
We concur. HCFA is pursuing a risk mitigation strategy using a PSC that supports existing program safeguard activities.

The general elements of this strategy are:

- Immediately tasking the statistical analysis PSC to: (1) identify all SNF and home health PPS episodes of care in three mid-western states; and (2) aggregate all Medicare claims paid within these episodes to determine which claims should not have been paid.

- Tasking the PSC to work with United Government Services and Wisconsin Physicians Service Insurance Corporation (the primary fiscal intermediary (FI) and carrier in the three involved states) and HCFA to: (1) develop mistaken payment reports (including reports on specific providers that appear to be the most aberrant in their billing patterns); and (2) develop methodologies to allow the FIs and carriers to recover mistaken payments via methods that minimize manual intervention.

Based on the results of this three-state activity, HCFA would then develop a strategy to export the three-state findings on a nationwide basis, either through an existing PSC or by issuing a new task order.

OIG Recommendation
HCFA should direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the SNF PPS consolidated billing provision.

Page 3- Michael F. Mangano

HCFA Response
We concur. HCFA recently completed a mandatory training conference for Medicare contractors to discuss the consolidated billing policy and to provide information on upcoming systems changes that will be put in place to prevent duplicate billing. The conference included detailed information on background and policy provisions of the consolidated billing program, and explained proposed systems edits being designed to assist the contractors to identify duplicate billings and recover duplicate payments. These edits are extremely sophisticated as they involve the ability to edit Part A and Part B claims against each other. During the conference, Medicare contractors received detailed information on the edit logic and feedback procedures.

In addition, we have instructed our contractors to schedule consolidated billing training this spring to make sure that their providers/suppliers understand related program requirements and billing procedures. We expect that contractors will then incorporate consolidated billing updates into their ongoing training programs.

OIG Recommendation
HCFA should monitor the Medicare contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis.

HCFA Response
We concur. HCFA will direct the Medicare FIs and carriers identified in the report to recover the potential $47.6 million in overpayments. When the final report is issued, the OIG will furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the Medicare contractors to initiate and complete recovery action. At that time, we will forward the final report and information needed by the Medicare contractors to effectuate recovery of the overpayments to the regional offices for appropriate action. We will also identify the OIG contact if any questions arise. We appreciate the OIG's offer to provide HCFA with the detailed claims information to assist in the recovery process.

HCFA will need to implement a special monitoring and reporting activity to meet the OIG's request that we report recoveries of overpayments by supplier to the OIG for future analysis. Since this reporting activity will require additional resources for the FIs, HCFA will need to review and determine appropriate funding for this activity in relation to other FI activities. HCFA will need to develop and issue technical instructions for the FIs to track and report recoveries by supplier. HCFA will furnish a semi-annual report to the OIG detailing the progress of the overpayment recoveries by supplier.

Page 4- Michael F. Managano

Technical Comments
While we concur with the methodology used for matching the SNF PPS and Part B claims, we suggest two minor clarifications in the methodology section, as follows:

1. Clarify the method by which SNF PPS claims were identified: SNF PPS was being phased in during fiscal year 1999, and the National Claims History File contained bills paid under both PPS and the prior cost reimbursement system. While not explicitly stated, we assumed that the researchers selected Part A claims that included at least one Revenue Code 22, the line item indicating the RUG-III group being billed.

2. Clarify the method used to exclude laboratory and radiology services matching outpatient intensive services identified in program memorandum (PM) A-37-98. The services identified in the PM must be provided in a hospital or critical access hospital (CAH) in order to qualify for exclusion under consolidated billing. The associated laboratory and radiology services are also excluded when billed by the hospital or CAH. It might be preferable to show the radiology and laboratory claims eliminated from the database under the outpatient data section. This would avoid confusion since the services would not be excluded when billed by an independent laboratory or radiology center.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Memorandum

Date NOV 13

From Janet Rehnquist
Inspector General

Subject Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported as Discharges (A-06-00-00041)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached is the Department of Health and Human Services, Office of Inspector General's (OIG) final audit report entitled, "Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported as Discharges." The objectives of our review were to: (1) identify incorrectly reported prospective payment system (PPS) transfers in Medicare PPS inpatient hospital claims posted to the Centers for Medicare & Medicaid Services's (CMS) National Claims History (NCH) file between January 1, 1992 and June 30, 2000 and (2) determine whether data trends indicated that overpayments resulting from incorrectly reported PPS transfers decreased.

Hospitals incorrectly reporting PPS transfers as discharges and fiscal intermediaries (FI) failing to detect and correct these errors has been a concern of OIG and CMS for a number of years. Previous OIG or joint OIG and CMS efforts in this area resulted in over $219 million in recoveries.

In this review, we identified over 153,000 claims for incorrectly reported PPS transfers that were posted to CMS's NCH between January 1, 1992 and June 30, 2000. The potential overpayments related to these transfers totaled nearly $233 million. The 153,000 incorrectly reported transfers and the $233 million in related potential overpayments consisted of the following:

- 79,000 incorrectly reported PPS transfers resulting in overpayments and 74,000 incorrectly reported PPS transfers that did not result in overpayments; and
- $163.9 million of overpayments suitable for administrative recovery through FIs and $69.1 million of overpayments which are currently the subject of investigative initiatives.

Our examination of the 153,000 incorrectly reported PPS transfers showed that the number of incorrectly reported PPS transfers and resulting potential overpayments trended downward since 1992. Our analysis showed that hospitals incorrectly reported an average of 1,132 PPS transfers per month in 1992 with this average decreasing to about 495 per month in 1999.

Notwithstanding these decreases, hospitals continued to incorrectly report PPS transfers and FIs continued to pay PPS transfers as discharges. Through discussions with officials from CMS, FIs, and hospitals, we identified several reasons which may have contributed to this ongoing problem. These included misapplication of the PPS transfer payment policy by CMS regional offices and FIs; problems with computer systems interfaces at hospitals; and breakdowns in communication between hospitals' medical and billing staffs.

Although the number of incorrectly reported PPS transfers and the resulting overpayments decreased in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, problems still continue. We believe that recovery of the $163.9 million in potential overpayments for incorrectly reported PPS transfers needs to begin. In addition, we believe that CMS should provide FIs with instructions to ensure consistent recovery of overpayments.

Accordingly, we recommended that CMS:

1. Issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date;

2. Issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer; and

3. Instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

The CMS generally concurred with our recommendations. Specifically, CMS concurred with our recommendation related to the collection of potential overpayments, but stated they will initially limit the recovery effort to the last 4 years in order to comply with the cost report reopening period designated in regulations 42 CFR 405.750. We continue to believe that the recovery of all overpayments for incorrectly reported PPS transfers should be pursued as diligently as in the past and should not be limited to the 4-year recovery period. We are prepared to assist CMS as it begins its recovery actions.

The CMS also concurred with our recommendation to issue clarifying instructions on the PPS transfer policy to FIs and hospitals. Lastly, although CMS agreed that additional steps need to be taken to identify improperly reported hospital transfers, they did not concur with our recommendation to instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment for PPS transfers. Instead, CMS is proposing to create a biannual data run to identify inappropriate transfers and require FIs to

make appropriate adjustments. While we agree that this action may help ensure that improper transfer claims are appropriately adjusted, we also believe that effective procedures implemented by FIs and hospitals could detect these improper claims prior to payment. We summarized CMS's comments and our response in the CONCLUSION section of the report. The CMS's entire response is included as APPENDIX F to our report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendation within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-06-00-00041 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM TRANSFERS INCORRECTLY REPORTED AS DISCHARGES

JANET REHNQUIST
Inspector General

NOVEMBER 2001
A-06-00-00041

EXECUTIVE SUMMARY

BACKGROUND

A prospective payment system (PPS) transfer occurs when a patient is admitted to a PPS hospital on the same day that he/she is discharged from a different PPS hospital. When a PPS transfer occurs, payment to the hospital from which the patient is transferred is based on a per diem methodology. If the transferring PPS hospital incorrectly reports the transfer as a discharge, it receives the full diagnosis related group payment, which is often more than the per diem payment for a transfer. In this review, the transferring hospital would have received a lesser payment about 52 percent of the time had it reported a transfer rather than a discharge.

Hospitals that do not accurately report PPS transfers have been a concern of both the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) for many years. Shortly after the implementation of PPS, OIG began work to determine whether PPS hospitals properly adapted to the new rules governing payment for PPS transfers. In 1988, OIG issued a report where it determined that PPS hospitals had not taken steps to properly report PPS transfers. In 1992, following a successful pilot project in Region VI, OIG and CMS initiated a nationwide PPS transfer recovery project. The pilot and nationwide recovery projects resulted in about $219 million in Medicare recoveries.

Based on OIG's work, CMS implemented claims processing edits or alerts to identify incorrectly reported PPS transfers and provided fiscal intermediaries (FI) with an opportunity to prevent or correct overpayments. In November 1990, CMS issued a program memorandum reiterating to FIs that the admission of a patient into a PPS hospital on the same day the patient was discharged from a different PPS hospital is a transfer. The program memorandum provided FIs with instructions on how to process adjustments to claims for incorrectly reported PPS transfers. It also instructed FIs to advise PPS hospitals in their jurisdictions of the PPS transfer policy and of each hospital's responsibility to take steps necessary to correctly code PPS transfers.

OBJECTIVES

The objectives of our current review were to (1) identify incorrectly reported PPS transfers in Medicare PPS inpatient hospital claims posted to CMS's National Claims History (NCH) file between January 1, 1992 and June 30, 2000 and (2) determine whether data trends indicated that overpayments resulting from incorrectly reported PPS transfers decreased.

SUMMARY OF FINDINGS

We identified over 153,000 claims for incorrectly reported PPS transfers which were posted to CMS's NCH file between January 1, 1992 and June 30, 2000. The potential overpayments related to these transfers totaled nearly $233 million. The 153,000 incorrectly reported transfers and the $233 million in related potential overpayments consisted of the following:

- 79,000 incorrectly reported PPS transfers resulting in potential overpayments and 74,000 incorrectly reported PPS transfers that did not result in overpayments; and

- $163.9 million of potential overpayments suitable for administrative recovery through FIs and $69.1 million of potential overpayments which are currently the subject of investigative initiatives.

Our examination of the 153,000 incorrectly reported PPS transfers showed that the number of incorrectly reported PPS transfers and resulting potential overpayments trended downward since the 1992 joint OIG/CMS recovery project. Our analysis showed that hospitals incorrectly reported an average of 1,132 PPS transfers per month in 1992 with this average decreasing to about 495 per month in 1999. For this period, we also found that: (1) the monthly average overpayment for incorrectly reported PPS transfers fell from $3 million in 1992 to $1.3 million in 1999 and (2) hospitals were most likely to incorrectly report a PPS transfer as either a discharge to the patient's home (43.50 percent) or a transfer to a non-PPS hospital (32.27 percent). APPENDICES A through E contain both graphs of the data and our analysis of various PPS transfer payment data discussed in our report.

Notwithstanding the decreases described above, hospitals continued to incorrectly report PPS transfers and FIs continued to pay PPS transfers as discharges. Through discussions with officials from CMS, FIs, and hospitals, we identified several reasons which may have contributed to this ongoing problem. These included misapplication of the PPS transfer payment policy by CMS regional offices and FIs; problems with computer systems interfaces at hospitals; and breakdowns in communication between hospitals' medical and billing staffs.

CONCLUSIONS AND RECOMMENDATIONS

Although the number of incorrectly reported PPS transfers and the resulting overpayments decreased in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, problems still continue. We believe that a number of factors involving the CMS regional offices, FIs, and hospitals contribute to the continuation of incorrectly reported PPS transfers, and that substantiation of the root causes is necessary in order for corrective action to be effective.

We believe that recovery of the $163.9 million in potential overpayments for incorrectly reported transfers needs to begin. In addition, we believe that CMS should provide FIs with instructions to ensure consistent recovery of the potential overpayments.

Accordingly, we recommended that CMS:

1. Issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date;

2. Issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates

an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer; and

3. Instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

The CMS generally concurred with our recommendations. Specifically, CMS concurred with our recommendation related to the collection of potential overpayments, but stated they will initially limit the recovery effort to the last 4 years in order to comply with the cost report reopening period designated in regulations 42 CFR 405.750. We continue to believe that the recovery of all overpayments for incorrectly reported PPS transfers should be pursued as diligently as in the past and should not be limited to the 4-year recovery period. We are prepared to assist CMS as it begins its recovery actions.

The CMS also concurred with our recommendation to issue clarifying instructions on the PPS transfer policy to FIs and hospitals. Lastly, although CMS agreed that additional steps need to be taken to identify improperly reported hospital transfers, they did not concur with our recommendation to instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment for PPS transfers. Instead, CMS is proposing to create a biannual data run to identify inappropriate transfers and require FIs to make appropriate adjustments. While we agree that this action may help ensure that improper transfer claims are appropriately adjusted, we also believe that effective procedures implemented by FIs and hospitals could detect these improper claims prior to payment. We summarized CMS's comments and our response in the CONCLUSION section of the report. The CMS's entire response is included as APPENDIX F to our report.

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INTRODUCTION

BACKGROUND

A prospective payment system (PPS) with payment based on discharges was adopted for Medicare Part A inpatient services in hospitals not excluded from PPS with hospital cost reporting periods beginning on or after October 1, 1983. The PPS hospitals are paid for discharges and the amount is determined by the assigned diagnosis related group (DRG). However, transfers between hospitals paid under PPS are not considered discharges and are paid based on a per diem rate. The per diem methodology provides for payment amounts computed from the DRG based payment. Payment to the transferring hospital may not exceed the full prospective amount (i.e., the payment for a discharge).

In implementing the Medicare Part A PPS, the Centers for Medicare & Medicaid Services (CMS) promulgated 42 CFR 412.4. Section 412.4 (b) which sets forth the basic rules for patient transfers states:

> "A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the discharge is made under any of the following circumstances:
>
> (1) From a hospital to the care of another hospital that is —
>
> (i) Paid under the prospective payment system; or
>
> (ii) Excluded from being paid under the prospective payment system because of participation in an approved Statewide cost control program...."

Since 1983, two significant changes were incorporated into 42 CFR 412.4:

- payment of two per diems for the first day for transfers occurring on or after October 1, 1995; and
- the inclusion of 10 specific post-acute care DRGs as PPS transfers if the patient receives specified post-acute care on or after October 1, 1998.

The CMS contracts with fiscal intermediaries (FI) which are responsible for receiving, processing, and paying Medicare hospital claims. The FIs are required to determine the correct payment amount for each inpatient hospital claim based on applicable Medicare law, regulation, and CMS policy.

In November 1990, CMS issued a program memorandum reiterating to FIs that the admission of a patient into a PPS hospital on the same day the patient was discharged from a different PPS hospital is a transfer. As such, the transferring PPS hospital was to be paid a per diem amount appropriate to the date the patient left that hospital. The program memorandum provided

FIs with instructions on how to process adjustments to claims for incorrectly reported PPS transfers. It also instructed FIs to advise PPS hospitals in their jurisdictions of the PPS transfer policy and of each hospital's responsibility to take steps necessary to correctly code PPS transfers.

Shortly after the implementation of PPS, the Office of Inspector General (OIG) began work to determine whether PPS hospitals properly adapted to the rules governing payment for PPS transfers. From the earliest OIG report through the current report, OIG determined that PPS hospitals were not always properly reporting PPS transfers.

Following a successful pilot project in Region VI, OIG and CMS initiated the first nationwide PPS transfer recovery project. The pilot and nationwide recovery projects resulted in approximately $219 million in Medicare recoveries related to incorrectly reported PPS transfers. Additional OIG work identified corrective actions that, if implemented, were estimated to save Medicare another $8 million.

Based on OIG's work, CMS implemented claims processing edits or alerts to identify incorrectly reported PPS transfers and provide FIs with an opportunity to prevent or correct overpayment situations. The CMS also issued the November 1990 program memorandum, described above.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our current PPS transfer review were to: (1) identify incorrectly reported PPS transfers in Medicare PPS inpatient hospital claims posted to CMS's National Claims History (NCH) file between January 1, 1992 and June 30, 2000 and (2) determine whether data trends indicated that overpayments resulting from incorrectly reported PPS transfers decreased.

The objectives of our review did not require the review of any internal controls. To accomplish our objectives we:

- obtained and analyzed Medicare Part A PPS data for claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000;

- determined the number of incorrectly reported PPS transfers in the Medicare Part A claims posted to CMS's NCH file between the period January 1, 1992 and June 30, 2000;

- identified potential overpayments associated with the incorrectly reported PPS transfers contained in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000;

- analyzed trends in the number of, and overpayments resulting from, PPS transfers contained in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000;

- analyzed trends in the incorrectly reported PPS transfers when two different FIs were involved in the payment process; and

- analyzed why incorrectly reported PPS transfers continue to be a problem despite ongoing correction efforts.

In addition to the steps performed to accomplish our objectives, we relied on information developed during other OIG assignments to provide the basis for forming an opinion as to the reasons hospitals continue to incorrectly report PPS transfers as discharges, and FIs continue to pay these transfers as discharges. The information we relied on was obtained through:

- interviews with hospital officials and reviews of medical records for patients incorrectly reported as discharged, when the patients were admitted to another PPS hospital on the same day;

- discussions with FI staff regarding FI procedures applied to incorrectly reported PPS transfers which the FI attributed to CMS regional office (RO) instructions or guidance, and review of FI provider files related to hospitals that had problems with correctly reporting PPS transfers; and

- discussions with CMS staff.

Our audit was made in accordance with generally accepted government auditing standards. Most of the field work related to this review was performed in OIG's Region VI, Baton Rouge field office.

FINDINGS AND RECOMMENDATIONS

We identified over 153,000 claims for incorrectly reported PPS transfers which were posted to CMS's NCH file between January 1, 1992 and June 30, 2000. The potential overpayments related to these incorrectly reported PPS transfers totaled nearly $233 million. The incorrectly reported transfers and the related potential overpayments consisted of the following:

- 79,000 incorrectly reported PPS transfers resulting in potential overpayments and 74,000 incorrectly reported PPS transfers that did not result in overpayments[1]; and

- $163.9 million of potential overpayments suitable for administrative recovery through FIs and $69.1 million of potential overpayments which are currently the subject of investigative initiatives.

[1]The total payment for a PPS transfer is limited to the amount payable had the patient been discharged. Therefore, incorrectly reported transfers with lengths of stay longer than that used to determine the per diem amount do not result in overpayments.

Our analysis of the incorrectly reported PPS transfers in claims posted to NCH between January 1, 1992 and June 30, 2000, showed a substantial decrease in both the rate of occurrence and in the resulting overpayments through the period. As reflected in graphs 1 and 2 of APPENDIX E, the period began with 24,128 incorrectly reported transfers in 1992 and ended with 14,869 incorrectly reported PPS transfers in 1999.[2] Through the period, incorrectly reported transfers resulting in overpayments fell from 13,581 in 1992 to 5,940 in 1999. The amount of potential overpayments made to hospitals incorrectly reporting transfers also fell from $36,026,722 in 1992 to $15,938,295 in 1999. More complete data regarding the incorrectly reported transfers and resulting potential overpayments are presented in APPENDICES A and B.

The decrease in the number of incorrectly reported PPS transfers and the associated overpayments showed that improvements are taking place. However, the downward trend did not appear to coincide with the prior recovery project or issuance of additional instructions and clarifications to PPS hospitals. The downward trend became most apparent following OIG's inclusion of additional PPS transfer work in its Fiscal Year 1995 work plan and the involvement of investigative agencies in reviews of incorrectly reported PPS transfers.

Notwithstanding the decreases described above, hospitals continued to incorrectly report PPS transfers. Through information gathered in other audit assignments, we identified several reasons that may have contributed to this ongoing problem. These included misunderstandings related to the purpose and application of the PPS transfer policy and systems weaknesses.

POTENTIAL CAUSES FOR CONTINUATION OF THE INCORRECTLY REPORTED PPS TRANSFERS

In general, the continuation of hospitals incorrectly reporting PPS transfers and FIs paying these transfers as discharges may be caused by confusion about the purpose and application of the PPS transfer policy, at both hospitals and FIs, and systems weaknesses.

Misunderstanding of PPS Transfer Policy and Systems Weaknesses at Hospitals

Hospital medical records were reviewed in other OIG work involving these, as well as other, incorrectly reported PPS transfer issues. During these reviews, OIG staff found sufficient information in the medical records to conclude that the hospitals involved could have, in most cases, correctly reported the PPS transfer. In the review of medical records, at least one hospital had knowledge of or participated in the transfer in more than 90 percent of the cases reviewed. Hospital staff, who also reviewed the medical records, agreed that the medical records provided sufficient information at the time the claims were filed, or shortly thereafter, to have submitted the claims as PPS transfers rather than PPS discharges.

Hospital officials provided three primary reasons as to why they had incorrectly reported PPS transfers as discharges. These were:

[2]Our analysis is based on January 1, 1992 through December 31, 1999 because the data for 2000 was far from complete and its inclusion would present an inaccurate impression of the data's true trend.

- problems in interfaces within hospital computer systems, most notably between the medical records and billing components, which led to the submission of claims as discharges rather than transfers;

- assumptions that the receiving hospital is excluded from PPS based on the type of patients accepted and the services rendered. Hospitals often reported transfers to long-term care hospitals using the discharge code 05 (discharged/transferred to another type of institution) without confirming that the receiving hospital was, in fact, excluded from PPS. For example, after receiving OIG's listing of incorrectly reported PPS transfers, a compliance officer at one hospital contacted the receiving hospital to verify that the hospital was not under PPS. However, the compliance officer found that the receiving hospital had only recently requested exemption from PPS. In light of this mistaken assumption, hospital staff agreed that they should have confirmed the receiving hospital's Medicare status prior to submitting their claim to Medicare; and

- breakdowns in communication between hospitals' medical and billing staffs. In some cases, the hospital's rate of incorrectly reported PPS transfers declined significantly, or ceased, after internal reviews detected the problem and steps were instituted to prevent the incorrect reporting of PPS transfers. However, as part of their efforts to improve communications between hospital departments, none of the hospitals which detected problems had taken steps to determine the significance of the problem and repay Medicare for the overpayments received.

Misunderstanding of PPS Transfer Policy and Systems Weaknesses at FIs

We also identified several instances where FIs' misunderstandings of the PPS transfer policy contributed to incorrectly reported transfers. Generally, these instances related to the reimbursement aspects of the PPS transfer policy being mistakenly overshadowed by medical necessity concerns, or the resolution of incorrectly reported PPS transfers referred by OIG to investigative agencies.

In one example, based on the correspondence reviewed, it was clear that the FI had followed the edit instruction and changed the hospital's reported discharge to a transfer and paid the claim accordingly. However, when the hospital protested, the FI referred both the discharge and the subsequent same day admission to the peer review organization (PRO). The FI requested that the PRO determine whether an inappropriate or premature discharge occurred at the first hospital, and whether the care at the second hospital was necessary. Although the PRO had not completed its work at the time of our review, FI staff stated that, if the PRO found both hospitalizations to be medically necessary, the FI would pay both claims as hospital discharges. Based on the instructions in the November 1990 program memorandum, we believe the appropriate action would have been for the FI to remind the hospital of CMS's policy regarding discharges and admissions on the same day and that reimbursement as a transfer was correct.

In a second example, we believe that the FI mistakenly resolved incorrectly reported PPS transfers declined by investigative agencies. These incorrectly reported PPS transfers were to be returned to OIG for recovery of potential overpayments. However, in at least one

declination, the investigative agency referred the incorrectly reported PPS transfers to the FI for administrative recovery. In an attempt to prevent duplication of recovery, we contacted the FI. In discussing the transfers, the FI stated that very few of the transfers required adjustment. The FI stated that it had reviewed the medical records and determined that most of the patients were subsequently admitted to hospitals located on the other side of the State, and therefore, both claims should be and were paid as a discharge.

