

15733

~~RESTRICTED~~ — Not to be released outside the General Accounting Office except on the basis of specific approval by the Office of Congressional Relations.

114140

Report To The Subcommittee On Oversight, House Committee On Ways And Means OF THE UNITED STATES

RELEASED

RELEASED

Department Of Health And Human Services Should Improve Monitoring Of Professional Standards Review Organizations

Professional Standards Review Organizations (PSROs) are designed to assure that health care services provided under Medicare and Medicaid are delivered as effectively, efficiently, and economically as possible

GAO reviewed the records of 809 patients that had 1,779 days of their hospital stays denied for payment because PSROs determined that hospitalization was not necessary on these days. An additional 384 days of care should have been denied if the patients' care was reviewed in accordance with applicable regulations and requirements. Monitoring of the PSRO program by the Department of Health and Human Services was not sufficient to make program officials aware of such noncompliance.



114140

The benefits of extending PSRO authority to perform hospital discharge planning appears questionable.

This report also discusses paying for physicians' services provided on days where hospitalization is not necessary and controlling PSRO type costs incurred by delegated hospitals.



HRD 81-26
DECEMBER 29, 1980

~~573948~~ 114140

For sale by

Superintendent of Documents
U S Government Printing Office
Washington, D C 20402

Telephone (202) 783-3238

Members of Congress, heads of Federal, State,
and local government agencies, members of the press,
and libraries can obtain GAO documents from

U S General Accounting Office
Document Handling and Information
Services Facility
P O Box 6015
Gaithersburg, Md 20760

Telephone (202) 275-6241



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D C 20548

B-201224

The Honorable Sam M. Gibbons
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Your November 8, 1978, letter asked us to review certain aspects of the Professional Standards Review Organization (PSRO) program. As agreed with representatives of your Subcommittee, we looked into (1) PSRO compliance with Department of Health and Human Services requirements for reviewing patient hospital care and for monitoring delegated reviews, (2) the desirability for PSROs to be given more responsibility for planning patients' postdischarge care, (3) the extent to which physicians are paid for inpatient care provided to patients whose hospital stay has been determined to be medically unnecessary, and (4) the Department's control over PSRO costs for hospital reviews.

This report discusses how noncompliance with applicable regulations and requirements has resulted in the payment for unnecessary days of hospital care. The Department's monitoring of the PSRO program did not disclose these instances of noncompliance. Also, the report discusses actions that the Department is taking to (1) obtain adequate control over hospital review costs and (2) implement review of physician services provided to hospitalized patients. The potential savings from reviewing these physician services does not appear to be significant. Finally, the report discusses the adequacy of postdischarge planning performed by hospitals.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 14 days from the date of the report. At that time we will send copies to interested parties and make copies available to others on request.

Sincerely yours,


Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT
TO THE SUBCOMMITTEE ON OVERSIGHT,
HOUSE COMMITTEE
ON WAYS AND MEANS

DEPARTMENT OF HEALTH AND
HUMAN SERVICES SHOULD
IMPROVE MONITORING OF
PROFESSIONAL STANDARDS
REVIEW ORGANIZATIONS

D I G E S T

More effective monitoring by the Department of Health and Human Services (HHS) and Professional Standards Review Organizations (PSROs) is needed to ensure that hospitals are not paid for medically unnecessary days of care for Medicare and Medicaid patients. (See ch. 2.)

PSROs--established by 1972 amendments to the Social Security Act--are designed to make sure that health care services provided under Medicare and Medicaid are delivered as effectively, efficiently, and economically as possible. This is accomplished, in part, by reviewing the care provided to hospital patients.

GAO reviewed the records of 809 acute care patients, at 39 hospitals in 13 PSRO areas, whose hospital stay was determined to be either partially or entirely medically unnecessary. These patients incurred 1,779 days of hospital care that were determined to be unnecessary and were not paid for by Medicare and Medicaid. (See p. 4.)

If HHS, PSRO, and State requirements had been followed, an additional 384 days of patient care would have been denied for payment. These inappropriate days were related to

--224 days for extensions of patients' hospital stays which were not consistent with HHS coverage requirements (see p. 11),

--148 days for delays in performing concurrent reviews (see p. 13), and

--12 days because of inconsistencies between PSRO and Medicare paying agent's procedures for counting patient days (see p. 15).