We disagreed with the FI. First, the discharges reviewed by the FI met the definition of a transfer, as set forth in the November 1990 program memorandum. Second, the FI did not review the medical records to determine whether the first hospital had knowledge of or participated in the transfer. We believe it is necessary for the FI to consider knowledge of, and participation in, the transfer in order to determine how to appropriately resolve the incorrectly reported PPS transfer.

PPS Systems Weaknesses

We also believe that systems weaknesses within FIs claims payment systems or between FIs and the Common Working File (CWF) system may have contributed to FIs continuing to pay PPS transfers as discharges. The systems weaknesses may have contributed to payments for incorrectly reported transfers, despite the edits or alerts for detecting incorrectly reported PPS transfers that were in both systems.

CONCLUSIONS AND RECOMMENDATIONS

Although the number of incorrectly reported PPS transfers and the resulting overpayments decreased in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, problems still continue. We believe that a number of factors involving the CMS ROs, FIs, and hospitals contributed to the continuation of incorrectly reported PPS transfers, and that substantiation of the root causes is necessary in order for corrective action to be effective.

We believe that recovery of the $163.9 million in potential overpayments for incorrectly reported transfers needs to begin. In addition, we believe that CMS should provide FIs with instructions to ensure consistent recovery of the potential overpayments.

Accordingly, we recommended that CMS:

1. Issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date;

2. Issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer; and

3. Instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

CMS COMMENTS

In their written response to our draft report, CMS generally agreed with our recommendations. Specifically, CMS agreed to issue instructions to and work with FIs to initiate the collection of potential overpayments. However, CMS plans to limit the recovery period to the last 4 years, in order to comply with the cost report reopening period provided for in 42 CFR 405.750. With respect to the potential overpayments beyond the 4-year period, CMS plans to research the overpayment data to determine whether any of the overpayments qualify for recovery under the regulations.

The CMS also concurred with our recommendation to issue clarifying instructions to FIs and hospitals regarding the PPS transfer policy. The CMS stated that they will issue an instruction to FIs reiterating the PPS transfer policy and ask that FIs include an educational article in their next provider bulletin reinforcing the need for proper coding procedures.

Further, CMS agreed that additional steps need to be taken to identify improperly reported hospital transfers. However, CMS did not agree with our recommendation to instruct FIs and hospitals to review all internal procedures and processes to assure that PPS transfers are properly detected, reported, and corrected. The CMS stated that because of the timing of processing claims from facilities involved in the improper transfers, FIs are only able to correct the improper transfers on a post-payment basis. Therefore, CMS believes it would be preferable and administratively more efficient to institute a process creating a biannual data run to identify the inappropriate transfers. The CMS would then forward identified claims to FIs for investigation, and where appropriate, adjustment bills would be created by FIs.

OIG RESPONSE

We are prepared to assist CMS as it begins its recovery actions to collect potential overpayments identified to date. However, we do not agree with CMS's plan to initially limit recoveries to the most recent 4-year period. While we recognize the recovery limitations imposed in regulations 42 CFR 405.750, we do not believe they apply to the collection of potential overpayments related to inappropriately reported PPS transfers. The CMS has continuously provided instructions to PPS hospitals addressing improper transfers. In spite of these instructions, many PPS hospitals have continued to submit inappropriate PPS transfer claims for reimbursement. In the past, CMS has been supportive of OIG's efforts to recover Medicare funds from those hospitals that have not adhered to CMS guidance regarding the proper way to report and claim reimbursement to PPS transfer claims. Until now, CMS had not limited those recoveries to the 4-year period imposed in 42 CFR 405.750. We believe that the recovery of all overpayments for incorrectly reported PPS transfers should be pursued as diligently as in the past, and not be limited to the 4-year recovery period.

With respect to CMS's plans to create a biannual data run to identify inappropriate transfers on a post-payment basis, we agree that such action may help ensure that Medicare claims for improper transfers are appropriately adjusted. However, we also believe that if both FIs and hospitals established effective procedures many improper PPS transfers could be detected prior to Medicare's payment for these inappropriate claims.

OTHER MATTERS

At CMS's request, we performed additional data analyses to determine whether: (1) certain patient discharge/transfer status codes were more commonly used on claims containing incorrectly reported PPS transfers; and (2) the involvement of different FIs in the claims payment process impacted the number of and potential overpayments resulting from incorrectly reported PPS transfers.

Discharge/Transfer Status Codes

Most of the claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, which contained an incorrectly reported PPS transfer, contained one of the two following discharge codes:

- Code (01) discharged to home or self-care — 66,647 (43.50 percent of all incorrectly reported PPS transfers) and $87,278,006 in overpayments (37.47 percent of all overpayments); and

- Code (05) discharged/transferred to another type of institution — 49,441 (32.27 percent of all incorrectly reported PPS transfers) and $86,957,189 in overpayments (37.33 percent of all overpayments).

In 1992, hospitals incorrectly reported PPS transfers as discharges to home or self-care, code (01), 11,552 times resulting in $15,911,424 in overpayments. In 1999, the last full year of data analyzed, hospitals incorrectly reported PPS transfers as discharges using code (01) 5,616 times resulting in potential overpayments of $5,269,948.

In 1992, hospitals incorrectly reported PPS transfers as discharges/transfers to another type of institution, code (05), 8,612 times resulting in $14,051,508 in overpayments. In 1999, hospitals incorrectly reported PPS transfers as discharges using code (05) 4,272 times resulting in potential overpayments of $5,337,099.

During the same time period in which the number of PPS transfers incorrectly reported as discharge codes (01) and (05) decreased, increases occurred in the usage of three other codes:

- Code (03) — discharged/transferred to a skilled nursing facility;

- Code (04) — discharged/transferred to an intermediate care facility; and

- Code (06) — discharged/transferred to home in care of a home health agency.

With the exception of discharge code (03), which accounted for 14.36 percent of all incorrectly reported PPS transfers and 14.43 percent of all overpayments between January 1, 1992 and June 30, 1999, hospitals did not make extensive use of these three codes to incorrectly report PPS transfers. Misuse of the code for reporting patients discharged or transferred to a skilled nursing facility occurred 21,999 times in the period and resulted in overpayments of $33,614,923. The occurrence of the codes and the amounts of overpayment by code are shown in APPENDIX B.

PPS Transfer Payments Involving Two FIs

We also examined claims related to the incorrectly reported PPS transfers to determine whether transfers were more likely to go undetected when different FIs paid the transferring and receiving hospitals. We found that 59,656 or 38.94 percent of the 153,214 undetected and uncorrected incorrectly reported PPS transfers occurred when different FIs paid the hospitals involved in transferring and receiving the patient. Of the $232,920,529 in overpayments for incorrectly reported PPS transfers, $92,798,399 or 39.84 percent occurred where different FIs paid the hospitals involved in transferring and receiving the patient. The rate that incorrectly reported PPS transfers went undetected and uncorrected when different FIs paid the hospitals involved in transferring and receiving the patient ranged from 11.40 percent to 100 percent.

Summary details regarding the involvement of multiple FIs in incorrectly reported PPS transfers are presented in APPENDICES C and D.

APPENDIX A
Page 1 of 1

SCHEDULE OF INCORRECTLY REPORTED PPS TRANSFERS[1]
January 1,1992 through June 30, 2000

Occurrence of Incorrectly Reported PPS Transfers With an Overpayment (OP)

Period	Start	End	Months	With OP	Monthly Average	Percentage Change
1992	01/01/92	12/31/92	12	13,581	1,132	
1993	01/01/93	12/31/93	12	13,512	1,126	0.51 ↓
1994	01/01/94	12/31/94	12	12,897	1,075	4.55 ↓
1995	01/01/95	12/31/95	12	10,089	841	21.77 ↓
1996	01/01/96	12/31/96	12	7,294	608	27.70 ↓
1997	01/01/97	12/31/97	12	7,404	617	1.51 ↑
1998	01/01/98	12/31/98	12	6,246	521	15.64 ↓
1999	01/01/99	12/31/99	12	5,940	495	4.90 ↓
2000	01/01/00	06/30/00	6	2,190	365	
			102	79,153	776	

Occurrence of Potential Overpayments for Incorrectly Reported PPS Transfers

Period	Start	End	Months	OP	Monthly Average	Percentage Change
1992	01/01/92	12/31/92	12	$36,026,722	$3,002,227	
1993	01/01/93	12/31/93	12	40,543,316	3,378,610	12.54 ↑
1994	01/01/94	12/31/94	12	39,815,173	3,317,931	1.80 ↓
1995	01/01/95	12/31/95	12	32,652,476	2,721,040	17.99 ↓
1996	01/01/96	12/31/96	12	21,540,779	1,795,065	34.03 ↓
1997	01/01/97	12/31/97	12	22,137,397	1,844,783	2.77 ↑
1998	01/01/98	12/31/98	12	18,581,542	1,548,462	16.06 ↓
1999	01/01/99	12/31/99	12	15,938,295	1,328,191	14.23 ↓
2000	01/01/00	06/30/00	6	5,684,826	947,471	
			102	$232,920,526	$2,283,535	

[1]Upward pointing arrows indicate the trend rate is increasing or getting worse and downward pointing arrows indicate that the trend rate is decreasing or getting better. For example, in 1993 the rate of occurrence of incorrectly reported PPS transfers improved by 0.51 percent while the overpayment for the incorrectly reported PPS transfers exceeded the 1992 overpayment by 12.54 percent. Percent of change omitted for 2000 because the period is incomplete.

APPENDIX B
Page 1 of 3

SCHEDULE OF CODES USED TO INCORRECTLY REPORT PPS TRANSFERS
January 1,1992 through June 30, 2000
BY DISCHARGE CODE INCORRECTLY USED BY HOSPITALS[2]

Code 01 Discharged to Home or Self Care (routine discharge)

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	5,020	6,532	11,552		$15,911,423	
1993	4,025	5,780	9,805	15.12↓	15,061,264	5.34↓
1994	3,890	5,967	9,857	0.53↑	15,755,271	4.61↑
1995	3,488	4,908	8,396	14.82↓	13,056,761	17.13↓
1996	3,651	3,130	6,781	19.24↓	7,465,031	42.83↓
1997	3,960	3,024	6,984	2.99↑	7,314,155	2.02↓
1998	3,296	2,380	5,676	18.73↓	5,552,179	24.09↓
1999	3,397	2,219	5,616	1.06↓	5,269,947	5.08↓
2000	1,183	797	1,980		1,891,971	
	31,910	34,737	66,647		$87,278,002	

Code 03 Discharged/Transferred to a Skilled Nursing Facility

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	1,098	1,190	2,288		$ 3,334,417	
1993	1,097	1,251	2,348	2.62↑	4,459,831	33.75↑
1994	1,123	1,403	2,526	7.58↑	4,740,600	6.30↑
1995	1,186	1,341	2,527	0.04↑	5,414,964	14.23↑
1996	1,268	1,142	2,410	4.63↓	3,634,181	32.89↓
1997	1,652	1,188	2,840	17.84↑	4,230,393	16.41↑
1998	1,870	1,137	3,007	5.88↑	3,810,711	9.92↓
1999	1,887	1,096	2,983	0.80↓	3,025,845	20.60↓
2000	686	384	1,070		963,975	
	11,867	10,132	21,999		$33,614,917	

[2]Upward pointing arrows indicate the trend rate is increasing or getting worse and downward pointing arrows indicate that the trend rate is decreasing or getting better. For example, in 1993 the rate at which hospitals incorrectly reported patients discharged to home (code 01) dropped by 15.12 percent over 1992 and the overpayments made because hospitals incorrectly reported patients discharged to home when the patient went on to another PPS hospital declined by 5.34 percent. Percent of change omitted for 2000 because the period is incomplete.

SCHEDULE OF CODES USED TO INCORRECTLY REPORT PPS TRANSFERS
January 1,1992 through June 30, 2000
BY DISCHARGE CODE INCORRECTLY USED BY HOSPITALS

Code 04 Discharged/Transferred to an Intermediate Care Facility

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	317	458	775		$1,015,864	
1993	318	447	765	1.29↓	1,374,264	35.28↑
1994	290	489	779	1.83↑	1,798,283	30.85↑
1995	319	533	852	9.37↑	1,740,446	3.22↓
1996	485	455	940	10.33↑	1,439,154	17.31↓
1997	503	432	935	0.53↓	1,259,129	12.51↓
1998	532	404	936	0.11↑	1,131,368	10.15↓
1999	593	429	1,022	9.19↑	1,184,846	4.73↑
2000	248	177	425		478,259	
	3,605	3,824	7,429		$11,421,613	

Code 05 Discharged/Transferred to Another Type of Institution
(e.g., jails, supervised residential facilities)

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	3,618	4,994	8,612		$14,051,508	
1993	3,727	5,617	9,344	8.50↑	17,642,986	25.56↑
1994	2,777	4,565	7,342	21.43↓	15,730,901	10.84↓
1995	1,894	2,807	4,701	35.97↓	10,205,996	35.12↓
1996	2,270	2,136	4,406	6.28↓	7,503,408	26.48↓
1997	2,485	2,382	4,867	10.46↑	7,921,255	5.57↑
1998	2,234	1,963	4,197	13.77↓	6,619,490	16.43↓
1999	2,425	1,847	4,272	1.79↑	5,337,098	19.37↓
2000	1,006	694	1,700		1,944,544	
	22,436	27,005	49,441		$86,957,186	

SCHEDULE OF CODES USED TO INCORRECTLY REPORT PPS TRANSFERS
January 1,1992 through June 30, 2000
BY DISCHARGE CODE INCORRECTLY USED BY HOSPITALS

Code 06 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	425	237	662		$ 718,443	
1993	374	271	645	2.57↓	886,266	23.36↑
1994	343	285	628	2.64↓	769,953	13.12↓
1995	386	290	676	7.64↑	883,244	14.71↑
1996	499	261	760	12.43↑	668,542	24.31↓
1997	493	231	724	4.74↓	552,398	17.37↓
1998	514	213	727	0.41↑	483,363	12.50↓
1999	505	193	698	3.99↓	422,625	2.57↓
2000	163	83	246		166,627	
	3,702	2,064	5,766		$5,551,461	

APPENDIX C
Page 1 of 2

SCHEDULE OF OCCURRENCE WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

FI	Total Errors	Same FI Pay Both	Other FI Pay Receiving	Percent of Error When Second FI Involved
00010	3,786	2,948	838	22.13%
00011	2	0	2	100.00%
00020	1,262	712	550	43.58%
00030	2,891	1,690	1,201	41.54%
00040	8,842	5,690	3,152	35.65%
00050	138	67	71	51.45%
00060	1,044	700	344	32.95%
00070	718	163	555	77.30%
00090	8,683	6,026	2,657	30.60%
00101	4,312	3,325	987	22.89%
00121	4,003	2,725	1,278	31.93%
00123	3,882	3,260	622	16.02%
00130	4,723	3,770	953	20.18%
00131	624	380	244	39.10%
00140	1,844	1,375	469	25.43%
00150	1,901	1,451	450	23.67%
00160	4,159	3,251	908	21.83%
00180	1,032	846	186	18.02%
00181	538	368	170	31.60%
00190	1,152	849	303	26.30%
00200	2,430	1,885	545	22.43%
00210	3,299	2,923	376	11.40%
00220	1,523	917	606	39.79%
00230	4,428	2,806	1,622	36.63%
00231	1,663	1,197	466	28.02%
00241	384	281	103	26.82%
00250	356	228	128	35.96%
00260	691	326	365	52.82%
00270	1,152	724	428	37.15%
00280	9,137	6,403	2,734	29.92%
00290	594	377	217	36.53%
00308	6,128	4,055	2,073	33.83%

SCHEDULE OF OCCURRENCE WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

FI	Total Errors	Same FI Pay Both	Other FI Pay Receiving	Percent of Error When Second FI Involved
00310	2,976	2,312	664	22.31%
00320	604	373	231	38.25%
00332	3,168	2,467	701	22.13%
00340	1,643	1,317	326	19.84%
00350	1,385	1,110	275	19.86%
00351	214	58	156	72.90%
00362	1,669	555	1,114	66.75%
00363	4,531	3,113	1,418	31.30%
00370	1,018	796	222	21.81%
00380	1,774	1,124	650	36.64%
00390	2,855	1,536	1,319	46.20%
00400	3,303	1,837	1,466	44.38%
00401	48	28	20	41.67%
00410	751	658	93	12.38%
00423	4,554	2,378	2,176	47.78%
00430	2,273	1,332	941	41.40%
00450	2,494	2,142	352	14.11%
00452	1,767	1,199	568	32.14%
00453	267	70	197	73.78%
00460	342	130	212	61.99%
00468	1,120	910	210	18.75%
17120	170	124	46	27.06%
50333	1,759	222	1,537	87.38%
51051	3,156	371	2,785	88.24%
51070	615	324	291	47.32%
51100	234	0	234	100.00%
51140	626	41	585	93.45%
51390	2,001	915	1,086	54.27%
52280	18,576	4,398	14,178	76.32%
Totals	153,214	93,558	59,656	38.94%

SCHEDULE OF POTENTIAL OVERPAYMENTS WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

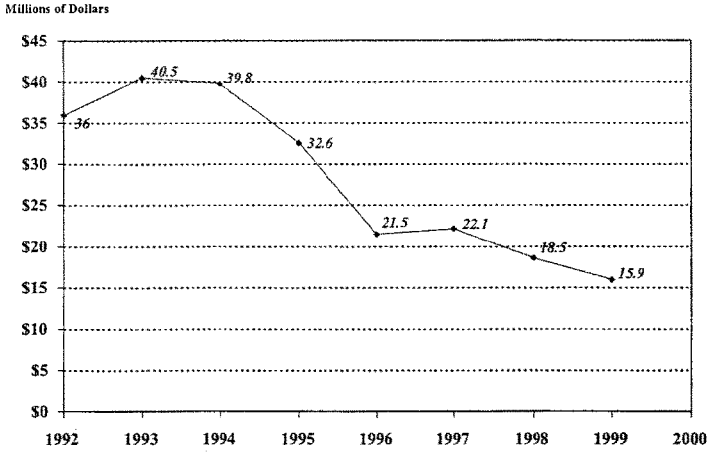
FI	Total Overpayments	Same FI Pay Both	Other FI Pay Receiving	Percent of Overpayment Two Intermediaries
00010	$ 4,537,017	$ 3,436,115	$ 1,100,902	24.26%
00011	506	0	506	100.00%
00020	1,580,716	796,061	784,655	49.64%
00030	4,976,125	3,040,607	1,935,518	38.90%
00040	20,266,406	12,777,687	7,488,719	36.95%
00050	208,849	82,056	126,793	60.71%
00060	1,372,821	951,509	421,312	30.69%
00070	1,038,719	212,295	826,424	79.56%
00090	13,928,578	9,774,730	4,153,848	29.82%
00101	5,190,046	4,030,698	1,159,348	22.34%
00121	8,009,711	6,047,634	1,962,077	24.50%
00123	6,597,420	4,475,860	2,121,560	32.16%
00130	7,361,136	6,134,672	1,226,464	16.66%
00131	732,520	473,574	258,946	35.35%
00140	1,990,349	1,508,990	481,359	24.18%
00150	2,546,773	1,843,420	703,353	27.62%
00160	5,523,113	4,210,255	1,312,858	23.77%
00180	1,431,941	1,125,035	306,906	21.43%
00181	855,673	530,015	325,658	38.06%
00190	2,796,382	1,531,131	1,265,251	45.25%
00200	4,376,506	3,305,572	1,070,934	24.47%
00210	5,208,578	4,530,187	678,391	13.02%
00220	2,657,692	1,417,014	1,240,678	46.68%
00230	4,602,492	2,903,022	1,699,470	36.92%
00231	2,809,490	2,102,856	706,634	25.15%
00241	720,629	433,500	287,129	39.84%
00250	480,916	296,841	184,075	38.28%
00260	831,934	464,035	367,899	44.22%
00270	1,802,441	1,067,143	735,298	40.79%
00280	9,461,983	6,369,592	3,092,391	32.68%
00290	1,213,726	714,669	499,057	41.12%
00308	7,820,756	5,583,603	2,237,153	28.61%

SCHEDULE OF POTENTIAL OVERPAYMENTS WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

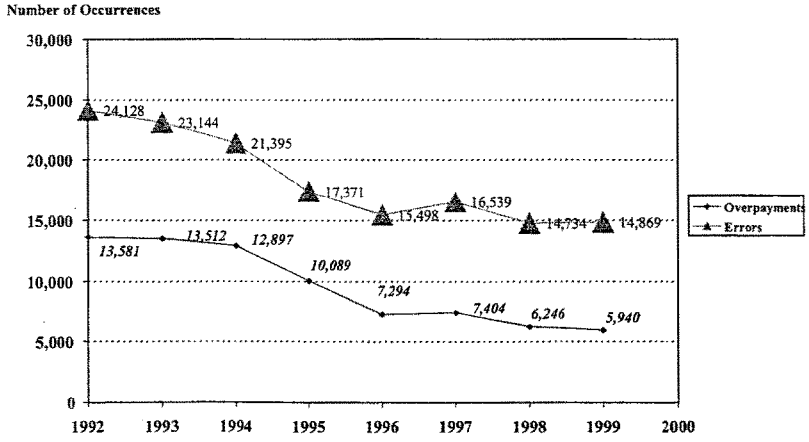
FI	Total Overpayments	Same FI Pay Both	Other FI Pay Receiving	Percent of Overpayment Two Intermediaries
00310	4,715,880	3,618,247	1,097,633	23.28%
00320	755,296	436,482	318,814	42.21%
00332	5,906,519	4,887,103	1,019,416	17.26%
00340	2,367,029	1,956,452	410,577	17.35%
00350	1,948,467	1,656,107	292,360	15.00%
00351	384,314	124,043	260,271	67.72%
00362	2,279,321	672,206	1,607,115	70.51%
00363	6,488,473	4,315,315	2,173,158	33.49%
00370	1,215,623	951,082	264,541	21.76%
00380	2,296,781	1,415,039	881,742	38.39%
00390	4,520,407	2,519,018	2,001,389	44.27%
00400	5,012,463	2,914,987	2,097,476	41.85%
00401	50,214	39,826	10,388	20.69%
00410	1,364,693	1,220,732	143,961	10.55%
00423	6,139,727	3,509,271	2,630,456	42.84%
00430	4,320,010	2,611,812	1,708,198	39.54%
00450	2,827,322	2,249,266	578,056	20.45%
00452	2,982,704	1,081,883	1,900,821	63.73%
00453	261,144	69,255	191,889	73.48%
00460	569,624	196,188	373,436	65.56%
00468	416,750	342,409	74,341	17.84%
17120	283,142	235,555	47,587	16.81%
50333	2,130,688	351,411	1,779,277	83.51%
51051	6,486,312	792,057	5,694,255	87.79%
51070	1,060,148	540,322	519,826	49.03%
51100	715,249	0	715,249	100.00%
51140	1,151,415	65,042	1,086,373	94.35%
51390	3,391,084	1,565,443	1,825,641	53.84%
52280	27,947,755	7,615,168	20,332,587	72.75%
Totals	$232,920,498	$140,122,099	$92,798,399	39.84%

APPENDIX E

Incorrectly Reported PPS Transfers
Overpayments Per Year
January 1, 1992 through December 31, 1999



Incorrectly Reported PPS Transfers
Number of Occurrences Per Year
January 1, 1992 through December 31, 1999



APPENDIX F
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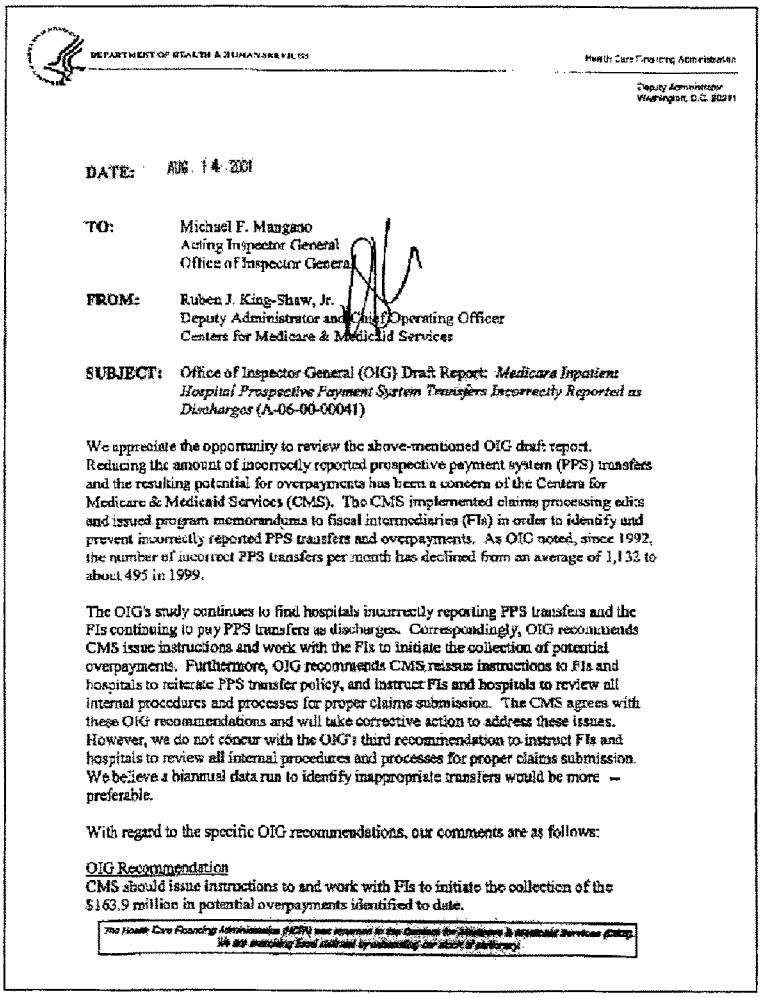

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 14 2001

TO: Michael F. Mangano
Acting Inspector General
Office of Inspector General

FROM: Ruben J. King-Shaw, Jr.
Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported as Discharges* (A-06-00-00041)

We appreciate the opportunity to review the above-mentioned OIG draft report. Reducing the amount of incorrectly reported prospective payment system (PPS) transfers and the resulting potential for overpayments has been a concern of the Centers for Medicare & Medicaid Services (CMS). The CMS implemented claims processing edits and issued program memorandums to fiscal intermediaries (FIs) in order to identify and prevent incorrectly reported PPS transfers and overpayments. As OIG noted, since 1992, the number of incorrect PPS transfers per month has declined from an average of 1,132 to about 495 in 1999.

The OIG's study continues to find hospitals incorrectly reporting PPS transfers and the FIs continuing to pay PPS transfers as discharges. Correspondingly, OIG recommends CMS issue instructions and work with the FIs to initiate the collection of potential overpayments. Furthermore, OIG recommends CMS reissue instructions to FIs and hospitals to reiterate PPS transfer policy, and instruct FIs and hospitals to review all internal procedures and processes for proper claims submission. The CMS agrees with these OIG recommendations and will take corrective action to address these issues. However, we do not concur with the OIG's third recommendation to instruct FIs and hospitals to review all internal procedures and processes for proper claims submission. We believe a biannual data run to identify inappropriate transfers would be more preferable.

With regard to the specific OIG recommendations, our comments are as follows:

OIG Recommendation

CMS should issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date.

[redacted]

Page 2- Michael F. Mangano

CMS Response
We concur. The CMS will initially limit the recovery period to the last 4 years in order to comply with the reopening period designated in regulations 42 CFR 405.750. The CMS will research the overpayment data beyond the 4 years to determine whether any of the overpayments qualify for recovery under the regulations. Additionally, CMS will issue a program memorandum directing the FIs to make recoveries for the last 4 years. We appreciate the OIG providing the FIs with the listing that identifies the coding errors and the corresponding overpayments.

OIG Recommendation
CMS should issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer.

CMS Response
We concur. We will issue an instruction to contractors reiterating our PPS transfer policy and ask that they include an educational article in their next provider bulletin reinforcing the need for proper coding procedures.

OIG Recommendation
CMS should instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

CMS Response
We agree with OIG that additional steps need to be taken to identify improperly reported hospital transfers. However, we do not agree with OIG's proposed solution. At the time FIs receive the "discharge claim" from the first facility, FIs do not know that a transfer has taken place. This information becomes apparent when the claim from the second facility is later received indicating a transfer, rather than a discharge. Thus, the FIs are only able to rectify these occurrences on a post-pay review basis.

We believe that it would be preferable and administratively more efficient for CMS to institute a process creating a biannual data run to identify the inappropriate transfers. The CMS will then forward identified claims to FIs for investigation, and, where appropriate, adjustment bills would be created by the FIs.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CHIROPRACTIC CARE

Controls Used by Medicare, Medicaid, and Other Payers

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1998
OEI-04-97-00490

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

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OEI's Atlanta Regional Office prepared this report under the direction of Jesse J. Flowers, Regional Inspector General and Christopher Koehler, Deputy Regional Inspector General. Principal OEI staff included:

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EXECUTIVE SUMMARY

PURPOSE

To describe how Medicare, Medicaid, and private insurers control chiropractic benefits.

BACKGROUND

The Balanced Budget Act of 1997 required the Health Care Financing Administration (HCFA) establish new utilization guidelines for Medicare chiropractic care by January 1, 2000. It also eliminated the X-ray requirement. In addition, New York recently enacted legislation requiring private insurers to include chiropractic coverage in their benefits packages.

We initiated two inspections to better understand the impact of these changes on the Medicare and Medicaid programs and to learn more about utilization controls. This report, "CHIROPRACTIC CARE: Controls Used by Medicare, Medicaid, and Other Payers, (OEI-04-97-00490)" describes Medicare, Medicaid, and private insurers' mechanisms for controlling expenditures and protecting the chiropractic benefit from potential waste and abuse. A companion report, "CHIROPRACTIC CARE: Medicaid Coverage, (OEI-06-97-00480)" describes current and expected chiropractic care benefits under State Medicaid programs.

Medicare, Medicaid, and private insurers do not consider control of chiropractic benefits a high priority or an area of major concern. All commented that more could be done to control utilization of the benefit but that resources are better spent controlling other more costly benefits.

FINDINGS

We found that Medicare, Medicaid, and private insurers rely on utilization caps, X-rays, physician referrals, co-payments, and post and prepayment reviews, in varying degrees, to control utilization of chiropractic benefits. Utilization caps are the most widely used, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments.

Utilization Caps Are the Most Widely Used Control Mechanisms

Ninety-five percent of Medicare and 46 percent of Medicaid programs use soft caps that can be exceeded with appropriate justification. Hard caps, which cannot be exceeded, are used by 50 percent of Medicaid programs and 94 percent of private insurers. Federal costs for Medicaid chiropractic benefits can exceed those for Medicare because Medicaid utilization caps are typically higher than those for Medicare.

X-rays Provide Little Control of Chiropractic Benefits

Few private insurers or Medicaid agencies require X-rays to document treatment necessity. Medicare currently requires X-rays; however, elimination of the X-ray requirement should have little impact on chiropractic controls since most contractors do not use X-rays as a control mechanism.

Physician Referral Is Commonly Used as a Control Mechanism for Managed Care, but Not for Fee-For-Service Plans

Sixty-eight percent of Medicaid and 66 percent of private managed care organizations used physician referrals to help control chiropractic utilization. However, only 8 percent of Medicaid and 9 percent of private fee-for-service plans required physician referrals. None of the Medicare fee-for-service plans required physician referrals.

Co-payments, Coinsurance, and Deductibles are Used to Help Control Chiropractic Benefits by Medicare and Private Insurers, but Not by Medicaid

Private insurers' co-payments ranged from $5 to $15 while Medicare coinsurance equaled 20 percent of approved charges. Both private insurers and Medicare used annual deductibles. Private insurers' deductibles ranged from $200 to $500 and Medicare's deductible equaled $100.

Prepayment Reviews Do Not Control Chiropractic Benefits

Medicare and Medicaid contractors typically do prepayment reviews, however, it is basically a forms verification process. For those claims that exceed the soft caps, Medicare and Medicaid medical necessity prepayment reviews are mostly paper audits.

Post Payment Reviews are Used by Medicaid, but Not by Medicare, to Help Control Chiropractic Benefits

Sixty-five percent of Medicaid contractors use post payment reviews to help control chiropractic utilization. Medicare contractors, however, rarely conduct post payment reviews of chiropractic claims.

Unauthorized Chiropractic Maintenance Treatments are Not Detected and Prevented

HCFA policies preclude Medicare reimbursements for chiropractic maintenance treatments. However, only 40 percent of Medicare respondents claimed to do utilization reviews to identify and prevent such treatments. Our analysis identified over $68 million in probable chiropractic maintenance treatments in 1996. If left unchecked, this could result in as much as $447 million in improper Medicare payments from 1998 through 2002.

RECOMMENDATIONS

This report describes controls used by Medicare, Medicaid, and other payers for chiropractic benefits. Utilization caps were the most widely used control mechanism. Needless to say, their intent is to limit the quantity of services. However, neither the utilization caps, nor any of the other controls, detected and prevented reimbursements for unauthorized Medicare chiropractic maintenance treatments.

Accordingly, we recommend that HCFA develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments. HCFA may do so by:

- requiring chiropractic physicians to use modifiers to distinguish the categories of the spinal joint problems (i.e. acute, exacerbation, recurrence, and chronic), and

- requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

COMMENTS

The HCFA Administrator, the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB) commented on our report. The full text of their comments are in appendix C.

The HCFA concurred with our recommendations. The Balanced Budget Act of 1997 required HCFA to develop utilization guidelines for chiropractic care. In developing such guidelines, HCFA will develop modifiers to distinguish categories of spinal joint problems, and utilization frequency edits as we recommended.

ASPE agreed that edits to identify inappropriate billings seemed desirable. However, ASPE commented that our use of "averages," on pages four through six, to summarize the range of utilization caps was inappropriate because they did not reflect "real practice." Our report provides the reader both the average utilization caps and the actual utilization caps for all Medicare and Medicaid respondents.

Further, ASPE suggested that more information is needed to substantiate two State Medicaid Administrators' claims that physician referrals are effective controls for chiropractic services. Specifically, ASPE wanted to know how these States measured effectiveness. Additionally, ASPE noted that it would be helpful to know how the use of chiropractic services is distributed between managed care and fee-for-service providers. These questions were not part of the scope of this study. However, we plan to continue our analysis of chiropractic services and utilization in the future. These and other questions are likely topics for inclusion in future analysis.

ASMB expressed serious concerns about the methodology we used to estimate payments for probable inappropriate chiropractic maintenance treatments. Specifically, ASMB was concerned about our use of a 10 percent estimate to represent the Medicare population who received

chiropractic care for chronic conditions. The 10 percent estimate, furnished by the American Chiropractic Association, is a universal percentage estimate of the population at large. Demographic data and specific analysis is not available to differentiate between the Medicare population and the population at large. However, we contacted several Medicare Carrier Medical Directors who stated, based on their reviews of Medicare chiropractic claims, that the 10 percent appeared to be a reasonable estimate for the Medicare population.

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INTRODUCTION

PURPOSE

To describe how Medicare, Medicaid, and private insurers control chiropractic benefits.

BACKGROUND

Chiropractic Treatment

Chiropractic treatment is becoming more commonplace with consumers, and gaining wider acceptance in the medical profession. Chiropractors treat neuromusculoskeletal disorders and related functional clinical conditions including, but not limited to, back pain, neck pain and headaches. Chiropractic care is most commonly sought for treatment of back pain. Back pain is one of the most common and costly problems affecting adults. An estimated 50 percent of adults experience back pain each year and almost 20 percent have frequent back pain.

A common chiropractic treatment for low back pain is spinal manipulation. Chiropractors use either their hands or hand held devices to perform manual spinal manipulations. Manual manipulations are most commonly performed to correct a subluxation of the spine. According to chiropractic theory, a subluxation is an incomplete dislocation, off centering, misalignment, fixation or abnormal spacing of vertebrae or intervertebral units. The Department of Health and Human Services, Agency for Health Care Policy and Research, has documented spinal manipulation to be a recommendable method of symptom control for low back pain in adults.[1]

Growth in Number of Chiropractors

The chiropractic profession is licensed in all States and the District of Columbia. All licensed chiropractors are entitled by law to use either the title doctor of chiropractic or chiropractic physician. Approximately 55,000 chiropractors actively practice today, while less than 14,000 existed in 1970, according to the U.S. Census. The number of chiropractors has outgrown the U.S. population by three-fold. In 1970, almost seven chiropractors practiced per 100,000 U.S. residents. By 1997, this had increased to over 20 chiropractors per 100,000 residents.

Medicare Chiropractic Eligibility

In 1965, title XVIII of the Social Security Act created Medicare to provide health insurance for people 65 and over, people who are disabled, and persons with permanent kidney failure. Medicare has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). In 1972, Section 273 of the Social Security Amendment (P.L. 92-603) expanded the definition of physician under Part B of Medicare to include chiropractors. This made chiropractors eligible to participate

[1] Agency for Health Care Policy and Research, Pub No. 95-0642, December 1994, Acute Low Back Problems in Adults

in the Medicare program. However, the only Medicare reimbursable chiropractic treatment is manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

Medicaid Chiropractic Eligibility

In 1965, title XIX of the Social Security Act created Medicaid as a program to provide medical assistance for certain individuals and families with low incomes and resources. This program is jointly funded by the Federal and State governments. Within broad Federal guidelines each State (1) establishes its own eligibility standards, (2) sets the type, amount, duration, and scope of services, (3) establishes rate of payment for services, and (4) administers the program.

In 1972, when chiropractors were recognized as physicians and became eligible to participate in Medicare, chiropractors also became eligible to participate in Medicaid. Under Medicaid, however, chiropractic services are not a mandatory benefit, but rather an optional service. Therefore, it is within each State's discretion whether to include chiropractic services in their Medicaid program. If offered, each State also establishes its own levels of services. However, according to Federal policy for Medicaid, chiropractic services should be limited to manual manipulation of the spine and X-ray services. Currently, 30 State Medicaid fee-for-service programs offer chiropractic services.

Private Insurers Chiropractic Benefits

Many private insurers now offer chiropractic benefits. The scope of chiropractic services are consumer driven. We found insurance plans ranging from no chiropractic coverage to substantial chiropractic coverage. Several insurers stated that they view the chiropractic benefit as a service they must provide to remain competitive. Moreover, they expect users of chiropractic services to "max-out" the benefit each year.

Chiropractic Controls

The Balanced Budget Act of 1997 required the Health Care Financing Administration (HCFA) establish new utilization guidelines for Medicare chiropractic care by January 1, 2000. It also eliminated the X-ray requirement. In addition, New York recently enacted legislation requiring private insurers to include chiropractic coverage in their benefits packages.

We initiated two inspections to better understand the impact of these changes on the Medicare and Medicaid programs and to learn more about utilization controls. This report, "CHIROPRACTIC CARE: Controls Used by Medicare, Medicaid, and Other Payers, (OEI-04-97-00490)" describes Medicare, Medicaid, and private insurers' mechanisms for controlling expenditures and protecting the chiropractic benefit from potential waste and abuse. A companion report, "CHIROPRACTIC CARE: Medicaid Coverage, (OEI-06-97-00480)" describes current and expected chiropractic care benefits under State Medicaid programs.

Medicare, Medicaid, and private insurers all use a variety of mechanisms to help control their chiropractic benefit. However, most did not consider control of this benefit a high priority or an

area of major concern. In fact, over 50 percent of Medicare and 60 percent of Medicaid respondents considered the chiropractic benefit to be a small part of their overall programs. Both Medicare contractors and State Medicaid agencies commented that more could be done to control utilization of the chiropractic benefit, but that resources are currently better spent controlling other more costly benefits. Also, private insurers were not concerned with controlling utilization, but it was because of their strict utilization caps rather than the size of the benefit.

SCOPE AND METHODOLOGY

We surveyed Medicare contractors, Medicaid agencies, and private insurers. More specifically, we surveyed:

- all Medicare fee-for-service Part B contractors,
- the 10 largest, by number of enrollees, Medicare managed care organizations from 10 different States,
- all 50 State Medicaid agencies, and the District of Columbia (each were sent a two-part survey - one for their fee-for-service contractors and one for their largest, by number of enrollees, managed care organizations), and
- twenty private insurers (10 judgmentally selected Federal employee health benefit plans, and benefit managers for the 10 largest, by number of employees, private sector companies).

In instances where respondents did not answer every survey question, our percentages are based on the number who responded.

In addition to the surveys, we did on-site evaluations of one Medicare fee-for-service contractor, one Medicare managed care organization, two Medicaid fee-for-service contractors, and three Medicaid managed care organizations. Moreover, we interviewed officials with the Indiana Chiropractic Association, the American Chiropractic Association, and the Carrier Medical Director Chiropractic Clinical Workgroup.

Finally, we used a 1 percent sample of HCFA's 1996 National Claims History data to determine if Medicare contractors paid claims in accordance with HCFA policies, and to quantify the extent of chiropractic utilization. Appendix A further details our scope and methodology.

- - - -

We conducted our inspection between October 1997 and December 1997. We conducted this inspection in accordance with *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

We found that Medicare, Medicaid, and private insurers use a variety of techniques to control utilization of chiropractic benefits. Allowable chiropractic benefits vary in both quantity and type of treatments. Along with varying benefits come varying controls. Typical controls include utilization caps, X-rays, physician referrals, co-payments, and post and prepayment reviews. Utilization caps are the most widely used, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments.

UTILIZATION CAPS ARE THE MOST WIDELY USED CONTROL MECHANISMS

Limiting the number of visits by establishing utilization caps was the most widely used control mechanism reported by all groups surveyed. A companion report on chiropractic benefits for Medicaid beneficiaries discusses benefits, treatment limits, and exceptions in detail (Chiropractic Care: Medicaid Coverage, OEI-06-97-00480).

Utilization caps are most commonly broken down into two separate types - soft caps and hard caps.

Soft caps are established service limits that can be exceeded with appropriate justification. For example, one such justification would be documentation that a beneficiary has aggravated an existing condition.

Hard caps, as the name implies, are concrete service limits or dollar amounts that cannot be exceeded for any reason within a specified time frame.

Table 1 shows the average soft and hard utilization caps for respondents included in our survey.

TABLE 1
AVERAGE SOFT AND HARD UTILIZATION CAPS

	MEDICARE	MEDICAID	PRIVATE
SOFT CAPS	21	28	N/A
HARD CAPS	N/A	104	27

Ninety-five Percent of Medicare and 46 Percent of Medicaid Programs Use Soft Caps

Ninety-five percent (52 of 55) of all Medicare survey respondents said they use soft caps. The soft caps ranged from 11 to 52 treatments per year, with 12 treatments being the most common. On average, the Medicare respondents used a soft cap of 21 treatments. Table 2 shows chiropractic soft caps used by the Medicare respondents included in our survey.

TABLE 2 MEDICARE CHIROPRACTIC SOFT CAPS TREATMENTS PER YEAR													
# Treatments	11	12	18	22	24	28	29	30	40	46	48	51	52
Respondents	1	29	3	1	4	3	1	1	2	1	2	1	3

HCFA requires all Medicare contractors to establish soft caps. Each contractor, however, determines the level of the cap (i.e. the number of treatments). HCFA further requires all Medicare contractors to evaluate the effectiveness of their caps on a quarterly basis. Based on these evaluations, HCFA granted 5 percent (3 of 55) of its contractors permission to deactivate their chiropractic caps. The three contractors documented that their soft caps were not cost effective. Instead, they now focus on post payment reviews to identify aberrant providers.

Forty-six percent (12 of 26) of States that provide chiropractic benefits reported using soft caps. The soft caps ranged from 1 to 80 treatments per year, with the average being 28 treatments. Table 3 shows chiropractic soft cap limits used by State Medicaid Agencies.

TABLE 3 MEDICAID CHIROPRACTIC SOFT CAPS TREATMENTS PER YEAR											
# Treatments	1	6	10	12	18	20	24	30	48	60	80
Respondents	1	1	1	1	1	1	2	1	1	1	1

Fifty Percent of Medicaid Programs and 94 Percent of Private Insurers Use Hard Caps

Half (13 of 26) of the States that provide chiropractic benefits reported using hard caps to control their Medicaid chiropractic benefits. The hard caps ranged from 12 to 365 treatments per year. The average hard cap is 104 treatments, however, this includes three States that allow one treatment per day. Excluding these three States, the average Medicaid hard cap is 29 treatments. Table 4 shows the chiropractic hard caps used by State Medicaid agencies.

TABLE 4 MEDICAID CHIROPRACTIC HARD CAPS TREATMENTS PER YEAR								
# Treatments	12	18	20	24	25	50	56	365
Respondents	2	1	1	3	1	1	1	3

Ninety-four percent (16 of 17) of private insurers relied on hard caps to control benefit utilization. The 16 private insurers used 11 utilization caps and 5 financial caps. The utilization caps ranged from 12 to 60 treatments per year, with the average being 27 treatments. Table 5 shows the chiropractic utilization hard caps used by private insurers.

TABLE 5

PRIVATE CHIROPRACTIC UTILIZATION HARD CAPS: TREATMENTS PER YEAR

# Treatments	12	20	24	25	26	30	40	60
Respondents	2	2	1	1	1	2	1	1

The financial caps, used by private insurers, ranged from $225 to $2,000 per year, with the average being $1,035. Table 6 shows the chiropractic financial hard caps used by private insurers.

TABLE 6

PRIVATE CHIROPRACTIC FINANCIAL HARD CAPS: TREATMENTS PER YEAR

$ Cap	$225	$250	$700	$2000
Respondents	1	1	1	2

Federal Costs for Medicaid Chiropractic Benefits Can Exceed That for Medicare

Twenty-six States offer Medicaid chiropractic benefits. However, we limited our comparative analysis of Medicaid and Medicare Federal costs for chiropractic benefits to 24 States. We did so because one State did not have a Medicaid utilization cap and the Medicare contractor in another State did not have a utilization cap.

The Federal reimbursement rates and cost per treatment rates for Medicaid chiropractic treatments are typically lower than they are for Medicare. Medicaid Federal matching reimbursement rates for the 24 States ranges from 50 percent to over 73 percent with 60 percent being the average. This is lower than Medicare, where Federal costs are 80 percent of allowed charges. Likewise, the average Federal cost for Medicaid manual manipulations of the spine is only $8.92, but for Medicare the average Federal cost is $18.92.

However, overall Medicaid Federal costs for chiropractic services can exceed the cost for such services paid for by Medicare. This is because Medicaid's utilization caps are significantly higher than Medicare's. Sixty-seven percent (16 of 24) of States offering chiropractic care through their Medicaid fee-for-service programs have higher utilization caps than Medicare. In one State, for example, the Medicare utilization cap is 12 treatments per year while the Medicaid utilization cap is 50 treatments.

Medicaid's average utilization cap for the 24 States is 71 treatments per year, whereas Medicare's average utilization cap is only 19 treatments per year. Federal costs, at the maximum utilization cap for Medicaid chiropractic benefits, average $554 per person, whereas in Medicare it is only $365 per person.