In addition, one of the PSROs visited by GAO accumulated information which suggests that, during a 1-year period, 2,500 of the Medicare and Medicaid patients in its area had 9,300 days of hospital care inappropriately certified as medically necessary for reasons that did not conform with HHS or State regulations and instructions. (See p. 9.)

GAO's examination of HHS monitoring reports for the 13 PSROs showed no specific mention of the compliance problems discussed above. In addition, HHS regional officials said that they were unaware of these deficiencies. (See p. 7.) Also, PSRO monitoring of concurrent review functions being performed by hospitals does not appear to be adequate. (See p. 8.)

PAYMENTS TO PHYSICIANS FOR
MEDICALLY UNNECESSARY DAYS OF
HOSPITAL CARE DO NOT APPEAR LARGE

Many hospital officials believe paying physicians but not hospitals for medically unnecessary days of hospital care is inequitable because physicians, not hospitals, discharge patients. PSRO and HHS officials believe that denying physician charges for inpatient services, on days when inpatient care is not needed, would provide the doctors with an incentive to discharge patients earlier. (See p. 18.)

GAO's review of 809 claims involving adverse determinations detected only 128 claims involving \$8,000 in payments to physicians for hospital services provided on days that the

hospital was denied payment because the patients' stays were not medically necessary. (See p 18.)

Because nationally the number of adverse determinations is relatively small-- 1 percent of the 4.8 million patient admissions subject to PSRO review during the first half of 1979--and the amounts paid to physicians for hospital services to patients not needing hospitalization also appear to be relatively small, GAO believes that the potential for savings by focusing reviews in this specific area is limited. (See p. 22)

CONTROLLING HOSPITAL
REVIEW COSTS

Concern has been expressed by the Congress and others regarding the cost of PSRO hospital review. In response to these concerns, HHS plans to reduce the average cost of patient review primarily by not reviewing areas which do not appear to offer a potential for cost savings or improved care. (See p. 24)

To strengthen PSROs' control over these review costs, HHS issued instructions in April 1979 which required hospitals to justify all costs over those previously estimated and agreed upon. The instructions required (1) PSROs to review and comment on the hospitals' costs and (2) Medicare paying agents to consider the PSROs' comments. In May 1979, HHS proposed regulations that would require that hospitals and PSROs to establish budgets and review plans. The regulations were published in final form on October 10, 1980. (See p. 25.)

In GAO's opinion, the regulations should, if properly implemented, provide HHS and PSROs with better control over hospital

review costs. Also, in December 1980, the Congress passed legislation that would provide HHS and PSROs with additional leverage to control the review costs of delegated hospitals. (See pp 25 and 26.)

PATIENT DISCHARGE PLANNING

Some PSRO officials believe that they should have more authority over discharge planning because hospitals do not adequately plan for posthospital care. Discharge planning includes arranging the transfer of patients to long-term care facilities. (See p. 11.)

For the 39 hospitals included in GAO's review, hospital discharge planning appeared to be adequate. About 100 of the 809 patients included in GAO's review had their stays extended, and hospitals were paid, for a total of 1,351 days, after their need for acute hospital care ended. Of these days, 1,127 were correctly extended and paid primarily because hospital staff had documented that no suitable long-term care bed was available for these patients. The other 224 days extended should not have been certified for payment by PSRO reviewers, but GAO believes that inadequacies in hospital discharge planning were not a principal cause (See p. 12)

RECOMMENDATION TO THE SECRETARY OF HHS

The Secretary should direct the Administrator, Health Care Financing Administration, to require that monitoring activities of the Office of Professional Standards Review Organizations emphasize the extent that PSRO and hospital concurrent review activities comply with HHS coverage and procedural requirements.

1 ?

HHS AND PSRO COMMENTS

Although HHS agrees with GAO's recommendation and is taking corrective action, its comments on the draft report state that it believes that GAO's review was slanted because the PSROs reviewed ranked relatively low in the agency's January 1979 program evaluation and GAO focused on adverse determinations where some lack of medical necessity had already been identified. (See pp. 16 and 22 and app. IV.) Comments received from one PSRO are discussed in appendix V.