X-RAYS PROVIDE LITTLE CONTROL OF CHIROPRACTIC BENEFITS

Few Medicaid Agencies and Private Insurers Require X-rays to Document Treatment Necessity

Thirty-one percent (8 of 26) of Medicaid programs require X-rays. However, 58 percent (15 of 26) of Medicaid programs will reimburse chiropractors for X-rays.

Only 12 percent (2 of 17) of private insurers require X-rays to ensure appropriateness of chiropractic claims.

Elimination of the X-ray Requirement Should Have Little Impact on Chiropractic Controls since Most Medicare Contractors Do Not Use X-rays as a Control Mechanism

Seventy-eight percent (43 of 55) of Medicare respondents claimed X-rays were not essential for ensuring the appropriateness of chiropractic claims. They said chiropractic benefit control would not be affected by the Balanced Budget Act of 1997, which eliminates the X-ray requirement by the year 2000. Several respondents commented that they do not use X-rays, but rather they compare diagnosis with treatment plans to determine appropriateness of treatments.

The remaining 22 percent (12 of 55) said elimination of the X-ray requirement would impact their ability to verify spinal subluxations.

PHYSICIAN REFERRAL IS COMMONLY USED AS A CONTROL MECHANISM FOR MANAGED CARE, BUT NOT FOR FEE-FOR-SERVICE PLANS

Physician Referral Is Common for Managed Care Plans

In 68 percent (15 of 22) of Medicaid managed care organizations and 66 percent (4 of 6) of private managed care organizations, physician referrals are required to obtain chiropractic care. According to the American Chiropractic Association, this common managed care gatekeeper practice restricts access to chiropractic care.

Private insurers typically use physician referrals in conjunction with hard caps to control chiropractic utilization. Only one private insurer used physician referrals as its only control mechanism.

Few Fee-For-Service Programs Require Physician Referral

Overwhelmingly, Medicare, Medicaid, and private insurers allow direct access to chiropractors without a physician referral. No Medicare fee-for-service program required physician referral for access to chiropractors.

Only 8 percent (2 of 26) of Medicaid fee-for-service programs require physician referrals to access chiropractic services. The two Medicaid programs that do require physician referrals, however, said physician referral is a very effective control mechanism. It allows primary care physicians to monitor and coordinate clients' health care needs.

About 9 percent (1 of 11) of private fee-for-service insurers require physician referrals to access chiropractic services.

CO-PAYMENTS, COINSURANCE, AND DEDUCTIBLES ARE USED TO HELP CONTROL CHIROPRACTIC BENEFITS BY MEDICARE AND PRIVATE INSURERS, BUT NOT BY MEDICAID

Medicare and private insurers require co-payments, coinsurance, or deductibles. Medicaid programs, however, typically do not require co-payments, coinsurance, or deductibles.

A co-payment is a set amount beneficiaries must pay when they visit a physician. The private insurers in our survey had co-payments ranging from $5.00 to $15.00 per chiropractic treatment. These co-payments are common in both managed care and fee-for-service plans.

Coinsurance is the percentage of medical expenses for which a patient is responsible. For Medicare Part B services, coinsurance equals 20 percent of approved charges.

A deductible is the amount a beneficiary must pay before a health plan begins payment for covered services. Medicare has a $100 annual deductible for Part B services, including chiropractic treatments. Private insurers' yearly deductibles ranged from $200 to $500 per year. These deductibles applied to all physician services, including chiropractic care.

Medicaid fee-for-service programs required co-payments in only three States. These co-payments ranged from 50 cents to $2.00 per chiropractic visit. Likewise, only one Medicaid managed care organization responded that a co-payment was required -- $1.00 per visit.

Such patient cost sharing may be important when considering how best to control chiropractic utilization. A study by the Agency for Health Care Policy and Research suggests that the actual out-of-pocket expense a patient incurs greatly affects their use of chiropractic services.[2] To illustrate, the study shows that when patients have to share 25 percent or more of the cost, they decrease their chiropractic usage by half.

PREPAYMENT REVIEWS DO NOT CONTROL CHIROPRACTIC BENEFITS

[2] Agency for Health Care Policy and Research, Pub No. HS06920, 1996, The Affect of Cost Sharing on the Use of Chiropractic Services

Medicare and Medicaid Contractors Typically Do Prepayment Reviews, However, it Is Basically a Forms Verification Process

All Medicare and Medicaid contractors conduct prepayment reviews. However, the reviews are merely computerized edits or manual reviews to ensure that claim forms are properly completed. The level of prepayment review for Medicare and Medicaid is similar and usually includes the following edits:

- appropriate procedure codes,
- appropriate diagnosis codes,
- date of X-ray,
- date of first treatment falling within a specified time period of the X-ray date,
- appropriate physician identification number, and
- no more than one treatment per day.

Medicare and Medicaid Prepayment Reviews for Medical Necessity Are Paper Audits

Medicare and Medicaid policies require that all services be medically necessary. However, Medicare and Medicaid contractors generally do not verify the medical necessity of chiropractic treatments.

Medicare and Medicaid contractors, for example, typically review claims for medical necessity only if they exceed their soft caps. One Medicare contractor's policy states "services exceeding more than what Medicare allows, in a given time frame, are subject to review for medical necessity." Another commented that "we review every claim for medical necessity that exceeds the cap." A Medicaid agency said "medical necessity must be documented in order to receive additional treatments (beyond the utilization cap)."

Medical necessity reviews in excess of the caps, however, are paper audits. Contractors typically determine medical necessity by verifying that a claim form was completed properly. They verify that the diagnosis codes are from the approved list. In addition, they verify that comments, such as "aggravated existing condition," are on the claim form. In effect, such reviews are "check the appropriate box" edits, and not verification that services are truly medically necessary. Patient records and other documentation of medical necessity are typically not reviewed.

POST PAYMENT REVIEWS ARE USED BY MEDICAID, BUT NOT BY MEDICARE, TO HELP CONTROL CHIROPRACTIC BENEFITS

Medicaid Contractors Use Post Payment Reviews to Help Control Chiropractic Utilization

Sixty-five percent (17 of 26) of State Medicaid fee-for-service agencies monitor and control chiropractic claims using post payment reviews. The reviews are typically limited to quarterly

Surveillance and Utilization Review Surveys. Such reviews identify aberrant providers. Three States said they do not do more extensive individual reviews due to the small nature of the chiropractic program and the limited number of problem claims found in the past.

Medicare Contractors Rarely Conduct Post Payment Reviews of Chiropractic Claims

HCFA policy requires Medicare contractors to conduct focused medical reviews and comprehensive medical reviews. A focused review is a treatment specific audit, whereas a comprehensive review is a provider specific audit. It is up to the contractors to determine which benefits to review. All Medicare respondents conduct these reviews, however, most had focused little to no activity on chiropractic benefits since 1994.

Eighteen percent (10 of 55) of Medicare respondents claimed to conduct focused reviews of chiropractic benefits. Since 1994, three of the 10 respondents claimed to have saved about $759,000 as a result of focused reviews. However, of the respondents, one accounted for over 99 percent of those savings. The remaining seven respondents conducted, on average, less than two focused reviews per year.

Thirty-six percent (20 of 55) of Medicare respondents claimed to conduct comprehensive reviews of chiropractic benefits. Ten respondents claimed their comprehensive reviews resulted in financial savings totaling about $330,500. However, one of the respondents accounted for about 71 percent of those savings. The remaining respondents conducted varying numbers of reviews resulting in such things as educational efforts and a couple of fraud referrals.

UNAUTHORIZED CHIROPRACTIC MAINTENANCE TREATMENTS ARE NOT DETECTED AND PREVENTED

According to HCFA policy,[3] chiropractic maintenance treatments are not authorized for payment. However, our analysis of a 1 percent sample of HCFA's National Claims History database showed that in 1996, Medicare likely paid for 28,889 chiropractic maintenance treatments. These inappropriate maintenance treatments cost Medicare $688,821. This projects to over $68 million for the Medicare program in 1996. Projected over five years, Medicare reimbursements for unauthorized chiropractic maintenance treatments is about $447 million.

Chiropractic Coverage Policies

HCFA's Medicare Carrier Manual identifies treatment of acute and chronic subluxations as Medicare reimbursable conditions. Maintenance treatments, however, are not a covered service.

HCFA and local carrier policies, and Agency for Health Care Policy and Research guidelines, show that chiropractic treatment for acute conditions should consist of intense treatments early on with additional treatments tapering off quickly. To illustrate, the HCFA approved Medicare Part

[3] HCFA Medicare Carrier Manual, section 2251.1

B Model Local Medical Review Policy for Chiropractic Service calls for "vigorous therapy" the first month, "less vigorous therapy" the second month, and finally, "minimum therapy" of up to four treatments the third month.

However, HCFA and local carrier policies allow chiropractic treatment for chronic conditions. Such conditions require less frequent treatments than acute conditions. A patient's condition is considered chronic if it has existed for an extended period of time. A chronic condition is not expected to be completely resolved, but continued chiropractic therapy is expected to result in some functional improvement. Hence, chiropractic treatments may need to extend over long periods.

On the surface, it seems difficult to distinguish between unauthorized chiropractic maintenance treatments and authorized treatments for chronic conditions. The treatment patterns are similar. Unauthorized chiropractic maintenance treatments are generally indicated by consecutive months of minimal therapy of four treatments or less. Likewise, authorized chiropractic treatments for chronic conditions are generally indicated by four or fewer treatments per month for an extended time period.

It is possible, however, to distinguish between the two. To illustrate, a utilization frequency analysis of chiropractic treatments will enable carrier staff to identify potential unauthorized maintenance treatments. However, some of these treatments could be for authorized chronic conditions. Therefore, carrier staff must also review individual claims documentation to identify treatments for chronic conditions. Beneficiary symptoms and chiropractor diagnosis are two pieces of claims information that allow carrier staff to distinguish between treatments for chronic conditions and maintenance.

Estimated Medicare Reimbursement for Maintenance Treatments

To estimate potential unauthorized Medicare reimbursements for chiropractic maintenance treatments, we conducted a utilization frequency analysis of chiropractic treatments in 1996. Thereafter, we adjusted our findings to exclude possible treatments for chronic conditions. In making the adjustment, we did not review individual claims, but rather we used an estimate on the extent of chronic conditions nationwide.

We based our utilization frequency analysis on a 1 percent sample of HCFA's 1996 National Claims History file. We used the local model policy criteria of minimum therapy of four treatments or less in the third and final month of treatment. We then identified beneficiaries with treatment utilization of two or more consecutive months of minimum therapy. This analysis identified beneficiaries who received either maintenance or chronic chiropractic treatments (see appendix A for additional information on our methodology).

HCFA data files did not distinguish between treatments for acute or chronic conditions. Therefore, we adjusted our findings by deleting chiropractic treatments for possible chronic conditions. To do so, we used information provided by the American Chiropractic Association. That research showed that 10 percent of chiropractic conditions are chronic. After eliminating

beneficiaries with chronic conditions from our analysis, we concluded that 7,594 Medicare beneficiaries received 28,889 probable unauthorized maintenance treatments at a cost of $688,821. Table 7 summarizes maintenance treatments in 1996.

TABLE 7
NUMBER OF MEDICARE BENEFICIARIES RECEIVING UP TO FOUR CHIROPRACTIC TREATMENTS DURING TWO OR MORE CONSECUTIVE MONTHS IN 1996

# Beneficiaries	# Consecutive Months	Probable Maintenance Treatments	Allowed Amounts
3,298	2	5,259	$125,058
1,486	3	4,370	$104,321
855	4	3,545	$84,788
563	5	3,090	$74,388
348	6	2,256	$53,751
247	7	1,881	$45,103
187	8	1,585	$37,462
128	9	1,204	$28,298
138	10	1,504	$36,012
88	11	962	$23,356
256	12	3,233	$76,284
7,594		28,889	$688,821

Our findings in Table 7 are based on a 1 percent sample, therefore, we projected them to the Medicare population. We concluded that 759,400 Medicare beneficiaries received 2,888,900 probable chiropractic maintenance treatments at a cost to the Medicare program of $68,882,100. Assuming chiropractic reimbursements continue to increase by 6.87 percent per year, Medicare reimbursements for unauthorized chiropractic maintenance treatments, over a five year window (1998-2002), would be about $447 million.

At the request of HCFA officials, we included the above information, broken out by State, in appendix B.

RECOMMENDATIONS

This report describes controls used by Medicare, Medicaid, and other payers for chiropractic benefits. Utilization caps were the most widely used control mechanism. Needless to say, their intent is to limit the quantity of services. However, neither the utilization caps, nor any of the other controls, detected and prevented reimbursements for unauthorized Medicare chiropractic maintenance treatments.

Accordingly, we recommend that HCFA develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments. HCFA can do so by:

- requiring chiropractic physicians to use modifiers to distinguish the categories of the spinal joint problems (i.e. acute, exacerbation, recurrence, and chronic), and

- requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

COMMENTS

The HCFA Administrator, the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB) commented on our report. The full text of their comments are in appendix C.

The HCFA concurred with our recommendations. The Balanced Budget Act of 1997 required HCFA to develop utilization guidelines for chiropractic care. In developing such guidelines, HCFA will develop modifiers to distinguish categories of spinal joint problems, and utilization frequency edits as we recommended.

ASPE agreed that edits to identify inappropriate billings seemed desirable. However, ASPE commented that our use of "averages," on pages four through six, to summarize the range of utilization caps was inappropriate because they did not reflect "real practice." Our report provides the reader both the average utilization caps and the actual utilization caps for all Medicare and Medicaid respondents.

Further, ASPE suggested that more information is needed to substantiate two State Medicaid Administrators' claims that physician referrals are effective controls for chiropractic services. Specifically, ASPE wanted to know how these States measured effectiveness. Additionally, ASPE noted that it would be helpful to know how the use of chiropractic services are distributed between managed care and fee-for-service providers. These questions were not part of the scope of this study. However, we plan to continue our analysis of chiropractic services and utilization in the future. These and other questions are likely topics for inclusion in future analysis.

ASMB expressed serious concerns about the methodology we used to estimate payments for probable inappropriate chiropractic maintenance treatments. Specifically, ASMB was concerned about our use of a 10 percent estimate to represent the Medicare population who received chiropractic care for chronic conditions. The 10 percent estimate, furnished by the American Chiropractic Association, is a universal percentage estimate of the population at large. Demographic data and specific analysis is not available to differentiate between the Medicare population and the population at large. However, we contacted several Medicare Carrier Medical Directors who stated, based on their reviews of Medicare chiropractic claims, that the 10 percent appeared to be a reasonable estimate for the Medicare population. Additionally, HCFA's implementation of our recommendations will produce demographic data needed to more precisely differentiate chiropractic chronic care use by Medicare beneficiaries.

APPENDIX A

SCOPE AND METHODOLOGY

Medicare

We had 55 responses to the Medicare fee-for-service survey. We received responses for all 50 States. The additional five responses are detailed in Table 1.

TABLE 1
MEDICARE RESPONSES

	# of responses
50 States	50
California - serviced by 2 contractors	1
Missouri - serviced by 2 contractors	1
New York - serviced by 3 contractors	2
District of Columbia	1
Total	55

Medicaid

Our sample population consisted of 26 State fee-for-service programs that offered a chiropractic benefit to the majority of their Medicaid population. Although 30 State fee-for-service programs reported offering some type of chiropractic service to Medicaid beneficiaries, four States only offered a very limited benefit to children as part of their Early and Periodic Screening, Diagnostic and Treatment program. Due to the limited scope of those four programs, we excluded them from our sample.

Although we surveyed both State Medicaid fee-for-service and managed care programs, for the purposes of this study we limited our primary Medicaid focus to those 26 State programs offering a chiropractic benefit through the traditional fee-for-service environment. Observations made regarding State Medicaid managed care programs will be noted by specifically referring to that group.

Utilization Caps

Seven Medicare utilization caps and nine State Medicaid utilization caps are based on time periods other than one year. For such States, we annualized their utilization caps accordingly. For example, one State reported a utilization cap of 76 treatments in 540 days. Annualized, the cap is 51 treatments.

Probable Maintenance Treatments

To identify probable maintenance treatments we took several steps. First, we used a 1 percent sample of HCFA's 1996 National Claims History file and identified 13,974 Medicare beneficiaries who received 122,047 chiropractic treatments at a cost of $2,937,668. Next we did a utilization frequency analysis of this data and identified 8,990 beneficiaries with two or more consecutive months of minimal therapy (1-4 treatments). These beneficiaries received 41,094 chiropractic treatments at a cost of $982,588. We considered this subpopulation to be receiving unauthorized maintenance treatments or treatments for chronic conditions.

In order to account for the chronic conditions, we used information provided by the American Chiropractic Association that showed that 10 percent of chiropractic conditions are chronic. To be conservative, we assumed that the full 10 percent of chronic conditions were included in our sample. Therefore, we took 10 percent of the 1 percent figures and subtracted them from our subpopulation figures. For example, we took 10 percent of the $2,937,668 and subtracted it from our subpopulation treatment costs of $982,588. This resulted in probable unauthorized maintenance charges, adjusted for chronic conditions, of $688,821.

We used the same process to reduce the number of beneficiaries to 7,594 and the number of chiropractic treatments to 28,889. Since these numbers are based on a 1 percent sample, we project them to the Medicare population to conclude that 759,400 Medicare beneficiaries received 2,888,900 probable chiropractic maintenance treatments at a cost to the Medicare program of $68,882,100.

Using Part B Extract and Summary System data for 1994 through 1997, we calculated the growth in Medicare chiropractic payments. This growth averaged 6.87 percent per year. We then used this growth rate to predict reimbursements for maintenance treatments for 1998 through 2002. Accepting that the $68.8 million in maintenance costs for 1996 would continue to go unchecked, and applying the 6.87 percent average growth, Medicare reimbursements for chiropractic maintenance treatments can cost in excess of $447 million from 1998 through 2002.

Private Insurers

Of the 20 private insurers surveyed, 10 were judgmentally selected Federal employee health benefit plans, and the other 10 were benefit managers for the largest, by number of employees, private sector companies.

All 10 Federal employee plans responded, two of which had both a "high" and a "standard" option. Therefore, we have 12 Federal employee plan responses.

Seven of the 10 private sector companies responded, two of which offered both fee-for-service and managed care plans. Therefore, we have 9 private sector company responses.

Combined, we received 21 private insurer responses to our chiropractic survey. However, four private insurers did not offer chiropractic benefits. Therefore, we based our analysis on the 17 private insurers that offered chiropractic benefits.

We included private insurers in our inspection for comparison purposes. We do not attempt to generalize to the private insurance population.

APPENDIX B

PROBABLE MAINTENANCE CHARGES					
STATE	TOTAL CHIROPRACTIC TREATMENTS	TOTAL ALLOWED CHARGES	MAINTENANCE TREATMENTS	ALLOWED MAINTENANCE CHARGES	MAINTENANCE CHARGES AS % OF ALLOWED CHARGES
NH	413	$9,902	147	$3,577	36.1%
DC	59	$1,586	20	$540	34.0%
IA	5,802	$130,193	1,975	$44,109	33.9%
VT	333	$7,889	111	$2,583	32.7%
SD	784	$17,343	231	$5,085	29.3%
MI	6,994	$175,359	2,019	$50,296	28.7%
MO	2,671	$58,477	756	$16,440	28.1%
GA	2,654	$63,211	745	$17,662	27.9%
DE	312	$7,863	85	$2,129	27.1%
MA	2,059	$53,678	545	$14,147	26.4%
OH	4,685	$111,027	1,232	$28,650	25.8%
ND	858	$19,600	221	$5,037	25.7%
AZ	2,415	$60,058	618	$15,285	25.5%
PA	7,340	$178,658	1,869	$45,255	25.3%
IL	6,739	$156,487	1,719	$39,517	25.3%
ME	1,035	$25,737	259	$6,471	25.1%
NM	349	$8,036	86	$1,990	24.8%
UT	512	$12,093	127	$2,973	24.6%
VA	1,878	$44,046	456	$10,449	23.7%
KY	1,213	$25,875	292	$6,065	23.4%
OR	1,598	$37,751	377	$8,834	23.4%
IN	2,277	$50,692	535	$11,758	23.2%
WA	3,635	$90,893	841	$21,081	23.2%
CA	8,133	$208,445	245	$47,839	23.0%
CO	1,059	$25,343	1,881	$5,818	23.0%
CT	1,237	$33,982	281	$7,762	22.8%
WY	223	$5,114	51	$1,160	22.7%
NY	7,988	$210,107	1,833	$47,299	22.5%
MN	2,916	$68,753	1,123	$15,008	21.8%
NJ	5,092	$137,541	645	$30,038	21.8%
TN	2,623	$59,188	1,045	$12,702	21.5%
WI	4,719	$107,771	567	$23,200	21.5%
MT	507	$11,360	107	$2,409	21.2%
WV	464	$10,443	100	$2,189	21.0%
KS	2,911	$67,623	608	$13,849	20.5%
AK	188	$5,179	37	$1,046	20.2%
NC	2,253	$50,867	457	$10,119	19.9%
TX	7,445	$172,613	1,481	$34,071	19.7%
AL	1,157	$25,410	231	$4,985	19.6%
NE	1,988	$44,682	390	$8,720	19.5%
FL	6,701	$166,095	1,294	$31,948	19.2%
MD	860	$20,989	162	$3,947	18.8%
ID	704	$15,722	127	$2,786	17.7%
SC	800	$17,540	145	$3,102	17.7%
AR	1,701	$38,920	287	$6,594	16.9%
NV	650	$16,521	106	$2,695	16.3%
RI	192	$4,972	30	$773	15.5%
PR	79	$1,632	12	$252	15.4%
LA	1,069	$23,820	163	$3,572	15.0%
HI	155	$4,169	22	$604	14.5%
MS	546	$11,758	67	$1,471	12.5%
OK	1,058	$24,267	130	$2,924	12.0%
Unknown	14	$388	0	$0	0.0%
TOTALS	122,047	$2,937,668	28,889	$688,821	23.4%

APPENDIX C

COMMENTS ON THE DRAFT REPORT

We present, in full, comments from the HCFA Administrator, the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB).

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: AUG 10 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports on Chiropractic Care: "Controls Used by Medicare, Medicaid, and Other Payers," (OEI-04-97-00490) and "Medicaid Coverage," (OEI-06-97-00480)

We reviewed the above-referenced reports that describe the current and anticipated chiropractic care benefits provided under each state Medicaid program and how Medicare, Medicaid, and private insurers control chiropractic benefits. The report recommends that The Health Care Financing Administration (HCFA) develop system edits which will detect and prevent unauthorized payments for chiropractic maintenance treatments.

We concur with the report recommendations. Our detailed comments follow.

OIG Recommendations
HCFA should: (1) require chiropractic physicians to use modifiers to distinguish categories of spinal joint problems (i.e., acute, exacerbation, recurrence, and chronic); and (2) require all Medicare contractors to implement system utilization frequency edits which will identify beneficiaries receiving consecutive months of minimal therapy.

HCFA Response
We concur. HCFA is developing utilization guidelines as specified in section 4513(c) of the Balanced Budget Act of 1997 (BBA). Section 4513(c) requires two actions: (1) the deletion of the x-ray requirement for chiropractic coverage; and (2) the development of utilization guidelines for chiropractic services in cases in which a subluxation has not been demonstrated by x-ray to exist. The implementation date for these provisions is January 1, 2000. We believe the OIG report recommendations will be addressed by the forthcoming action in response to the BBA. Once the utilization guidelines are developed, we will be able to develop modifiers and edits as necessary.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of the Secretary

Washington, D.C. 20201

JUL 20 1998

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DIG-AS	
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AIG-LC	
OGC/IG	✓
ExecSec	
Date Sent	7-24

TO: June Gibbs Brown
Inspector General

FROM: Margaret A. Hamburg, M.D.
Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Reports on Chiropractic Care -- COMMENTS

We were pleased to have the opportunity to review these two draft reports concerning chiropractic care in the Medicaid program and controls on chiropractic benefits used by Medicare, Medicaid and private insurers.

We offer the following observations based on our review:

- While the development of edits or other mechanisms to identify inappropriate billings for chiropractic care certainly seems desirable, Medicare contractors must weigh the returns on investment in this activity against the returns likely on other investments of their resources for administration.

- The two State Medicaid programs that use physician referral in fee-for-service cite this requirement as a very effective means of control. More information is needed to substantiate this observation by State officials. How do these States measure the effect of physician referral? Is physician referral the only tool these States use to control spending on and/or use of chiropractic benefits? If they use other measures, how do they isolate the effect of physician referral? Finally, do these States factor in to their assessment of effectiveness the additional cost to the State of physician visits that may be necessary for the referral?

- To assess the relative importance of controls in Medicaid managed care compared to fee-for-service, it would be helpful to know how utilization of chiropractic services is distributed between these two sectors and the Medicaid populations they may roughly reflect (i.e., low-income families and SSI eligibles, respectively).

- The use of weighted averages (pp. 4-6) to summarize the range of utilization caps is inappropriate. The average values, which do not reflect real practice by any state or contractor, are actually meaningless and may mislead. For example, although 28 treatments/year is cited as the average among Medicaid plans that cover chiropractic services, not a single state actually has 28/year as its cap. Even more striking, the 104/year among plans with a hard cap doesn't even come close to any of the hard caps actually used by any of the 13 states that use them.

If you have any questions, please contact Julia Paradise of my staff at 690-6476 or jparadis@osaspe.dhhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUL 31 1998

MEMORANDUM TO: June Gibbs Brown
Inspector General

FROM: John J. Callahan
Assistant Secretary for Management and Budget

SUBJECT: OIG Draft Reports on Chiropractic Care

Thank you for the opportunity to review the draft OIG reports entitled "Chiropractic Care - Medicaid Coverage (Ref. OEI-06-97-00480), and Chiropractic Care - Controls Used by Medicare, Medicaid and Other Payers (Ref. OEI-04-97-00490). For your consideration, we have comments on both reports as follows:

The manner of Data Collection for Both Reports

With respect to the manner of data collection, we believe that the collection of this information has Paperwork Reduction Act (PRA) implications. As we have recently discussed, we encourage you to establish a coherent OIG-wide approach to compliance with PRA requirements.

Chiropractic Care - Medicaid Coverage

While the report provides much useful information, more discussion of the methodology might be helpful. Also, we noted that there is one state - Utah - with a consistent upward trend in Chiropractic expenses. Are you aware of any reason for this growth?

Chiropractic Care - Controls

Methodology

We have serious reservations concerning the methodology used to estimate the incidence of chiropractic maintenance treatments billed to Medicare and the "probable" inappropriate payment estimates of $68 million ($447 million over five years). We do not believe the study's methodology supports these estimates. The application of a universal percentage estimate of chiropractic "conditions" to Medicare claims for chiropractic services does not seem to account for differences between all chiropractic services and those for which insurance claims are submitted, not to mention the differences in service usage, condition, etc. between the universe of chiropractic patients and Medicare chiropractic patients. Without: a) some extensive demographic analysis: b) a comparison of frequency of service utilization and insurance

coverage information for all chiropractic patients v. Medicare chiropractic patients, or c) a small subsample of claims which have actually been reviewed, there is nothing to validate your estimates. We recommend eliminating the estimates of inappropriate payment from the report.

We hope our comments have been useful. Questions can be addressed to Frank Burns on 690-6353.

HOUSE COMMITTEE ON SMALL BUSINESS
April 10, 2002

Merry Walker Corporation
11475 Commercial Avenue
Unit 9
Richmond, Illinois 60071
815-678-3388
E-mail: mmharrou@aol.com

Opening remarks by Dan Gruzdis, attorney for Merry Walker Corporation:

Mr. Chairman, Committee Members, we appreciate the opportunity to be here today to address you and alert you to a serious regulatory problem. My name is Dan Gruzdis, an attorney who, for the past five years has been representing the Merry Walker Corporation. Mary M. Harroun started the corporation in 1990 as the inventor of the Merry Walker ®Ambulation Device, which assists the elderly with independent walking. The device she invented is protected by two US patents and is federally trademarked. The Merry Walker Corporation, she founded is dedicated to rehabilitating the elderly by providing products that allows for freedom and mobility by allowing them to get out of wheelchairs and walk independently. The device has been so innovative that it spawned at least eighteen imitators over the past twelve years.

This invention and her initiative should be singled out for special praise, but instead CMS has irrationally singled out her product for special restrictions. CMS's illogical rules do not merely injure this woman's small business, as this is not just a small business issue. The capricious restrictions CMS imposes also causes tens of thousands of nursing homes residents to be confined to wheelchairs when they need not be confined at all.

In the MDS User's Manual, CMS Irrationally categorizes the Merry Walker Ambulation Device as a "Chair that Prevents Rising". The Merry Walker Ambulation Device is not a chair that prevents rising. Due to the self-imposed limitations that CMS placed in this section, a claim is made, by CMS that no other category exists. The Merry Walker Ambulation Device will be demonstrated to show that the device is in no way a chair that prevents rising. It does not meet CMS's own published definition of a "Chair that Prevents Rising" and CMS has completely ignored the definition CMS itself created. It is also felt that CMS did not certify the Merry Walker Ambulation Device under the regulations of Regulatory Flexibility Act, prior to publication of the regulations in the Federal Register.

Testimony by Mary M. Harroun, MS, LNHA
President Merry Walker Corporation

My name is Mary M. Harroun and I too thank you, the House Small Business Committee, Mr. Chairman, and members of the House Small Business Committee.

My credentials are the following. I am a geriatric psychologist and an Illinois licensed nursing home administrator who spent twenty years in the clinical field prior to inventing the Merry Walker Ambulation Device in 1990. I am presently the President of the Merry Walker Corporation, which is located in Richmond, Illinois.

I have several concerns that will be addressed here today. The first concern is with the Federal Flexibility Act- federal regulations that interfere with small businesses, the certification process that was not initiated to protect the Merry Walker Corporation from harmful regulations. This oversight occurred due to the fact that no one realized in the five editions that have been published since 1995 of the MDS User's Guide that Merry Walker Ambulation Device is a federally registered trademark and that the Merry Walker Corporation is a small woman owned business. When the MDS User's Guide was first published in 1995, and then fully enacted in 1998, the Merry Walker Ambulation Device, listed as "merry walkers" in the guide, did not receive the recognition of a federally registered trademark. Nor was the product listed under a correct category, resulting in negative endorsement from the federal agency and a major marketing blackball by CMS. The MDS and the MDS User's Guide have the implied status as the most important regulatory publication in the nursing home industry. The damage to my corporation with this erroneous category has been catastrophic to both the elderly in the nursing homes who might have benefited from utilizing my product and also for Medicare disbursements in billions of dollars because of increased fractured hips and increased pressure ulcers that were allowed to occur to the 1.8 million elderly who were not allowed to walk independently in a device designed to meet their needs due to CMS and the MDS User's Guide erroneous category listing.

Let's look and the history of nursing home care in this country. If one should walk into a nursing home today, one would see most residents sitting in wheelchairs, and sitting around waiting for something to happen. Is this the quality of care they deserve or are the wheelchairs in use for staff convenience? Wheelchairs that we know of today were invented in the early 1900's for use by paraplegics by a company by the name of Ernest and Jennings, and not ever intended for use by nursing homes residents. They are used today for the main purpose of staff convenience and certainly not used in the best interests of the resident of long term care. I have been told over and over by physical therapists that once a resident in a nursing home is placed in a wheelchair it takes about three weeks of non-ambulation, that is, getting up and walking independently, before a resident is no longer able to walk at all. Wheelchairs use is not required to be assessed as such, nor regulated as a restraint under chair prevents rising.

I will now demonstrate a wheelchair and how elderly use it. The only part of the legs that can be extended are the lower legs, and I am now required to foot

paddle my feet to move the wheelchair. If I want to get up and stand and walk, or just get up and stretch, I must first set the brakes. I then have to move the footrests out of the way in order to get to a standing position. If the nursing home staff have determined that I am at risk for falls, they have now placed a chair alarm on the back of my wheelchair that is attached to me to sound an alarm should I decide to rise without assistance. This alarms will be very loud, eighty decibels, but this is what is used everyday in nursing homes. You need to see what the elderly are enduring, today. What I have just shown you is a quality of life issue and should not be allowed in any nursing home for any resident to endure this type of treatment.

If a resident is at risk for falls, why not place them in a fitness training program to strengthen their muscles, instead of further contributing to their deterioration, possible hip fracture and possible pressure ulcer involvement. Resistive exercise is not in the regulations and it should be to counteract against muscle atrophy.

OBRA Guidelines for Long Term Care were passed by Congress in 1987, enacted into law in 1990, referred to as the Nursing Home Reform Act. It was designed to be a guidance to surveyors for nursing homes, skilled nursing facilities and nursing facilities who are required to be in compliance with the requirements in 42 CFR Part 483 subpart B to receive payment under the Medicare and Medicaid programs. Under this Guidance, under Quality of care, F309, each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Under the restraint regulations, "Restraints: F221 & F222 restraints. The resident has the right to be free from any physical or chemical restraints imposed for purpose of discipline or convenience, and not required to treat the resident's medical symptoms." The purpose of the nursing home reform act was to improve the quality of care the elderly could expect to receive in nursing homes across the country. Use of wheelchairs and chair alarms are not considered restraints, but their use is not giving the residents of nursing homes the highest quality of care nor meeting the residents needs.

On June 1, 1990, the Merry Walker Ambulation Device was designed and invented by me to address the issue to restraint free care. The premise that I thought of prior to inventing and designing the Merry Walker Ambulation Device was: all elderly walked once, why aren't they walking now? There are very few medical diagnoses that prevent an elderly resident from walking if given the chance and the necessary physical fitness training required to maintain ambulation.

Nothing had been invented since nor previous to the Merry Walker Ambulation Device to assist residents with independent ambulation before 1990. We had standard walkers in many variations, but nothing that protected the resident from falls, and nothing that provided a seat behind the resident to sit down on, should a rest be needed and a safe framework in which to walk, prior to the invention of the Merry Walker Ambulation Device. The Merry Walker Ambulation Device was invented to replace wheelchairs, and to simply get the residents walking independently. The Merry Walker Ambulation Device was invented for all

residents who need one assist in walking in order to walk all by themselves. Independent ambulation- self rehabilitation-against learned dependency that is so common in nursing home life. Since all residents in nursing homes walked once, with this product designed to meet their needs, they would walk again- and the device would be the answer to sacropenia or muscle wasting away. All atrophied muscles can be reversed and with a walker/ chair combination, a restraint free ambulation device, an enabler, adaptive equipment—to allow for functional ambulation and a return to functional mobility, a major focus of the federal regulations.

I will now demonstrate the Merry Walker Ambulation Device. I will get into the device and walk around. The front gate latches securely due to the fact that I need the front arm closed in order to use the product safely. Whoever uses the Merry Walker Ambulation Device is usually under medical care, such as nurses in long term care. Their responsibility is to supervise and care for the residents, so when a resident wishes to enter or exit the Merry Walker, staff is there to make sure care and assistance is given to them. The Merry Walker Ambulation Device is an enabler, adaptive equipment, not a restraint. Since the Merry Walker Ambulation Device first appeared on the market in the fall of 1990, I have counted eighteen copycats of the design, of which about three or four are left on the market, gone from the medical field mainly due to design flaws.

When the Minimum Data Set (MDS) assessment format first appeared in 1995 when it was enacted, I did obtain a copy and had few problems with the format except for the fact that qualifying five hundred accurate answers from seventeen thousand nursing homes seemed a bit idealistic to me. I did not realize that the MDS User's Guide existed nor did I realize that the "merry walkers", in generic format, were listed in the MDS User's Guide. In July 2002 at the Alzheimer's Disease Educational Conference, a seminar was given on the merits of the Merry Walker Ambulation Device by Mary Lucero, from Geriatric Resources. After the seminar, attendees came to my booth and stated they could not use the Merry Walker and one suggested that I call North Carolina Public Health Department and find out what the problem was with the Merry Walker they claimed they were not allowed to use for their residents. I called the North Carolina Public Health Department, and after explaining the situation, received Page 3-158 from the RAI/MDS User's Guide and read the passage, much to my shock and amazement. And I quote from the RAI/ MDS User's Guide, listed under: "Devices and Restraints: Intent: to record the frequency, over the last seven days, with which the resident was restrained in any of the devices listed below at any time during the day or night. Definitions: this category includes the use of any device (e.g. physical or mechanical device, material, or equipment attached or adjacent to the resident's body) that the resident cannot easily remove and that restricts freedom of movement or normal access to his or her body." It further lists definition for full bed rails, other types of bed rails, trunk restraint, and limb restraint. Under "Chair Prevents Rising: any type of chair with a locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor (e.g. bean bag chair). Includes "comfort cushions' (e.g. lap buddy), 'merry

walkers.' "Merry Walker Ambulation Device is not any type of chair with a locked lap board that places a resident in a recumbent position that restricts rising not is it a chair that is soft and low to the floor such as a bean bag chair. It is not a comfort cushion. How had this happened? I found out that Jeane Nitsch was the MDS coordinator for CMS and called her and asked her what a Merry Walker was, since it was listed under "Chair Prevents Rising". According to my notes she stated that Merry Walker has a lap belt and that was why it was listed in the MDS User's Guide under chairs that prevent rising. I informed her that Merry Walker Ambulation Device has never had a lap belt, ever, and that it is also protected under a federally registered trademark, issued in 1992.

These are the issues: Merry Walker Ambulation Device is not a chair that prevents rising. Merry Walker was listed as a generic product when it is protected under a Federal Trademark awarded in 1992. And also protected under two letters of patent, 1991 and 1996. I was told in later conversations with Jeane Nitsch to write letters to Tom Scully, Steve Pelovitz, Jeane Nitsch, and Fred Gladden and I would receive a response. I did write letters, dated August 3, 2001 and included copies of my registered trademark and two patents and a careful explanation of what the Merry Walker Ambulation Device was intended for and that it certainly was not a chair that prevents rising. On September 11, a Question and Answer Clarification appeared on the CMS web page that answered my letter. I received a hard copy of the letter the next week. And I quote from the Q and A: "The Merry Walker that is referenced on page 3-158 of the RAI User's Manual section entitled Devices and Restraint should be referred to as the Merry Walker ®Ambulation Device. While the Merry Walker® Ambulation Device and other devices like it do not prevent a resident from standing, the device could restrict the resident's freedom of movement) e.g. entering areas with steps; transferring to another chair, to the commode or into their bed) and thus meets the definition of a restraint. For residents using this device, or a similar device, who cannot open the front gate easily, whether it is because the resident has cognitive or physical limitation that prevent them from exiting the device or because the device has been altered to prevent the resident from exiting the device, code P4e chair prevents rising with either a "1" used less than daily or a "2" used daily. If the resident used the device to walk during the last 7 days, item G5a Cane/walker/crutch, should also be checked. If a resident is able to open the front gate and exit the device, then the Merry Walker ® Ambulation Device would not be a restraint for this particular resident. It could still be coded on Item G5a as a Cane/walker/crutch."

Since I am a licensed nursing home administrator, I decided to check into the federal regulations. In checking over the regulations, and also checking with a known expert and college professor on the federal regulations, Dr. John Cirn,PhD., he stated after reading over the response that there are no listed regulations on freedom of movement, e.g. entering areas with steps, transferring to another chair, to the commode or into their bed, written in the federal regulations.

At a meeting on March 4, 2002, at the Social Security Building in Baltimore, with Steve Pelovitz, Director of Survey and Certification Group, Jeane Nitsch, Health Insurance Specialist, Center for Medicaid and State Operations, Fred Gladden, Acting Director, Division of Nursing Homes and Continuing Care Services

and others were in attendance. Steve Pelovitz indicated that duck tape has been used on the Merry Walker to keep people locked inside, and that some assessments are not done on the elderly who use the Merry Walker. The Merry Walker will stay under the category of chair that prevents rising.

As a responsible corporation, the Merry Walker Corporation, includes specific instructions that are sent out with each and every Merry Walker Ambulation Device specifically addressed to the medical professional who ordered the device for a resident. Included in the package are detailed instructions on use, and the medical professional is instructed to never use the Merry Walker Ambulation Device without supervision and the resident using the Merry Walker Ambulation Device must be under observation at all times. These instructions follow the federal guidelines.

Since Jeane Nitsch seems to be accessible easily by email, I asked Jeane Nitsch to cite the federal regulations on freedom of movement, entering area with steps, transferring to another chair, to the commode or into their bed, in an email of March 15, 2002, and April 4, 2002. As of this date, April 8, 2002, no answer has been received to answer these questions. I also asked for a numbers of residents confined to wheelchairs in nursing homes.

In a letter received on March 12, 2002 from Steve Pelovitz, he states that "clarifying for nursing home staff that complete the MDS that while the Merry Walker® Ambulation Device and other devices like it do not prevent a resident from standing, due to limited category choices on the MDS, these devices when they have the effect of restraining the resident should be coded in the category chair prevents rising." He also further states that, as he stated in his September 11, 2002 letter, that "he informed the national provider groups, American Health Care Association and the American Association of Homes and Services for the Aged of the above clarifications." In asking both of these groups, if they had received this letter from Steve Pelovitz, both groups told me that they had not received any notification from Mr. Pelovitz.

Steve Pelovitz further states in his letter of March 12, 2002, that, and I quote, "we are currently constrained by the five categories available on the MDS from which a reviewer has to choose when coding devices that have had the effect of restraining the resident. Two categories deal with bed rails. The remaining categories are trunk restraint and limb restraint and chair prevents rising. We will replace the phrase merry walker in the RAI User's Manual with a more generic description such as enclosed framed wheeled walker with posterior seat. The updated RAI User's manual will include revisions that instruct evaluators to code enclosed framed wheeled walkers with posterior seats (or a similar description in the category chair prevents rising and explain that, while the device may not prevent a person from standing, in those cases that the device meets the definition of a physical restraint, the device should be coded in this category. If you would prefer us to instruct evaluators to code products like yours in one of the other categories, please let us know and we will consider making this change."

I will object strongly to the generic wording he is proposing due to the fact that Merry Walker Ambulation Device has a specific HCPCS code, E0144, which defines the Merry Walker Ambulation Device with almost the same wording. Merry

Walker Ambulation Device or any description of the device, still does not fit under any of the categories under devices and restraints. Since it does not fit under any of the categories that CMS is constrained by, maybe the Merry Walker Ambulation Device does not fit under devices and restraints at all and should be mandated to be removed from the list immediately, not when the revisions occur or are supposed to occur in 2004.

You may ask why I didn't pursue this earlier than last July. Eight years ago, in 1994, I had many conversations with Lois Steinfort who was Chief of Nursing Homes Branch , Office of Survey and Certification HSQB. She stated to me that she was familiar with the Merry Walker Ambulation Device and she really liked the Merry Walker and saw its merits. She wrote a letter, dated December 8, 1994 stating; " If treating a resident's medical symptoms includes assisting the resident to ambulate, and the Merry Walker appropriately provides this assistance, then the use of the walker would be justified". Further, Charles Bennett –branch Chief for Region V stated in the letter, dated January, 1995 that " If a comprehensive assessment and care planning process determined that the use of the walker would be advantageous in assisting the resident to ambulate, then the resident would only be confined in the walker for specific periods for which the device has been determined to be a therapeutic intervention (an enabler for ambulation). Staff assistance must be readily available to release the resident for the walker when the period of ambulation is completed." I felt at the time that I had covered the possible restraint issue with HCFA and that this information would be carried over to encompass the total agency.

The effect of this regulation on the 17,000 nursing homes and 1.8 million residents is that of a product on market that nursing homes residents are unable to use due to the inaccuracy of the regulations. Residents are resolved to be placed in wheelchairs due to possible falls and residents are placed in wheelchairs with chair alarms to prevent them from standing up and walking. Because of this there is also an increased prevalence of pressure ulcers and fractured hips and the cost to Medicare is in the billions of dollars. We taxpayers are paying for CMS lack of not enforcing their own nursing home regulations to provide quality care for their residents. CMS does not provide for regulating or assessing the overuse use of wheelchairs in nursing homes and 1.8 million elderly are suffering needlessly because of it. All muscle atrophy can be reversed through exercise, thus reducing the probability of falls.

In looking at state regulations that better describe the use of the Merry Walker Ambulation Device, this Illinois Administrative Code regulation better describes the Merry Walker Ambulation Device. Under the 77 Illinois Administrative Code under Definitions: Adaptive equipment: a physical or mechanical device, material or equipment attached or adjacent to the resident's body that may restrict freedom of movement or normal access of ones' body, the purpose of which is to permit or encourage movement, or to provide opportunities for increased functioning, or to prevent contractures of deformities. Adaptive equipment is not a physical restraint.

Physical restraints are defined under the federal guidelines: physical restraints include, but are not limited to leg restraints, arm restraints, hand mitts, soft ties, lap cushions and lap trays the resident cannot remove. These do not define a Merry Walker Ambulation Device.

Under the FDA restraints regulations a restraint is defined as, " a device, including but not limited to a wristlet, anklet, vest, mitt, straight jacket, body/limb holder, or other type of strap that is intended for medical purposes and that limits the patient's movements to the extent necessary for treatment, examinations, or protection of the patient from others." By FDA regulations, Merry Walker Ambulation Device is not a restraint and did not have to provide premarket notification prior to being placed on the market.

How has this MDS regulation on "Chair Prevents Rising" affected the Merry Walker Corporation? In discussions with all the major nursing homes chains, Manor Care, Marriott, Good Samaritan, Life Care Centers, etc., about twenty of the major corporations in all, all the MDS coordinators for these corporations stated to me in conversations that they are not allowed to purchase the Merry Walker Ambulation Device due to the MDS regulations against the Merry Walker. They all agree that the Merry Walker Ambulation Device is not a chair that prevents rising but since the MDS User's Guide states that it is, it must be so. The nursing home industry follows the MDS to the letter in order to protect their Medicare reimbursement that pays them for resident care. So none of the nursing home corporations will allow their facilities to purchase Merry Walker Ambulation Devices for their residents, although all stated that they would like to use the product to improve quality of care for their residents.

A further issue that needs to be raised is that not only did HFCA (CMS) not follow federal regulatory procedures under the Regulatory Flexibility Act, in certifying that a small business would not be affected by the MDS, but they made irrational decisions in placing the Merry Walker Ambulation Device under a chair that prevents rising, and since then, they have continued to cover up their mistakes by citing federal regulations that do not exist. HCFA (CMS) was given the task of writing and enforcing regulations to make sure that each resident living in a long term care facility would receive and the facility must provide the necessary care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment plan of care. These regulations are not being enforced, and because of this the residents, all 1.8 million of them are not receiving the level of care they so sorely deserve and is required by law.

Using a product name in any regulation should never have occurred. Since pointing this tort out to the CMS staff involved has only caused more confusion and has not solved the problem to this date.

Merry Walker Corporation does not have any government contracts.

Mary M. Harroun, MS, LNHA
President
Merry Walker Corporation

DMCGVI00,

From: Shaubah, Elena
Sent: Wednesday, April 10, 2002 9:05 AM
To: DMCGVI00,; Jones, Aranthan; Modeste, Brian
Subject: FW: as per your request

I just spoke to Doug Menzies and they are sending via email the info. it is the same that we have.