C o n t e n t s

	<u>Page</u>
DIGEST	1
CHAPTER	
1 INTRODUCTION	1
PSRO review	2
Program status and funding	3
Objectives, scope, and methodology	3
2 HHS AND PSROs NEED TO MORE EFFECTIVELY MONITOR CONCURRENT REVIEW ACTIVITIES	6
HHS monitoring of PSROs	7
PSRO monitoring of delegated hospitals	8
Incorrect certifications of the need for hospital care	8
Delays in performing concurrent review	13
Inconsistencies between PSRO and Medicare paying agent procedures	15
Conclusions	16
Recommendation	16
HHS comments and our evaluation	16
3 PAYMENTS TO PHYSICIANS FOR MEDICALLY UNNECESSARY DAYS OF HOSPITAL CARE ARE NOT LARGE	18
Payments to physicians for services on medically unnecessary days of hospital care	18
Progress toward reviewing physicians' hospital services	19
Patients' liability for physician services under Medicare	21
Conclusions	22
HHS comments and our evaluation	22
4 CONTROLLING HOSPITAL REVIEW COSTS	24
Need and progress to control hospital review costs	24
Conclusions	26

APPENDIX

I	Letter dated November 8, 1978, from the Chairman, Subcommittee on Oversight, House Ways and Means Committee	27
II	PSROs visited	29
III	Approved extensions of stay for one PSRO, 1978	30
IV	Letter dated July 31, 1980, from the Acting Inspector General, HHS	32
V	PSRO comments and our evaluation	36

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HSQB	Health Standards and Quality Bureau
PSRO	Professional Standards Review Organization

CHAPTER 1

INTRODUCTION

The Social Security amendments enacted in October 1972 (Public Law 92-603) authorized the Department of Health, Education, and Welfare 1/ to establish independent Professional Standards Review Organizations (PSROs) nationwide. PSROs review health care services provided under the Medicare, Medicaid, and Maternal and Child Health programs.

Medicare provides health insurance benefits to the aged, the disabled, and those with end stage kidney disease. This program is estimated to cost about \$33.1 billion in fiscal year 1980. Medicaid--a Federal/State program--provides medically necessary services to persons who cannot pay for them. For 1980 this program is estimated to cost about \$25.3 billion, including the States' share of about \$11 billion. Under the Maternal and Child Health program, HHS provides grants to enable States to expand and improve medical services that help reduce infant mortality and promote the health of mothers and children, primarily in rural and poverty areas. These grants are estimated to be about \$345.5 million for fiscal year 1980.

The Senate Committee on Finance recommended establishing the PSRO program as a partial solution to the dual problems of rising health care costs and the high incidence of medically inappropriate services rendered to Medicare and Medicaid patients. The Committee noted that the economic impact of the overutilization of services was significant. It also expressed concern over the effect that such overutilization had in terms of the health of the aged and the poor.

The amendments required PSROs to ensure that Federal funds are spent only for medically necessary services provided in accordance with professional standards and in the appropriate setting. PSROs currently review services in hospitals and certain nursing homes. The 1977 amendments to the Social Security Act (Public Law 95-142) also require PSROs to review medical care outside institutions. The program is administered by the Health Standards and Quality

1/These activities became the responsibility of the Department of Health and Human Services (HHS) on May 4, 1980.

Bureau (HSQB), which is a part of the Health Care Financing Administration (HCFA).

PSRO REVIEW

PSROs are groups of local physicians who review federally funded patients' health care to ensure that it conforms to professional standards and is delivered efficiently, effectively, and economically. Among other things, PSROs review the medical necessity of hospital admissions and of extensions of patients' stays. This procedure is generally referred to as concurrent review.

Typically, a PSRO review coordinator, such as a nurse, performs concurrent review by screening Medicare and Medicaid patients' admissions and extensions of stay. The coordinator refers records of patients who do not appear to need hospital services to a PSRO physician--known as the physician adviser. He or she reviews the records and rules on the medical necessity of the patients' admissions or extensions of stay. If the physician adviser believes a patient does not need to be hospitalized, the adviser discusses the case with the attending or admitting physician. If the adviser still believes hospitalization of the patient is not medically necessary, an "adverse determination letter" is issued to the patient, the patient's physician, the hospital, and the fiscal intermediary--such as Blue Cross--responsible for paying the patient's bill, informing them that except for grace days Medicare or Medicaid will not pay for medically unnecessary days.

PSRO reviewers grant 1 grace day--2 more, if needed--for Medicare patients to arrange postdischarge care and relocate from the hospital. For Medicaid patients, each State prescribes whether grace days may be paid.

PSRO reviewers may also review patient care after the service has been provided and issue "restrospective" adverse determination letters to advise the appropriate persons that the type of service provided was not medically necessary or appropriate. These letters are primarily an educational device; Medicare will usually pay for restrospectively denied days of hospital care. Each State prescribes whether it will pay for restrospectively denied days of hospital care under Medicaid.

PSROs delegate concurrent review activities to hospitals which they find willing and able to perform this function. Such hospitals are referred to as delegated hospitals. PSROs monitor delegated hospitals and are ultimately responsible for the quality of concurrent review performed in these facilities.

Data collected by HSQB show that, during the first half of 1979, about 4.8 million patient admissions were subject to PSRO hospital acute care review. During this period, PSROs and delegated hospitals denied payments related to 49,428 admissions--1 percent of cases subject to review--because the patients' hospital care was not medically necessary.

PROGRAM STATUS AND FUNDING

In June 1980 there were 195 PSRO areas--concurrent review was being performed in 183 of these areas.

The PSRO program is financed from both the Medicare trust fund and general revenue funds. Fiscal year 1979 program costs totaled \$150 million--\$65 million was from general revenue funds and \$85 million was from the Medicare trust fund.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Chairman, Subcommittee on Oversight, House Committee on Ways and Means, in a November 8, 1978, letter asked us to review the (1) delegation of PSRO review functions to hospitals, (2) monitoring of delegated review functions by PSROs, and (3) PSRO's role with respect to hospital discharge planning for Medicare and Medicaid patients. We performed survey work in these areas and on March 23, 1979, met with representatives of the Subcommittee.

During this meeting, we agreed to look into (1) PSRO compliance with HHS requirements for reviewing patient admissions and extensions of stay and monitoring delegated reviews and (2) the desirability for PSROs to be given more responsibility for planning Federal patients' discharges and later care. These issues are discussed in chapter 2.

We also agreed to look into (1) the extent to which physicians are paid for inpatient care provided to patients

on days where the hospital stay was deemed not medically necessary or appropriate and (2) HHS' control over PSRO costs. These issues are discussed in chapters 3 and 4, respectively.

In response to these agreements, we reviewed PSRO operations at HSQB in Baltimore, Maryland, and at HHS regional offices in Atlanta, Chicago, Philadelphia, and San Francisco. We selected 13 PSROs (see app. II), which are geographically dispersed. According to HCFA's January 1979 evaluation of the PSRO program, one of the PSROs ranked in the top 25 percent of the 96 PSROs evaluated in terms of reduction in days of care, two ranked in the second 25 percent, three ranked in the third 25 percent, and six ranked in the bottom 25 percent. One PSRO was not included in the HCFA evaluation.

We reviewed various reports and statistical data to select 26 delegated and 13 nondelegated hospitals with significant numbers of adverse determinations. At these hospitals we reviewed the lesser of 25, or all of the Medicare and Medicaid patient records with adverse determinations during the past year. This resulted in our examination of 809 patient records involving adverse determinations. These patients had 1,779 days of care that were denied by the PSROs and not paid for by Medicare and Medicaid.

Because the PSROs, hospitals, and patient records that we reviewed were not randomly selected, the results of our review cannot be projected to the rest of the PSRO program.

We selected cases with adverse determinations for three reasons. First, we had to review patients whose hospital stay had been denied to respond to the request to determine the extent to which physicians are paid for inpatient care provided to patients whose payment for days of the hospital stay was denied

The second reason pertains to our looking into PSRO compliance with HHS requirements for reviewing patient admissions and extensions of stay. Several HHS requirements pertain to the timeliness of PSRO reviews. By comparing the number of hospital days actually denied with those that would have been denied if the reviews were performed in accordance with HHS requirements, we attempted to measure the effect of PSRO compliance or noncompliance with HHS timeliness requirements.