-----Original Message-----
From: Robert Monokian [mailto:robmonokian@yahoo.com]
Sent: Wednesday, April 10, 2002 9:01 AM
To: Shaubah, Elena
Subject: as per your request

From: Robert Monokian **Sent:** Wednesday, February 20, 2002 5:52 PM **To:** Rosa Gonzalez **Cc:** Tracy Sanders **Subject:** question

(I've attached the same message in case this is not readable)

Dear Ms. Gonzalez,

Below is the running time line of our Medicare experiences. There are many issues we did not document. I am sending

this to you and our adviser, Tracy Sanders. We have decided to follow two tracts. One is to continue to try to work things

out with Triple S and the other is to start the process of no longer being providers of Medicare services. The time we have

spent providing the services, paying staff, working on doing what Triples S tells us to do and finding out we need to do it

another way, getting charged 10% penalties, and still having problem after problem is costing us more than we bring in and

that is just plain bad business. And the bad business is not a fault of our own, nor one we have any control over. We can not

continue to lose money, be aggravated and frustrated. We are asking for assistance in how to properly leave Medicare. Can

you give me a starting point on what we would have to do to. Hopefully, it is less complicated than what we have been

through. Perhaps it is in one of the many books we already have. Don_t get me wrong, you have

been helpful and a

pleasure to work with. Never the less, we must stop this endless nightmare. The doctors and staff moral and finances have

all reached their limits. We have been at this too long. Any direction you could give would be most appreciated. By this

letter, we are also asking Ms. Sanders to advise us on the procedures of opting out of Medicare and its ramifications.

Robert Monokian

DATE	CONTACT	ISSUE
March 28,2001	Kristine Cintron	Told everyone needs a submitter # within facility.
	Tracy Sanders	Will look into submitter # as this is new information to us. Get Dr McMahon to sign enrollment form for Medicare.
March 29,2001	Tracy Sanders	I brought signed papers from Dr McMahon and a letter of urgency addressed to Mr Aponte to Tracy's office by 12:00P
	Tracy Sanders	Called and reported all in order, will Fed-Ex paperwork.
March 30,2001	Mr Ferdinand Aponte	Only one submitter # is necessary, will remove the 90 day process and will turn off edit and allow to rebill .
	Tracy Sanders	Will wait for call from Mr Aponte, and needs Natalie to fax paperwork to 778-0654. We have a submitter #7000005616. Tracy will fax letter. After submit new batches, told receive money in 13 days.
April 2,2001	Mrs Casablanca & Javier	System down and given new password, it was unsuccessful.
April 3,2001	Victor	Working on system/ error report not there
April 9,2001	Victor	8:00 AM/ 10:30 left message with Ada. Promised error report by this afternoon. There is no report.
April 16,2001		No report, all info confirmed.

April 17, 2001		Doug gave me the mail and over $50,000 denied for various reasons. Call into Mrs Bermudez and Mr Felix Rosario. Left message with Tracy & Kristine.
	Tracy Sanders	Told of dilema. She will meet with us at 2:30pm on Thurs.
April 18,2001	Mr Rosario	Told to fax some of the denials and advised us to get in touc with Kristine to set up class to learn software and procedures
April 20,2001	Tracy Sanders	Meeting at 10:am on Monday. Go over software, billing procedures, ICD & CPT codes.
April 23,2001	Kristine Cintron	Meeting and faxed over info regarding error report
April 26, 2001	Tracy Sanders	Will drop off some new regulations, e-mail confidentiality regs.
May 1, 2001	Kristine	After meeting called in regard to error report and referrals from DC. She is still looking into it. Requested a class for software again.
May 8, 2001	Kristine	Rob told me about a class at JFL Hospital on the 15th of Ma Kristine said that class will probably be postponed. The rep from PR has too much to do. Will call and let me know.
May 15, 2001	Kristine	No class, has never heard of new date and time.
May 31, 2001		Medicare meeting via conference call from NY.
June 11, 2001	Nilda	Spoke with Nilda regarding meeting with Felix and dates Available. Dr Monokian related to me that we will speak with Jelita from now on #787-749-4087 ex 4442. She will teach software.
July 9, 2001	Jelita	Rob asked me to call regarding reconcilliation report and repair execute. Do we do that?

		Jelita called back: we do not do repair execute, they do. She will call in AM with reconcilliation report, system down.
July 10, 2001	Jelita	9:00AM called but no era file to reconcile. She will cal later. Auto reconcile?
July 11, 2001	Jelita	Should see error file this weekend. She will call Tues. Am to go over it with me. Monday is a holiday
July 17, 2001	Jelita Tracy	Never called back, but don't see in the system. Get info together and we will fax on Thursday.
July 18, 2001		Sent batch #100
July 25, 2001		Sent batch#101, checked to see if error report here. Not seen.
Aug 2, 2001		Sent batch# 102, called Jelita, still no error report.
Aug 6, 2001		Rob called Jelita, there is a big problem. The submitter # is wrong. All these batches have been submitted under the Incorrect #. It was put in as 5000005616. It should be 7000005616. Will correct with Jelita.
Aug 6, 2001	Jelita	Came down to my office and went through sending the batch Correctly. Batch #103 was sent. Call Jelita later to confirm.
Aug 7, 2001	Jelita	Called at 8:00 to go over error report in BBS. LM wFernand
Aug 8, 2001	Hector	Spent about an hour on the phone, going over the error repor Downloaded the error report finally successfully. Had to call him back because the first time I downloaded it, there was a wrong submitter and batch number. The majority of errors were due to a pt having two insurances and we should be using Medigap rather than other insurance. I told Hector we were never told this.
Aug 17, 2001		Rob spoke with the Congresswoman/meeting on Monday.

Aug 27, 2001	Hector	LM
Aug 29, 2001	Christine Cintron	Faxed questions re: Nat submitter # etc., told to ask Tracy Gave info to Rob.
Aug 30, 2001	Hector # 787-749-4949 x4463	Went over error reports & fixed. Spoke re: Nat needing submitter # and her provider # does not work. Told to call Provider area @787-749-4232
Aug 30, 2001	Aida Rivera	Need clarification on submitter # for Natalie, told we must Submit claims manually. Call EMC @787-749-4949x4411 Or x4408. It was difficult to understand but I think we're ok
Aug 31, 2001	Aida Rivera Fax #'787-277-6668	Faxed request for clarification re Natalie paper claims.

Sept 11, 2001 Faxed Rob_s letter to Ms Santiago @787-749-4191

Her # 787-749-4949x4514

Sept 20, 2001 Hector Called and left message re: reconciling account

Sept 20, 2001 Rob All Cardiac charges can be billed under Dr Marshall in 2000.

This is great news from Medicare.

Sept 21, 2001 Hector Went over reconciling reports. We have none to reconcile. Told

to call Provider Relations. They are behind due to tragedy of Sept

11th.

Sept 24, Rosa Sent by fax info re: remittance notices.

Sept 25, 2001 Rosa Called and is working on notices. Might be awhile,

they are old.

Sept 27, 2001 Rosa Called and gave necessary info to correct Remittance

Notice.

Oct 4, 2001 Rosa Faxed info re: Cardiac Rehab & Kevin McCormack

Oct 15, 2001 Rosa Returned Rosa call but now she is out for the week

Oct 22, 2001 Rosa Left message for her to call me. Need answers to those

Questions. She called back-will answer and then e-mail to Rob.

Oct 29, 2001 Rosa E-mailed questions re: Natalie # and paper claims and

Cardiac rehab.

Nov.15, 2001 Rosa Submitted list of patients and their claim numbers for

penalty fee to be waived.

Dec 12, 2001 Rosa Said that those three files that were sent were well

documented. Need to submit # of claims in same

situation and date of service for each claim. Rosa will submit

total 10% late filing fee to Mr Stanton from Regional Office in NY.

He will decide on amount by Friday, the 14th.

Jan. 25, 2002 Rosa Noticed half of what we submitted was in error and asked her to look into it for us.

Jan 30, 2002 Rosa Told us that Natalie did not have the proper number and she would Fed-Ex the correct paperwork. All claims would have to be re-done.

Jan 31, 2002 Rosa Sent back corrected forms as outlined by Rosa. Asked if somehow all those claims in error could be corrected internally.

She will let me know.

Feb 6, 2002 Tracy Signed letter and got three files together for Medicare,

Murphy,Flores, and Johansen.

Feb 7, 2002 Rosa Phoned and said all was not complete with Natalie_s forms due to error and she would fax me the necessary forms and have Nat

sign again and answer a couple more questions.

Feb 8, 2002 Rosa Faxed the corrected forms. Hopefully all is well, said we must

submit claims again.

Feb.13, 2002 Rosa Rosa said all was ok. Correct claims and re-submit w/

Nat # 0061089A.

Feb 14, 2002 Rosa Laura tried to re-submit claims but was unable so we faxed Rosa

and told her of our problem.

Feb 15, 2002 Rosa Called and said to install Medifast software again; different

directories for Natalie and Beeston Hill. Called Victor @

787-749-4085, ext-4468.

Feb 18, 2002 Rosa Closed for Holiday.

Feb 19, 2002 Victor Left message for him to call me.

Feb 20, 2002 Hector Explained situation w/ Natalie provider # and he said to call

the Contract Dept @ 787-749-4949 x-4487 to add her under

our provider #------10367. Left message for Rosa to call me.

Feb 20, 2002 Rosa Returned my call----said Natalie must have her own # as she has

to act independently of the center but all money would go Rehab Ctr. She will call later on and try for a conference call w/ Victor.

Feb 20, 2002 Victor Called and we set up the directory for Natalie.

Feb 20, 2002 Rosa We have the provider # for Natalie; now she needs a billing #.

She will Fed-Ex the paperwork tomorrow.

Good morning Dr. Monokian,

As requested in your email, the alternatives that you have are either change
the group status to non-participant or op-out. We published two articles in

the Medicare Informa Bulletin in October/November 1997 and December, 1997,
January/February, 1998. These articules include the instructions and documents that need to be submitted to us. If your decision is to change
the status, you only need to submit a letter informing us your decision to change the status.

If you have any further question, please feel free to contact me.

Rosa M. González
Gerente Auxiliar
Depto. de Evaluación
Extensión 4420

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to

Region II
Federal Building
26 Federal Plaza
New York NY 10278

October 17, 2001

The Honorable Donna M. Christensen
House of Representatives
Washington, DC 20515-5501

Re: Your correspondence dated August 23, 2001

Dear Ms. Christensen:

We received your correspondence dated August 23, 2001 on behalf of Dr. Douglas Manses, President and Owner of the St. Croix Health Club and Rehabilitation Center.

Our Division of Financial Management is currently investigating your complaints. We expect the issues to be resolved as soon as possible. In the interim, if you have any questions, please contact Ms. Sandra Tokayer at 212-264-0019.

Sincerely,

Judith Berek
Regional Administrator

Cc: Ana Salerna
Sandra Tokayer

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS). We are exercising fiscal restraint by exhausting our stock of stationery.

Congress of the United States

Washington, DC 20515

March 19, 2001

Mr. Thomas Scully
Administrator
Health Care Financing Administrator
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

Dear Administrator Scully:

On Wednesday, March 6, 2001, the House Committee on Small Business held a hearing on the Small Business Regulatory Enforcement Fairness Act (SBREFA). Mr. Norman Goldhecht, Regulatory Chairman for the National Association of Portable X-Ray Providers, testified on problems that the Portable X-Ray industry has had with the Center for Medicaid Service lack of compliance with the Regulatory Flexibility Act. This was the third time that Mr.Goldhect has come before the committee to provide insight on this matter. Some of the members of the committee were informed, off the record, that the president of the National Association of Portable X-Ray Providers was subject to an unexpected audit on the very same morning of the audit. The timing of the audit could possibly have given the impression that it was scheduled as a punitive measure for the Association testifying before the committee. We would like your personal assurance that this is not the case. In previous hearings on the topic of CMS compliance with SBREFA, the committee received testimony that physicians have been subject to unexpected audits that appeared to be in retribution to a their complaints about CMS. This has caused much concern and resulted in investigations to be conducted by the Chairman of the Committee, Congressman Donald Manzullo.

Additionally, the National Association of Portable X-Ray Providers met in Washington, D.C. this week. The members of the Small Business Committee were told that representatives from CMS were invited to participate but declined. This would have been a perfect opportunity for CMS to meet with the Association to discuss their concerns.

The above information that the Association shared with the members of the committee concerns us. We request that you look into this matter as soon as possible. It is our objective, as we hope is yours, to make federal regulations less burdensome on our nations small businesses. In reaching this objective, we hope that CMS will do what is possible to comply with SBREFA. Your assistance in this matter would be greatly appreciated.

Sincerely,

Congresswoman Nydia Velazquez
Ranking Member
House Committee on Small Business

Congresswoman Donna M. Christensen
Member
House Committee on Small Business

R.L. BUCHER, M.D.
ENDOCRINOLOGY

5309 Sunny Isle • St. Croix, VI 00823-5309 • (340) 778-3455 • fax (340) 778-3455 • e-mail rlb@islands.vi

NOV 2 9 2001

November 5, 2001

Gonzalo V. Gonzalez-Liboy, MD, FACP
Medical Director/CAC Co-Chair
Medicare Division, Triple-S, Inc.
PO Box 71391
San Juan, PR 00936-1391

Dear Dr. Liboy:

Twelve more claims for blood sugars done in my office in August and September have been denied because "treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." The POS on all claims is "11", my office. All the claims are clean. All the patients have diabetes. As you know, I have CLIA Certification to perform this exempt test.

I have not received a reply from my letter to you dated October 1, 2001 about 33 claims rejected for the same reason.

What is the problem? Why do I have to keep writing to you about this? If Medicare is no longer going to pay for testing the blood sugars of patients with diabetes, just let us know.

I've instructed my staff to stop billing Medicare for this service until the problem is resolved. All I'm getting is reams of paper and aggravation.

Sincerely,

R.L. Bucher, M.D.

cc: Donna Christensen, M.D., Delegate to Congress
Cora Christian, M.D., VIMI
Kristine Cintron, Medicare Office

Medicare/Triple S,Inc.
1441 Roosevelt Ave.
San Juan, Puerto Rico 00920
Tel.(787) 749-4232 / 749-4281

MEDICARE
REMITTANCE
NOTICE

ROBERT L BUCHER
PO BOX 5309
CHRISTIANSTED, VI 00823-5309

PROVIDER #: 0080235
PAGE #: 1 OF 1
DATE: 10/09/01
CHECK/EFT #: 01282000928
STATEMENT #: 12823AA0082SYS

*** Visit our WEB Page at: www.triples-med.org*** Our toll free phone number is: 1-877-715-1921****

Medicare 101 Seminars. Don't miss the opportunity to learn more about Medicare billing concepts, regulations and sources of information available for providers. The seminar will be held at the Triple-S, Inc. anfitheather from 5:30 to 9:30pm on the following dates; 10/24 or 25 and 11/28 or 29.

New ICD-9 update begin on 10/01/2001. Then, effective for claims received on or after 01/01/2002 the update codes must be used. Obtained your copy at: AMA; P O Box 7046 Dover, DE 19903

"The safest way to receive Medicare Payments" The EFT method allows Medicare to deposit payments directly to your bank account. For more information, call at; 787-749-4232 or 1-877-715-1921.

Any Medicare checks payment on or after 10/31/2001, we recommend to cash these checks on or before February 01/2001. Because the bank that process Medicare checks will change the Routing Transit Number on every checks printed on or after February 1/2001.

```
PERF PROV  SERV DATE  POS NOS  PROC  MODS   BILLED   ALLOWED  DEDUCT   COINS  GRP/RC-AMT      PROV PD

NAME BELL, GLORIA          HIC 580055025A   ACNT            ICN 01274474083000   ASG Y  MOA MA13  MA01
0080235    0918 091801 11   1 82962         12.00    0.00     0.00     0.00  CO-58    12.00     0.00
PT RESP    0.00               CLAIM TOTALS  12.00    0.00     0.00     0.00           12.00     0.00
                                                                       0.00  NET

NAME CARRION, LUIS         HIC 076289032A   ACNT            ICN 01274474093000   ASG Y  MOA MA13  MA01
0080235    0920 092001 11   1 82962         12.00    0.00     0.00     0.00  CO-58    12.00     0.00
PT RESP    0.00               CLAIM TOTALS  12.00    0.00     0.00     0.00           12.00     0.00
                                                                       0.00  NET

NAME NICHOLAS, LINCOLN     HIC 580125902A   ACNT            ICN 01274474085000   ASG Y  MOA MA13  MA01
0080235    0920 092001 11   1 82962         12.00    0.00     0.00     0.00  CO-58    12.00     0.00
PT RESP    0.00               CLAIM TOTALS  12.00    0.00     0.00     0.00           12.00     0.00
                                                                       0.00  NET
```

TOTALS:	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
	3	36.00	0.00	0.00	0.00	36.00	0.00

ADJS:	TOTAL PREV PD	TOTAL PD TO BENE	TOTAL INT	TOTAL PRIMARY	TOTAL OFFSET	TOTAL OTHER ADJS	AMOUNT OF CHECK
	0.00	0.00	0.00	0.00	0.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes:

CO	Contractual obligation. The patient may not be billed for this amount.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim conduct the review. However, in order to be eligible for a review, you must write to us within 6 month of the date of this notice, unless you have a good reason for being late.
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient Responsability) group code.

received
11-1-01

[redacted]

MEDICARE PART B APPROVED OMB-0938-0008
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 05 5025 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BELL GLORIA

3. PATIENT'S BIRTH DATE MM DD YY: 09 01 1927 — SEX: M ☐ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 3737

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: C STD — STATE: VI

8. PATIENT STATUS: Single ☐ Married X Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: — STATE:

ZIP CODE: 00822 3737 — TELEPHONE (Include Area Code): (340) 773 3559

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES ☐ NO X

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State): YES ☐ NO X

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE: 09 18 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: P L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO X — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 03 — 2. 272 0 — 3. 401 9 — 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
09182001	09182001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 C514586 — SSN EIN: X — 26. PATIENT'S ACCOUNT NO: 1998250600 — 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO ☐

28. TOTAL CHARGE: $ 12 00 — 29. AMOUNT PAID: $ 0 00 — 30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 18 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# — GRP# 8 0235

DATE

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88 — PLEASE PRINT OR TYPE — FORM HCFA-1500 (12-90) — FORM OWCP-1500 — FORM RRB-1500 — EN-R

[redacted]

MEDICARE PART B APPROVED OMB-0938-0008

MEDICARE PART B APPROVED OMB-0938-0008
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

MEDICARE (Medicare #) X	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)
CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)
OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	076 28 9032 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CARRION LUIS	07 25 1935 M X F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
P O BOX 2144 KINGSHILL	Self X Spouse Child Other	
CITY	STATE	8. PATIENT STATUS	CITY	STATE
ST CROIX	VI	Single Married X Other		
ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
00851 2144	(809 778 0970	Employed Full-Time Student Part-Time Student		( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N/A		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
	YES X NO	M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
M F	YES X NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
R L BUCHER MD	D58324	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES
		YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. 250 63 3. 571 5		
2. 349 90 4. 437 1		23. PRIOR AUTHORIZATION NUMBER CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001 09202001	11		82962	1	12 00	1				

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 0514586	X	1993092500	X YES NO	$ 12 00	$ 0 00	$ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

DATE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RRB-1500

Denied
PMT

MEDICARE PART B APPROVED OMB-0938-0008
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
							580 12 5902 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
NICHOLAS LINCOLN K	12 08 1938 M [X] F [ ]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
P O BOX 5545 SUNNY ISLES		
CITY / STATE	8. PATIENT STATUS Single [ ] Married [X] Other [ ]	CITY / STATE
ST CROIX VI		
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
00823 5545 (809) 773 4045		( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N/A		NONE
9a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
9b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]	b. EMPLOYER'S NAME OR SCHOOL NAME
9c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
9d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 09 20 2001

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
R L BUCHER MD	D58324	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 250 73 2. 599 8 3. 571 5 4. 607 84		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 12 00	29. AMOUNT PAID $ 0 00	30. BALANCE DUE $ 12 00
66 0514586	1993093700				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #
R L BUCHER MD	R L BUCHER MD	R L BUCHER M D
ROBERT L BUCHER M D	ISLAND MEDICAL CENTER	P O BOX 5309 SUNNY ISLE
09 20 2001	ST CROIX VI 00823 5309	ST CROIX VI 340 778 3455
SIGNED DATE		PIN# GRP# 8 0235

PLEASE PRINT OR TYPE

FORM HCFA-1500 12-90 FORM OWCP-1500 FORM RRB-1500

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

Medicare/Triple S,Inc.
1441 Roosevelt Ave.
San Juan, Puerto Rico 00920
Tel.(787) 749-4232 / 749-4281

MEDICARE
REMITTANCE
NOTICE

ROBERT L BUCHER
PO BOX 5309
CHRISTIANSTED, VI 00823-5309

PROVIDER #: 0080235
PAGE #: 1 OF 2
DATE: 10/05/01
CHECK/EFT #: 01278000922
STATEMENT #: 12783AA0102SYS

***** Visit our WEB Page at: www.triples-med.org *****

Our new toll free telephone number for provider is: 1-877-715-1921.

Medicare 101 Seminars. Don't miss the opportunity to learn more about Medicare billing concepts, regulations and sources of information available for providers. The seminar will be held at the Triple-S, Inc. anfitheather from 5:30 to 9:30pm on the following dates; 10/24 or 25 and 11/28 or 29.

"As a results of HIPAA, providers who use electronic transactions may realize significant savings. Contact 787-749-4232 now for further information on how you can begin or expand your use of electronic transactions".