The third reason was to identify any problems in discharge planning.

We reviewed applicable legislation, HHS regulations and instructions, requirements developed by individual PSROs, and hospital review plans. We also reviewed monitoring reports prepared by HSQB on individual PSROs and those prepared by PSROs on individual delegated hospitals. In addition, we reviewed PSRO and hospital cost records and interviewed officials at HHS, the 13 PSROs, and 39 hospitals.

CHAPTER 2

HHS AND PSROs NEED TO MORE EFFECTIVELY

MONITOR CONCURRENT REVIEW ACTIVITIES

Some Medicare and Medicaid days of hospital care that are being certified and paid as being medically necessary do not meet HHS and PSRO criteria for such days of care. Some of the unnecessary days of care are being incurred and paid because PSRO concurrent review did not comply with HHS requirements. During discussions with HHS officials, we were informed that they were generally unaware of the incidences of noncompliance that we noted during our review. HHS' monitoring activities need to be more comprehensive with respect to PSRO concurrent review. Also, with respect to delegated hospitals, the monitoring activities of PSROs generally did not disclose these incidences of noncompliance.

We examined the records of 809 patients at 39 hospitals which involved adverse determinations. Our examination was directed at determining if (1) hospitals were taking appropriate discharge planning actions and (2) concurrent review and certifications of patients' stays conformed to PSRO, HHS, and State requirements. We found that hospitals were appropriately planning for the discharge of Medicare and Medicaid patients; however, noncompliance with PSRO, HHS, and State requirements resulted in the expenditure of Federal funds for 384 days of medically unnecessary patient care. This amounts to an additional 21.6 percent of the 1,779 days of care that were denied for these patients. These incorrect certifications were related to (1) inappropriate extensions of patients' hospital stays (224 days), (2) delays in performing concurrent review (148 days), and (3) inconsistencies between PSRO and Medicare paying agent procedures for counting days (12 days). In addition, one of the PSROs included in our review accumulated information which suggests that, during a 1-year period, 2,500 of the Medicare/Medicaid patients in its area had 9,300 days of extended hospital care inappropriately certified as medically necessary because the PSRO considered such factors as inefficient discharge planning and convenience to the family, which HHS instructions say should not be considered in determining medical necessity for reimbursement purposes.

HHS MONITORING OF PSROs

HHS monitors PSRO activities primarily by two methods: (1) periodic assessments by teams composed of HCFA personnel and peers from other PSROs and (2) day-to-day contacts by HSQB project officers. In addition, the Post-Payment Monitoring Program, which features a postpayment review of a sample of admissions by Medicare intermediaries, provides an additional method for monitoring PSRO activities. (See our report "Need To Better Use The Professional Standards Review Organization Post-Payment Monitoring Program," HRD-80-27, Dec. 6, 1979.)

HCFA officials told us that periodic assessments are directed primarily at determining if the PSRO has established appropriate guidelines, instructions, and working relationships to permit it to operate effectively. However, little is done to assess whether the PSRO is actually operating consistently with program requirements and guidelines. We examined the assessment reports for the PSROs included in our review and found no specific mention of the noncompliance issues discussed in this chapter.

During meetings with HHS regional officials, including project officers, we were informed that they were unaware of the areas of noncompliance discussed in this chapter. This is apparently because the project officers' day-to-day contacts with PSROs do not involve direct monitoring of PSRO concurrent review activities.

Regarding the use of the Post-Payment Monitoring Program, our December 6, 1979, report stated that HHS was not effectively using this program to manage PSRO concurrent review activities. One of the stated purposes of the program is to help HHS assess individual PSROs. Under the program, fiscal intermediaries review a 20-percent sample of claims related to Medicare inpatient admissions previously reviewed by a PSRO. Claims questioned by fiscal intermediary physicians are brought to the attention of the PSRO, which is expected to comment on the intermediary's findings. Reports are prepared which show the number of cases questioned by the intermediary and the number of cases where the PSRO agrees with the intermediary. The reports show these numbers for each PSRO and each hospital. We found that the program was not being effectively used by HHS and PSROs to identify and correct deficiencies in the PSRO concurrent review process because HHS had not issued guidelines or instructions on how the Post-Payment Monitoring Program is to be used to meet its objectives.