New ICD-9 update begin on 10/01/2001. Then, effective for claims received on or after 01/01/2002 the update codes must be used. Obtained your copy at: AMA; P O Box 7046 Dover, DE 19903

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME CHRISTIAN, BODIL		HIC 068282579A		ACNT				ICN 01274474082000		ASG Y MOA MA13	MA01
0080235	0918 091801 11	1		82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME HARVEY, DAPHANE		HIC 580074853A		ACNT				ICN 01274474086000		ASG Y MOA MA13	MA01
0080235	0920 092001 11	1		82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME HAZZARD, ALLYSON		HIC 580037605A		ACNT				ICN 01274474084000		ASG Y MOA MA13	MA01
0080235	0920 092001 11	1		82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME RUIZ DE SOT, DALILA		HIC 118301086D		ACNT				ICN 01274474081000		ASG Y MOA MA27 MA13 MA01	
0080235	0918 091801 11	1		82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME SOLIS, DOREEN		HIC 580032226A		ACNT				ICN 01274474088000		ASG Y MOA MA13	MA01
0080235	0918 091801 11	1		82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME WALCOTT, MADALINE		HIC 580030030D		ACNT				ICN 01274474092000		ASG Y MOA MA13	MA01
0080235	0920 092001 11	1		82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME WASHINGTON, ROSE		HIC 580033562A		ACNT				ICN 01274474091000		ASG Y MOA MA13	MA01
0080235	0920 092001 11	1		82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	

Medicare/Triple S,Inc.
PROVIDER #: 0080235
CHECK/EFT #:01278000922

10/05/01

Tel.(787) 749-4252 /
ROBERT L BUCHER
PAGE #: 2 OF 2

MEDICARE REMITTANCE NOTICE

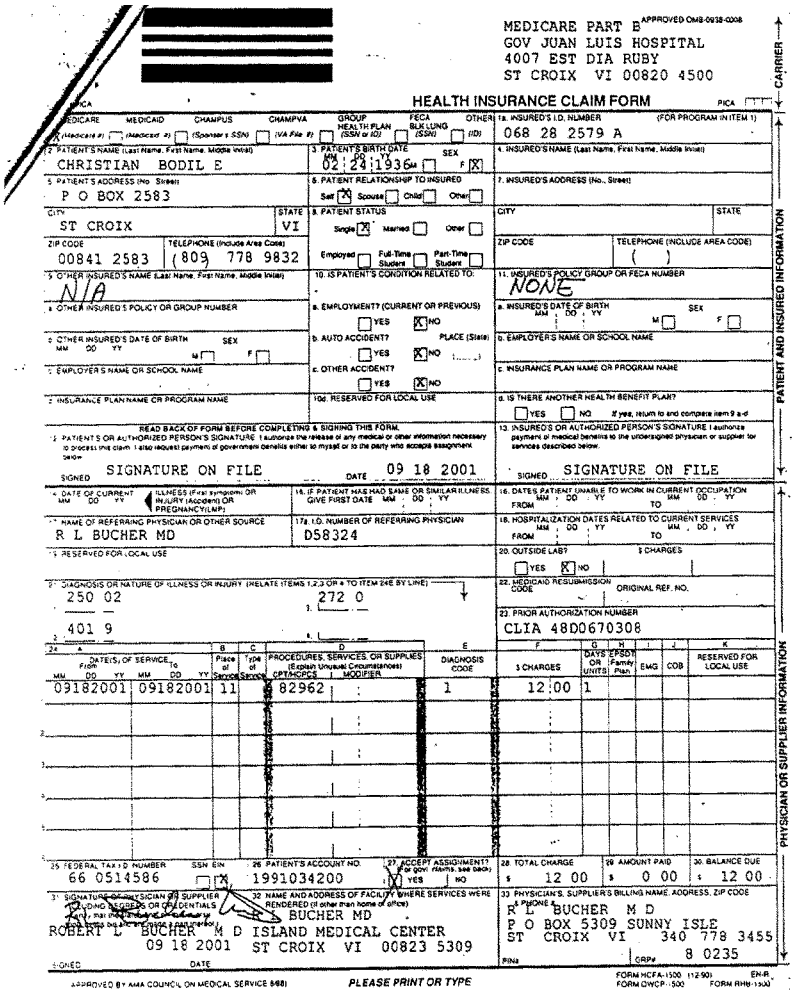
PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
NAME WOODRUP, LEROY		HIC 580032931A		ACNT				ICN 01274474090000		ASG Y	MOA MA13	MA01
0080235	0921 092101	11	1	82962		12.00	0.00	0.00	0.00	CO-58	12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00		12.00	0.00
											0.00 NET	

TOTALS:	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
	8	96.00	0.00	0.00	0.00	96.00	0.00

ADJS:	TOTAL PREV PD	TOTAL PD TO BENE	TOTAL INT	TOTAL PRIMARY	TOTAL OFFSET	TOTAL OTHER ADJS	AMOUNT OF CHECK
	0.00	0.00	0.00	0.00	0.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes:

CO	Contractual obligation. The patient may not be billed for this amount.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim conduct the review. However, in order to be eligible for a review, you must write to us within 6 month of the date of this notice, unless you have a good reason for being late.
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient Responsability) group code.
MA27	Incorrect entitlement number shown on the claim. Please use the entitlement number shown on this notice for future claims for this patient.



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MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

MEDICARE (X) (Medicare #) | MEDICAID ( ) (Medicaid #) | CHAMPUS ( ) (Sponsor's SSN) | CHAMPVA ( ) (VA File #) | GROUP HEALTH PLAN ( ) (SSN or ID) | FECA BLK LUNG ( ) (SSN) | OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 068 28 2579 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CHRISTIAN BODIL E

3. PATIENT'S BIRTH DATE: 02 24 1936 | SEX: M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No. Street): P O BOX 2583

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street):

CITY: ST CROIX | STATE: VI

8. PATIENT STATUS: Single (X) Married ( ) Other ( ) | Employed ( ) Full-Time Student ( ) Part-Time Student ( )

CITY: | STATE:

ZIP CODE: 00841 2583 | TELEPHONE (Include Area Code): (809) 778 9832

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH: MM DD YY | SEX: M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY | SEX: M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 09 18 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO (X) | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 02
2. 401 9
3. 272 0
4.

22. MEDICAID RESUBMISSION CODE: | ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09182001	09182001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 | SSN | EIN (X)

26. PATIENT'S ACCOUNT NO.: 1991034200

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES (X) NO ( )

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 18 2001

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

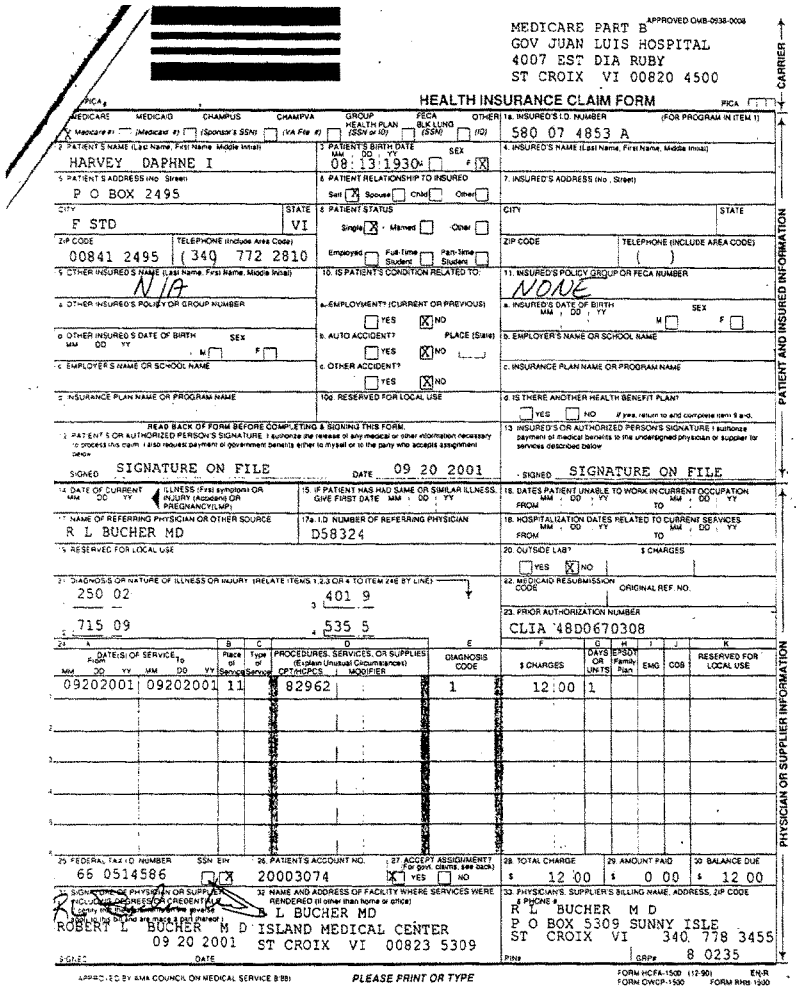
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# | GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-500 FORM RHB-1500



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MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

X (Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 07 4853 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HARVEY DAPHNE I

3. PATIENT'S BIRTH DATE MM DD YY: 08 13 1930 | SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 2495

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: F STD | STATE: VI

8. PATIENT STATUS: Single X | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 00841 2495 | TELEPHONE (Include Area Code): (340 772 2810

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | X NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? PLACE (State): YES | X NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO (If yes, return to and complete item 9 a-d.)

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 02
2. 715 09
3. 401 9
4. 535 5

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA '48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 66 0514586 | SSN | EIN: X

26. PATIENT'S ACCOUNT NO.: 20003074

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001
SIGNED | DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# | GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

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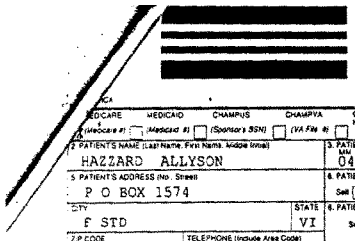
FORM HCFA-1500 (12-90) E/M-R
FORM OWCP-1500 FORM RHS 1500



MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 03 7805 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HAZZARD ALLYSON

3. PATIENT'S BIRTH DATE: 04 01 1928 | SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 1574

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: F STD | STATE: VI

6. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: | STATE:

ZIP CODE: 00841 1574 | TELEPHONE (Include Area Code): (340 772 5036

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 03
2. 401 9
3. 437 1
4. 782 3

22. MEDICAID RESUBMISSION CODE: | ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H I.D. QUAL.	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 66 0514586 | SSN | EIN

26. PATIENT'S ACCOUNT NO.: 1998249200

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# | GRP# 8 0235

SIGNED | DATE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500
FORM RRB-1500

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MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)
				X		

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 118 30 1086 B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RUIZ DE SOTO DALILA

3. PATIENT'S BIRTH DATE (MM DD YY): 06 28 1932 — SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No. Street): P O BOX 1535

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: F STD — STATE: VI

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: — STATE:

ZIP CODE: 00841 1535 — TELEPHONE (Include Area Code): (340) 772 3075

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE: 09 18 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY):

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 00
2. 253 1
3. 244 9
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09182001	09182001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 — SSN EIN: X

26. PATIENT'S ACCOUNT NO.: 1998245800

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 18 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

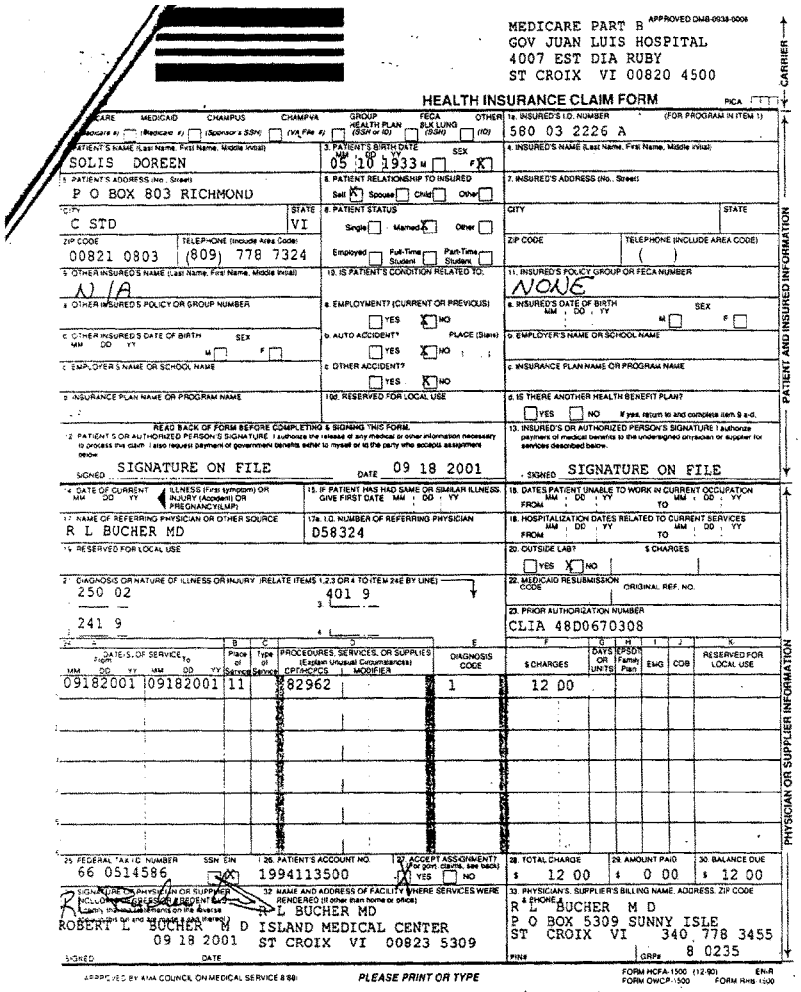
R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# — GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RHS-1500



MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SS#)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
							580 03 2226 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
SOLIS DOREEN	05 10 1933 M [ ] F [X]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
P O BOX 803 RICHMOND	Self [X] Spouse [ ] Child [ ] Other [ ]	
CITY / STATE	8. PATIENT STATUS	CITY / STATE
C STD / VI	Single [ ] Married [X] Other [ ]	
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
00821 0803 / (809) 778 7324		( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N/A		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 09 18 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
R L BUCHER MD	D58324	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 250 02 2. 241 9 3. 401 9 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER CLIA 48D0670308

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09182001 09182001	11		82962	1	12 00					

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 0514586 [X]	1994113500	YES [X] NO [ ]	$ 12 00	$ 0 00	$ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
R L BUCHER MD
ROBERT L BUCHER M D
09 18 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455
PIN# GRP# 8 0235

SIGNED DATE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RHS-1500

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

MEDICARE X	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)	580 03 0030 D

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WALCOTT MADELINE

3. PATIENT'S BIRTH DATE MM DD YY: 07 04 1920 — SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 2259

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: F STD — STATE: VI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: — STATE:

ZIP CODE: 00841 2259 — TELEPHONE (Include Area Code): (340) 772 1260

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 03
2. 729 5
3. 401 9
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 — SSN EIN: EIN ☒

26. PATIENT'S ACCOUNT NO.: 1999273200

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D

SIGNED: 09 20 2001 — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# — GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP 1500

ENAR
FORM Rms 1500

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[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
X						

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 03562 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WASHINGTON ROSE A

3. PATIENT'S BIRTH DATE (MM DD YY): 02 11 1931 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 1033

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: F STD STATE: VI

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: STATE:

ZIP CODE: 00841 1033 TELEPHONE (Include Area Code): (809) 772 0451

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

8. INSURED'S DATE OF BIRTH (MM DD YY) SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 058324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 00
2. 401 9
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATES OF SERVICE From (MM DD YY)	To (MM DD YY)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 66 0514586 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 1996179000

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

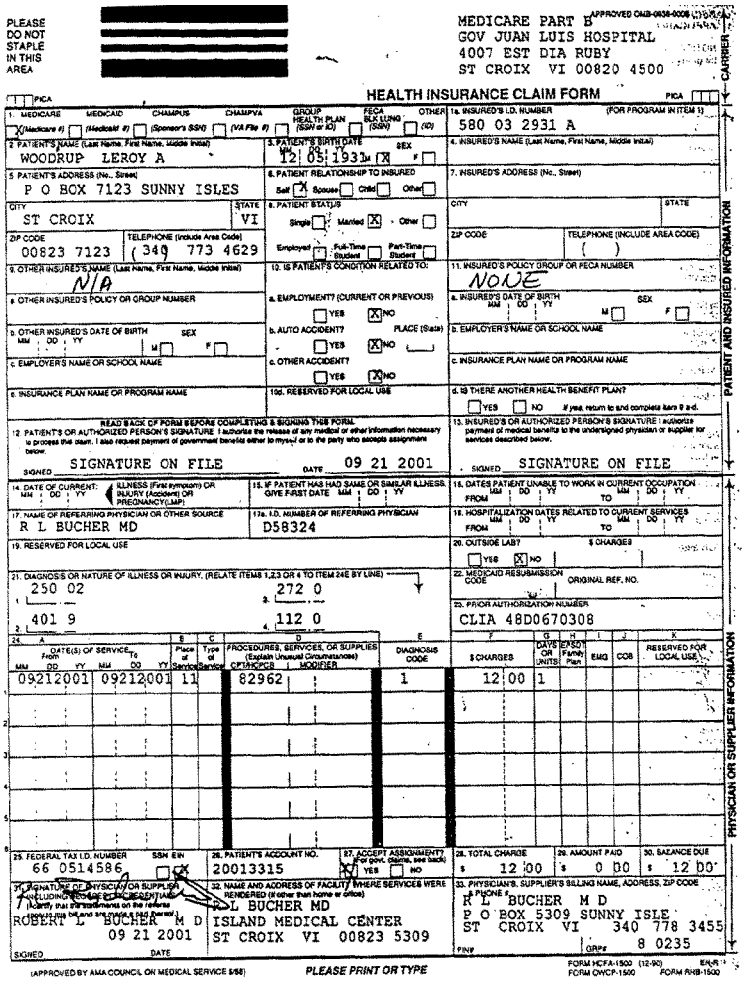
PHONE #
R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (X) (Medicare #) | MEDICAID ( ) (Medicaid #) | CHAMPUS ( ) (Sponsor's SS#) | CHAMPVA ( ) (VA File #) | GROUP HEALTH PLAN ( ) (SS# or ID) | FECA BLK LUNG ( ) (SS#) | OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 03 2931 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WOODRUP LEROY A

3. PATIENT'S BIRTH DATE: MM 12 DD 05 YY 1933 | SEX: M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 7123 SUNNY ISLES

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street):

CITY: ST CROIX | STATE: VI

8. PATIENT STATUS: Single ( ) Married (X) Other ( )

CITY: | STATE:

ZIP CODE: 00823 7123 | TELEPHONE (Include Area Code): (340) 773 4629

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH: MM DD YY | SEX: M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY | SEX: M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 09 21 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO (X) | $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 02
2. 401 9
3. 272 0
4. 112 0

22. MEDICAID RESUBMISSION CODE: | ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09212001	09212001	11		82962		1	12 00	1				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 66 0514586 | SSN | EIN (X)

26. PATIENT'S ACCOUNT NO.: 20013315

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES (X) NO ( )

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 21 2001
SIGNED | DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# | GRP# 8 0235

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) E4/R
FORM OWCP-1500 FORM RRB-1500

Medicare/Triple S,Inc.
1441 Roosevelt Ave..
San Juan, Puerto Rico 00920
Tel.(787) 749-4232 / 749-4281

MEDICARE
REMITTANCE
NOTICE

ROBERT L BUCHER
PO BOX 5309
CHRISTIANSTED, VI 00823-5309

PROVIDER #: 0080235
PAGE #: 1 OF 1
DATE: 10/10/01
CHECK/EFT #: 01283000996
STATEMENT #: 12833AA0082SYS

*** Visit our WEB Page at: www.triples-med.org*** Our toll free phone number is: 1-877-715-1921****

Medicare 101 Seminars. Don't miss the opportunity to learn more about Medicare billing concepts, regulations and sources of information available for providers. The seminar will be held at the Triple-S, Inc. anfitheather from 5:30 to 9:30pm on the following dates; 10/24 or 25 and 11/28 or 29.

New ICD-9 update begin on 10/01/2001. Then, effective for claims received on or after 01/01/2002 the update codes must be used. Obtained your copy at: AMA; P O Box 7046 Dover, DE 19903

"The safest way to receive Medicare Payments" The EFT method allows Medicare to deposit payments directly to your bank account. For more information, call at; 787-749-4232 or 1-877-715-1921.

Any Medicare checks payment on or after 10/31/2001, we recommend to cash these checks on or before February 01/2001. Because the bank that process Medicare checks will change the Routing Transit Number on every checks printed on or after February 1/2001.

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME ARCHIBALD, J		HIC 581106381A		ACNT				ICN 01274479124000		ASG Y MOA MA13	MA01
0080235	0927 092701 11	1	82962			12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	

TOTALS:	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
	1	12.00	0.00	0.00	0.00	12.00	0.00

ADJS:	TOTAL PREV PD	TOTAL PD TO BENE	TOTAL INT	TOTAL PRIMARY	TOTAL OFFSET	TOTAL OTHER ADJS	AMOUNT OF CHECK
	0.00	0.00	0.00	0.00	0.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes:

CO	Contractual obligation. The patient may not be billed for this amount.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim conduct the review. However, in order to be eligible for a review, you must write to us within 6 month of the date of this notice, unless you have a good reason for being late.
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient Responsability) group code.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
[X] Medicare #) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
580 11 6381 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
ARCHIBALD JOSHUA

3. PATIENT'S BIRTH DATE MM DD YY SEX
03 28 1912 M [X] F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)
P O BOX 446

6. PATIENT RELATIONSHIP TO INSURED
Self [X] Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No. Street)

CITY
C STD

STATE
VI

8. PATIENT STATUS
Single ( ) Married [X] Other ( )

CITY

STATE

ZIP CODE
00821 0446

TELEPHONE (Include Area Code)
(340) 778 6747

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE

TELEPHONE (INCLUDE AREA CODE)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
N/A

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER
NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS)
( ) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX
M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX
M ( ) F ( )

b. AUTO ACCIDENT? PLACE (State)
( ) YES [X] NO

b. EMPLOYER'S NAME OR SCHOOL NAME

EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
( ) YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
( ) YES ( ) NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 09 27 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN
D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
( ) YES [X] NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1 250 63
2 401 9
3 233 4
4 715 09

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09272001	09272001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN
66 0514586 [X]

26. PATIENT'S ACCOUNT NO.
20003175

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
[X] YES ( ) NO

28. TOTAL CHARGE
$ 12 00

29. AMOUNT PAID
$ 0 00

30. BALANCE DUE
$ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ROBERT L BUCHER M D
09 27 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455
PIN# GRP# 3 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 12-90
FORM OACP 1500

EN-R
FORM Rev. 1500

10-1-01 CB

R.L. BUCHER, M.D.
ENDOCRINOLOGY

5309 Sunny Isle • St. Croix, VI 00823-5309 • (340) 778-3455 • fax (340) 778-3455 • e-mail rlb@islands.vi

November 5, 2001

Gonzalo V. Gonzalez-Liboy, MD, FACP
Medical Director/CAC Co-Chair
Medicare Division, Triple-S, Inc.
PO Box 71391
San Juan, PR 00936-1391

Dear Dr. Liboy:

Twelve more claims for blood sugars done in my office in August and September have been denied because "treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." The POS on all claims is "11", my office. All the claims are clean. All the patients have diabetes. As you know, I have CLIA Certification to perform this exempt test.

I have not received a reply from my letter to you dated October 1, 2001 about 33 claims rejected for the same reason.

What is the problem? Why do I have to keep writing to you about this? If Medicare is no longer going to pay for testing the blood sugars of patients with diabetes, just let us know.

I've instructed my staff to stop billing Medicare for this service until the problem is resolved. All I'm getting is reams of paper and aggravation.

Sincerely,

R.L. Bucher, M.D.

cc: Donna Christensen, M.D., Delegate to Congress
Cora Christian, M.D., VIMI
Kristine Cintron, Medicare Office

Medicare/Triple S,Inc.
1441 Roosevelt Ave.
San Juan, Puerto Rico 00920
Tel.(787) 749-4232 / 749-4281

MEDICARE
REMITTANCE
NOTICE

ROBERT L BUCHER
PO BOX 5309
CHRISTIANSTED, VI 00823-5309

PROVIDER #: 0080235
PAGE #: 1 OF 1
DATE: 10/09/01
CHECK/EFT #: 01282000928
STATEMENT #: 12823AA0082SYS

*** Visit our WEB Page at: www.triples-med.org*** Our toll free phone number is: 1-877-715-1921****

Medicare 101 Seminars. Don't miss the opportunity to learn more about Medicare billing concepts, regulations and sources of information available for providers. The seminar will be held at the Triple-S, Inc. anfitheather from 5:30 to 9:30pm on the following dates; 10/24 or 25 and 11/28 or 29.

New ICD-9 update begin on 10/01/2001. Then, effective for claims received on or after 01/01/2002 the update codes must be used. Obtained your copy at: AMA; P O Box 7046 Dover, DE 19903

"The safest way to receive Medicare Payments" The EFT method allows Medicare to deposit payments directly to your bank account. For more information, call at; 787-749-4232 or 1-877-715-1921.

Any Medicare checks payment on or after 10/31/2001, we recommend to cash these checks on or before February 01/2001. Because the bank that process Medicare checks will change the Routing Transit Number on every checks printed on or after February 1/2001.

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME BELL, GLORIA				HIC 580855025A	ACNT			ICN 01274474083000		ASG Y MOA MA13 MA01	
0080235	0918 091801 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME CARRION, LUIS				HIC 076289032A	ACNT			ICN 01274474093000		ASG Y MOA MA13 MA01	
0080235	0920 092001 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME NICHOLAS, LINCOLN				HIC 580125902A	ACNT			ICN 01274474085000		ASG Y MOA MA13 MA01	
0080235	0920 092001 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	

TOTALS:	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
	3	36.00	0.00	0.00	0.00	36.00	0.00
ADJS:	TOTAL PREV PD	TOTAL PD TO BENE	TOTAL INT	TOTAL PRIMARY	TOTAL OFFSET	TOTAL OTHER ADJS	AMOUNT OF CHECK
	0.00	0.00	0.00	0.00	0.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes:

CO	Contractual obligation. The patient may not be billed for this amount.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim conduct the review. However, in order to be eligible for a review, you must write to us within 6 month of the date of this notice, unless you have a good reason for being late.
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient Responsability) group code.

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)			(ID)	580 05 5025 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
BELL GLORIA	09 01 1927 M [ ] F [X]	
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No. Street)
P O BOX 3737	Self [X] Spouse [ ] Child [ ] Other [ ]	
CITY: C STD / STATE: VI	8. PATIENT STATUS: Single [ ] Married [X] Other [ ]	CITY / STATE
ZIP CODE: 00822 3737 / TELEPHONE (Include Area Code): (340) 773 3559	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER INSURED'S NAME OF SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 09 18 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: P L BUCHER MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 250 03 2. 272 0 3. 401 9 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09182001	09182001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586	SSN EIN: X	26. PATIENT'S ACCOUNT NO.: 1998250600	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES [ ] NO	28. TOTAL CHARGE: $ 12 00	29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ROBERT L BUCHER M D
09 18 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455
PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) NUCC
FORM OWCP-1500
FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

[redacted] MEDICARE PART B APPROVED OMB-0938-0008

[redacted]

MEDICARE PART B APPROVED OMB-0938-0008
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

PICA #

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [X] (Medicare #) | MEDICAID [ ] (Medicaid #) | CHAMPUS [ ] (Sponsor's SSN) | CHAMPVA [ ] (VA File #) | GROUP HEALTH PLAN [ ] (SSN or ID) | FECA BLK LUNG [ ] (SSN) | OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 076 28 9032 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CARRION LUIS

3. PATIENT'S BIRTH DATE MM DD YY: 07 25 1935 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 2144 KINGSHILL

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ST CROIX | STATE: VI

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY | STATE

ZIP CODE: 00851 2144 | TELEPHONE (Include Area Code): (809 778 0970

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X] ( )

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 63
2. 349 90
3. 571 5
4. 437 1

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 | SSN | EIN [X]

26. PATIENT'S ACCOUNT NO.: 1993092500

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# 8 0235 GRP#

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN:R
FORM OWCP-1500 FORM RRB-1500

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

Pended
PMT

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)
CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)
OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	580 12 5902 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	NICHOLAS LINCOLN K	
3. PATIENT'S BIRTH DATE MM DD YY / SEX	12 08 1938 M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)	P O BOX 5545 SUNNY ISLES	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] / 7. INSURED'S ADDRESS (No. Street)
CITY / STATE	ST CROIX / VI	8. PATIENT STATUS: Single [ ] Married [X] Other [ ] / CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	00823 5545 (809) 773 4045	Employed [ ] Full-Time Student [ ] Part-Time Student [ ] / ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	N/A	10. IS PATIENT'S CONDITION RELATED TO: / 11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X] / a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]		b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State) / b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES [ ] NO [X] / c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE / d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 250 73 2. 571 5 3. V89 5 4. 607 84		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: SSN EIN: 66 0514586	26. PATIENT'S ACCOUNT NO.: 1993093700	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 12 00 / 29. AMOUNT PAID: $ 0 00 / 30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.): R L BUCHER M D
09 20 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): R L BUCHER MD ISLAND MEDICAL CENTER ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: R L BUCHER M D P O BOX 5309 SUNNY ISLE ST CROIX VI 340 778 3455 / GRP# 8 0235

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM HHB-1500

Medicare/Triple S,Inc.
1441 Roosevelt Ave.
San Juan, Puerto Rico 00920
Tel.(787) 749-4232 / 749-4281

MEDICARE
REMITTANCE
NOTICE

ROBERT L BUCHER
PO BOX 5309
CHRISTIANSTED, VI 00823-5309

PROVIDER #: 0080235
PAGE #: 1 OF 2
DATE: 10/05/01
CHECK/EFT #: 01276000922
STATEMENT #: 12783AA0102SYS

***** Visit our WEB Page at: www.triples-med.org *****

Our new toll free telephone number for provider is: 1-877-715-1921.

Medicare 101 Seminars. Don't miss the opportunity to learn more about Medicare billing concepts, regulations and sources of information available for providers. The seminar will be held at the Triple-S, Inc. amfitheather from 5:30 to 9:30pm on the following dates; 10/24 or 25 and 11/28 or 29.

"As a results of HIPAA, providers who use electronic transactions may realize significant savings. Contact 787-749-4232 now for further information on how you can begin or expand your use of electronic transactions".

New ICD-9 update begin on 10/01/2001. Then, effective for claims received on or after 01/01/2002 the update codes must be used. Obtained your copy at: AMA; P O Box 7046 Dover, DE 19903

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME CHRISTIAN, BODIL			HIC 068282579A		ACNT			ICN 01274474082000		ASG Y MOA MA13	MA01
0080235	0918 091801 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME HARVEY, DAPHANE			HIC 580074853A		ACNT			ICN 01274474086000		ASG Y MOA MA13	MA01
0080235	0920 092001 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME HAZZARD, ALLYSON			HIC 580037805A		ACNT			ICN 01274474084000		ASG Y MOA MA13	MA01
0080235	0920 092001 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME RUIZ DE SOT, DALILA			HIC 118301086D		ACNT			ICN 01274474081000		ASG Y MOA MA27 MA01	MA13
0080235	0918 091801 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME SOLIS, DOREEN			HIC 580032226A		ACNT			ICN 01274474088000		ASG Y MOA MA13	MA01
0080235	0918 091801 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME WALCOTT, MADALINE			HIC 580030030D		ACNT			ICN 01274474092000		ASG Y MOA MA13	MA01
0080235	0920 092001 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	
NAME WASHINGTON, ROSE			HIC 580033562A		ACNT			ICN 01274474091000		ASG Y MOA MA13	MA01
0080235	0920 092001 11		1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	

Medicare/Triple S,Inc.
PROVIDER #: 0080235
CHECK/EFT #:01278000922 10/05/01

Tel.(787) 749-4232 /
ROBERT L BUCHER
PAGE #: 2 OF 2

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME WOODRUP, LEROY *		HIC 580032931A		ACNT				ICN 01274474090000		ASG Y	MOA MA13 MA01
0080235	0921 092101	11	1	82962		12.00	0.00	0.00	0.00	CO-58 12.00	0.00
PT RESP 0.00				CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	

	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
TOTALS:	8	96.00	0.00	0.00	0.00	96.00	0.00

	TOTAL PREV PD	TOTAL PD TO BENE	TOTAL INT	TOTAL PRIMARY	TOTAL OFFSET	TOTAL OTHER ADJS	AMOUNT OF CHECK
ADJS:	0.00	0.00	0.00	0.00	0.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes:

CO	Contractual obligation. The patient may not be billed for this amount.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim conduct the review. However, in order to be eligible for a review, you must write to us within 6 month of the date of this notice, unless you have a good reason for being late.
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient Responsability) group code.
MA27	Incorrect entitlement number shown on the claim. Please use the entitlement number shown on this notice for future claims for this patient.

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 068 28 2579 A

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CHRISTIAN BODIL E	02 24 1936 M [ ] F [X]	
5. PATIENT'S ADDRESS (No. Street): P O BOX 2583	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: ST CROIX	STATE: VI	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
ZIP CODE: 00841 2583	TELEPHONE (Include Area Code): (809) 778 9832	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY	STATE	
ZIP CODE	TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 09 18 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 250 02 2. 272 0 3. 401 9 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09182001 09182001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES	NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 0514586		X	1991034200	X		$ 12 00	$ 0 00	$ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ROBERT L BUCHER M D
09 18 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
PHONE #
R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455
PIN# GRP# 8 0235

SIGNED DATE

PHYSICIAN OR SUPPLIER INFORMATION

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RRB-1500

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 07 4853 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HARVEY DAPHNE I

3. PATIENT'S BIRTH DATE: 08 13 1930 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No. Street): P O BOX 2495

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: F STD STATE: VI

8. PATIENT STATUS: Single X Married Other

CITY: STATE:

ZIP CODE: 00841 2495 TELEPHONE (Include Area Code): (340) 772 2810

Employed Full-Time Student Part-Time Student

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. AUTO ACCIDENT? YES NO X PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 02
2. 715 09
3. 401 9
4. 535 5

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: CLIA '48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H (EPSDT) Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 SSN EIN: X

26. PATIENT'S ACCOUNT NO.: 20003074

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RHB-1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
X						

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 03 7805 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HAZZARD ALLYSON

3. PATIENT'S BIRTH DATE: 04 01 1928 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 1574

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: F STD STATE: VI

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: STATE:

ZIP CODE: 00841 1574 TELEPHONE (Include Area Code): (340 772 5036

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (accident) OR PREGNANCY (LMP) MM DD YY:

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 03
2. 437 1
3. 401 9
4. 782 3

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 SSN EIN: EIN [X]

26. PATIENT'S ACCOUNT NO.: 1998249200

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

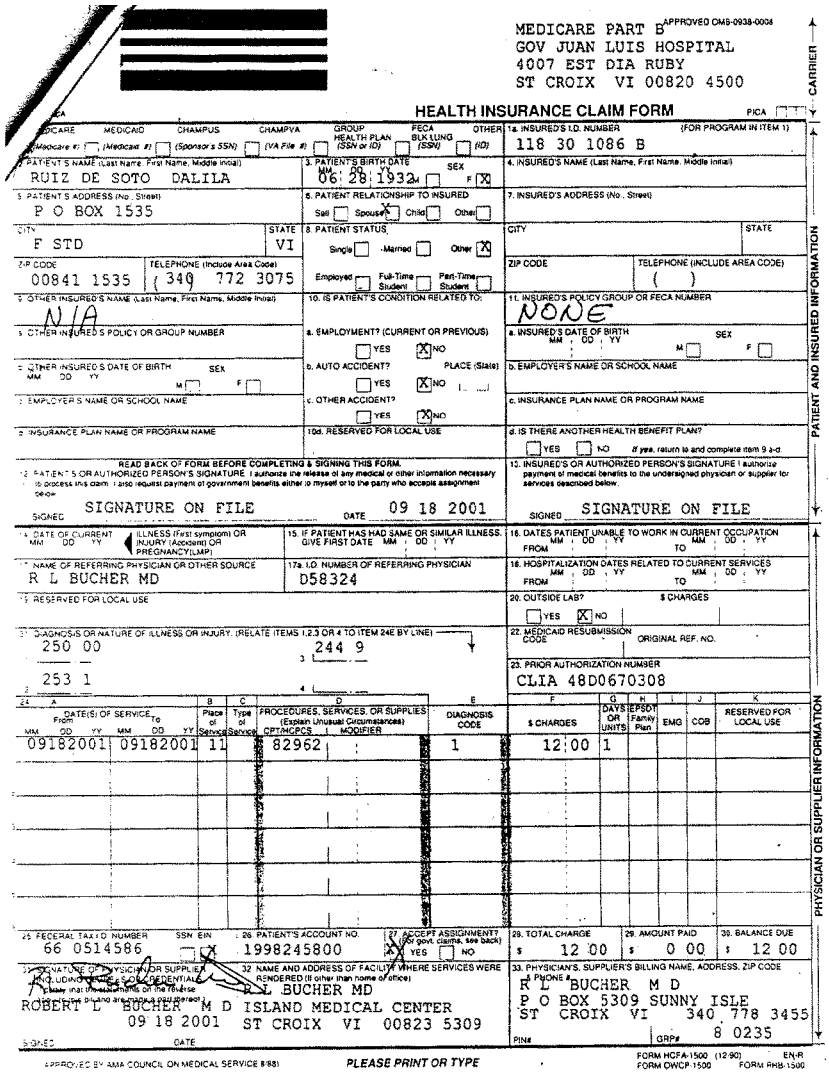
PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RHB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 118 30 1086 B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RUIZ DE SOTO DALILA

3. PATIENT'S BIRTH DATE: 06 28 1932 M

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 1535

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse X | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: F STD | STATE: VI

8. PATIENT STATUS: Single | Married | Other X

CITY | STATE

ZIP CODE: 00841 1535 | TELEPHONE (Include Area Code): (340) 772 3075

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? PLACE (State): YES | NO X

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 18 2001

12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 00
2. 253 1
3. 244 9
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09182001	09182001	11		82962		1	12 00	1				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 66 0514586 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 1998245800

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X | NO

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D

09 18 2001

SIGNED | DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# | GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RRB-1500

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 03 2226 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SOLIS DOREEN

3. PATIENT'S BIRTH DATE (MM DD YY): 05 10 1933 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 803 RICHMOND

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: C STD STATE: VI

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: STATE:

ZIP CODE: 00821 0803 TELEPHONE (Include Area Code): (809) 778 7324

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): SEX: M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X]

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 18 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 250 02
2. 241 9
3. 401 9
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09182001	09182001	11		82962		1	12 00					

25. FEDERAL TAX I.D. NUMBER: 66 0514586 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 1994113500

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 18 2001

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 EN-R FORM RRB-1500

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 03 0030 D

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WALCOTT MADELINE

3. PATIENT'S BIRTH DATE MM DD YY: 07 04 1920 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 2259

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: F STD | STATE: VI

8. PATIENT STATUS: Single Married Other X

CITY | STATE

ZIP CODE: 00841 2259 | TELEPHONE (Include Area Code): (340) 772 1260

Employed Full-Time Student Part-Time Student

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES X NO

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. AUTO ACCIDENT? PLACE (State): YES X NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F

c. OTHER ACCIDENT? YES X NO

c. EMPLOYER'S NAME OR SCHOOL NAME

d. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 03
2. 729 5
3. 401 9
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 1999273200

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) E/M R
FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (X)	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(X) (Medicare #)	( ) (Medicaid #)	( ) (Sponsor's SSN)	( ) (VA File #)	( )	( )	( )	580 03562 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
WASHINGTON ROSE A	02 11 1931 M ( ) F (X)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
P O BOX 1033	Self (X) Spouse ( ) Child ( ) Other ( )	
CITY: F STD	STATE: VI	CITY:	STATE:
ZIP CODE: 00841 1033	TELEPHONE (Include Area Code): (809 772 0451	ZIP CODE:	TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N/A		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ( ) YES (X) NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )	b. AUTO ACCIDENT? ( ) YES (X) NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ( ) YES (X) NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES ( ) NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 20 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ( ) YES (X) NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 250 00 2. 401 9 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09202001	09202001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 0514586	( )	(X)	1996179000	(X) YES ( ) NO	$ 12 00	$ 0 00	$ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 20 2001

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

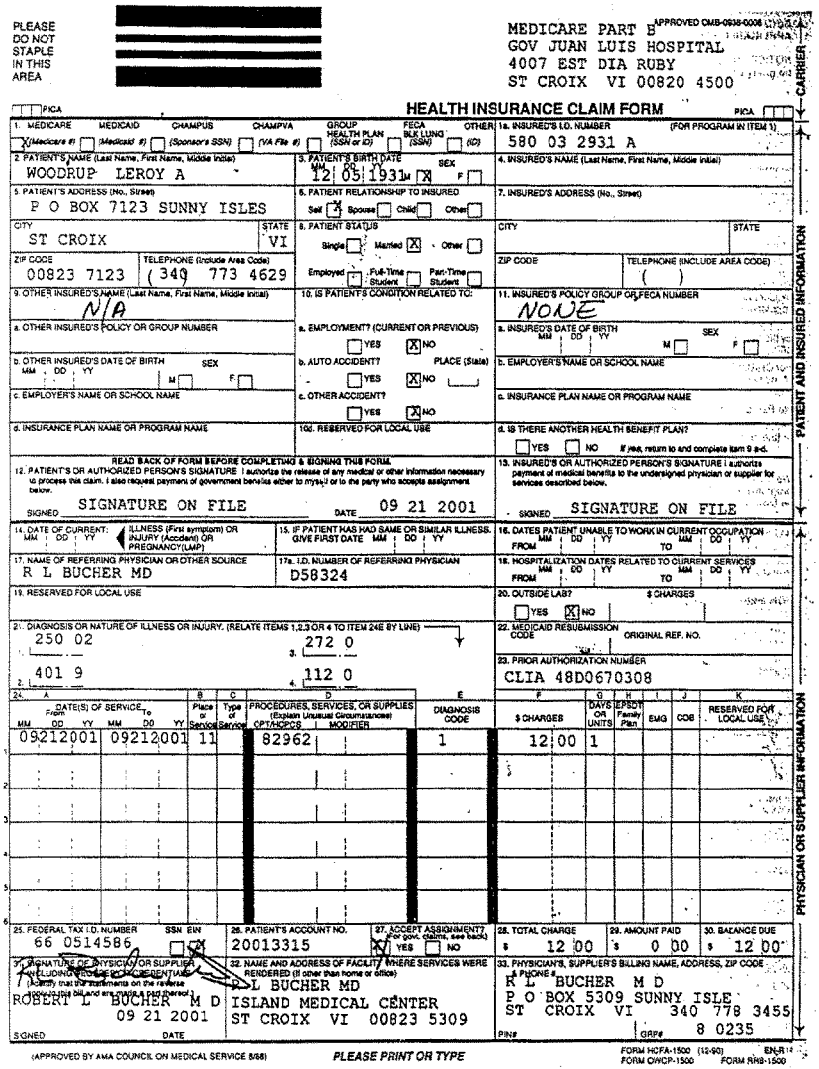
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RRS-1500



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 580 03 2931 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WOODRUP LEROY A

3. PATIENT'S BIRTH DATE: 12 05 1931 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): P O BOX 7123 SUNNY ISLES

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ST CROIX STATE: VI

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: STATE:

ZIP CODE: 00823 7123 TELEPHONE (Include Area Code): (340) 773 4629

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324

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19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250 02
2. 401 9
3. 272 0
4. 112 0

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09212001	09212001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER: 66 0514586 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 20013315

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 12 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D
09 21 2001
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) ENLR14
FORM OWCP-1500 FORM RRB-1500

Medicare/Triple S,Inc.
1441 Roosevelt Ave.
San Juan, Puerto Rico 00920
Tel.(787) 749-4232 / 749-4281

MEDICARE
REMITTANCE
NOTICE

ROBERT L BUCHER
PO BOX 5309
CHRISTIANSTED, VI 00823-5309

PROVIDER #: 0080235
PAGE #: 1 OF 1
DATE: 10/10/01
CHECK/EFT #: 01283000996
STATEMENT #: 12833AA0082SYS

*** Visit our WEB Page at: www.triples-med.org*** Our toll free phone number is: 1-877-715-1921****

Medicare 101 Seminars. Don't miss the opportunity to learn more about Medicare billing concepts, regulations and sources of information available for providers. The seminar will be held at the Triple-S, Inc. anfitheather from 5:30 to 9:30pm on the following dates; 10/24 or 25 and 11/28 or 29.

New ICD-9 update begin on 10/01/2001. Then, effective for claims received on or after 01/01/2002 the update codes must be used. Obtained your copy at: AMA; P O Box 7046 Dover, DE 19903

"The safest way to receive Medicare Payments" The EFT method allows Medicare to deposit payments directly to your bank account. For more information, call at; 787-749-4232 or 1-877-715-1921.

Any Medicare checks payment on or after 10/31/2001, we recommend to cash these checks on or before February 01/2001. Because the bank that process Medicare checks will change the Routing Transit Number on every checks printed on or after February 1/2001.

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME ARCHIBALD, J			HIC 580106381A	ACNT				ICN 01274470124000	ASG Y	MOA MA13	MA01
0080235	0927 092701 11		1	82962		12.00	0.00	0.00	0.00 CO-58	12.00	0.00
PT RESP	0.00			CLAIM TOTALS		12.00	0.00	0.00	0.00	12.00	0.00
										0.00 NET	

TOTALS:	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
	1	12.00	0.00	0.00	0.00	12.00	0.00

ADJS:	TOTAL PREV PD	TOTAL PD TO BENE	TOTAL INT	TOTAL PRIMARY	TOTAL OFFSET	TOTAL OTHER ADJS	AMOUNT OF CHECK
	0.00	0.00	0.00	0.00	0.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes:

CO	Contractual obligation. The patient may not be billed for this amount.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim conduct the review. However, in order to be eligible for a review, you must write to us within 6 month of the date of this notice, unless you have a good reason for being late.
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient Responsability) group code.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MEDICARE PART B
GOV JUAN LUIS HOSPITAL
4007 EST DIA RUBY
ST CROIX VI 00820 4500

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
[X] Medicare # [ ] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)	580 11 6381 A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ARCHIBALD JOSHUA	3. PATIENT'S BIRTH DATE (MM DD YY): 03 28 1912 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):	
5. PATIENT'S ADDRESS (No., Street): P O BOX 446	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):	
CITY: C STD	STATE: VI
8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	
ZIP CODE: 00821 0446	TELEPHONE (Include Area Code): (340) 778 6747
CITY:	STATE:
ZIP CODE:	TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH (MM DD YY) SEX: M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX: M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X]
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 09 27 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: R L BUCHER MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: D58324	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 250 63 2. 401 9 3. 233 4 4. 715 09		22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:
		23. PRIOR AUTHORIZATION NUMBER: CLIA 48D0670308

24. A DATE(S) OF SERVICE From (MM DD YY) To (MM DD YY)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09272001 09272001	11		82962		1	12 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
66 0514586 [ ] [X]	20003175		$ 12 00	$ 0.00	$ 12 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROBERT L BUCHER M D

SIGNED

DATE 09 27 2001

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

R L BUCHER MD
ISLAND MEDICAL CENTER
ST CROIX VI 00823 5309

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE (PHONE #)

R L BUCHER M D
P O BOX 5309 SUNNY ISLE
ST CROIX VI 340 778 3455

PIN# GRP# 8 0235

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) EN-R
FORM OWCP-1500 FORM RRB-1500

10-1-01 CB

Congress of the United States

Washington, DC 20515

March 19, 2001

Mr. Thomas Scully
Administrator
Health Care Financing Administrator
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

Dear Administrator Scully:

On Wednesday, March 6, 2001, the House Committee on Small Business held a hearing on the Small Business Regulatory Enforcement Fairness Act (SBREFA). Mr. Norman Goldhecht, Regulatory Chairman for the National Association of Portable X-Ray Providers, testified on problems that the Portable X-Ray industry has had with the Center for Medicaid Service lack of compliance with the Regulatory Flexibility Act. This was the third time that Mr.Goldhect has come before the committee to provide insight on this matter. Some of the members of the committee were informed, off the record, that the president of the National Association of Portable X-Ray Providers was subject to an unexpected audit on the very same morning of the audit. The timing of the audit could possibly have given the impression that it was scheduled as a punitive measure for the Association testifying before the committee. We would like your personal assurance that this is not the case. In previous hearings on the topic of CMS compliance with SBREFA, the committee received testimony that physicians have been subject to unexpected audits that appeared to be in retribution to a their complaints about CMS. This has caused much concern and resulted in investigations to be conducted by the Chairman of the Committee, Congressman Donald Manzullo.

Additionally, the National Association of Portable X-Ray Providers met in Washington, D.C. this week. The members of the Small Business Committee were told that representatives from CMS were invited to participate but declined. This would have been a perfect opportunity for CMS to meet with the Association to discuss their concerns.

The above information that the Association shared with the members of the committee concerns us. We request that you look into this matter as soon as possible. It is our objective, as we hope is yours, to make federal regulations less burdensome on our nations small businesses. In reaching this objective, we hope that CMS will do what is possible to comply with SBREFA. Your assistance in this matter would be greatly appreciated.

Sincerely,

Congresswoman Nydia Velazquez
Ranking Member
House Committee on Small Business

Congresswoman Donna M. Christensen
Member
House Committee on Small Business