In our opinion, HHS needs to establish an effective monitoring program so that it can identify areas where PSROs need guidance and direction. Without such monitoring, instances of noncompliance, such as those discussed in this chapter, could continue to go undetected.

PSRO MONITORING OF DELEGATED HOSPITALS

PSROs that delegate concurrent review activities remain responsible for the quality of the reviews being performed by the hospitals. To fulfill this responsibility, HHS requires PSROs to develop and implement a plan for monitoring the review activities of delegated hospitals. These plans are reviewed and approved by HHS. The PSRO monitoring activities have not, however, been effective in disclosing the deficiencies discussed in this chapter.

INCORRECT CERTIFICATIONS OF THE NEED FOR HOSPITAL CARE

Medicare/Medicaid patients have extensions of hospital care certified and paid for as medically necessary that do not conform to HHS or State criteria for medically necessary days of hospital care. According to Medicare instructions, PSROs can certify as medically necessary those days of care on which patients need acute hospital care or are awaiting the availability of a bed in a skilled nursing facility. In addition, patients can be assigned up to 3 grace days for arranging postdischarge care and relocating from the hospital.

Under State Medicaid instructions, PSROs can certify as medically necessary, days of care on which patients need acute hospital care. Medicaid provisions with respect to grace days and certification of days of care while waiting for a bed in a nursing facility vary from State to State.

During a 1-year period, one of the PSROs we visited accumulated information which suggested that it incorrectly certified 9,300 days of extended hospital care for Medicare and Medicaid patients. In addition, our review of 809 patient records at 13 PSROs to determine the adequacy of hospital discharge planning activities and compliance with PSRO, HHS, and State requirements, showed that discharge planning appeared to be adequate; however, 224 days of extended hospital care were incorrectly certified as medically necessary for reasons that were not consistent with HHS criteria.

Inappropriate certification of 9,300
days of extended care at one PSRO

One PSRO (with over 100 hospitals) recorded extensions of care totaling about 9,300 days for about 2,500 Medicare and Medicaid patients for reasons that did not conform with HHS or State regulations and instructions. The State's Medicaid instructions, regarding grace days and the medical necessity of hospital care for patients waiting the availability of a bed in a skilled nursing facility, are the same as Medicare's.

The PSRO classified extensions of medically necessary stays into 15 categories. (See app. III.) In our opinion, the following two categories do not, however, conform with requirements for medically necessary days of care.

<u>Extension category</u>	<u>1978 extensions</u>	
	<u>Number of patients</u>	<u>Certified days</u>
	(rounded)	
Delay in discharge not due <u>to hospital</u>		
Hospital has made all necessary arrangements, but discharge is delayed due to lack of transportation, snowstorm, admission policies of nursing homes, home care arrangements have been delayed, etc., as reflected by physician documentation	1,600	6,700
<u>Other</u>		
To be used only when the remaining 14 extension categories do not describe the reason for the patient to remain in an acute care hospital as indicated by physician documentation <u>Implies no acute care is being given</u> (underscoring added)	<u>900</u>	<u>2,600</u>
Total	<u>2,500</u>	<u>9,300</u>

The first category provided extensions for patients whose discharges were delayed for various reasons. Neither the law nor the regulations provide for extending patients' stays for this category of reasons, although they do provide up to 3 grace days for arranging postdischarge care. In addition to the 6,700 days of care certified under this category, grace days were assigned for arranging postdischarge care--which in effect provided duplicate coverage extensions for the same reasons.

For example, in one case 35 days of hospital care were categorized as a delay in discharge not due to the hospital because the hospital's social services department was unable to successfully contact the patient's family to arrange for discharge planning. The social service records indicate that the family had been dodging the hospital's calls. In addition to the 35 days, 3 days were given and paid as grace days to arrange for the patient's discharge.

In another case, a physician adviser approved 7 days of hospital care for a patient, whose attending physician had ordered placed in a skilled nursing facility. The physician adviser later approved 7 and then 5 more days of hospital care. During this 19-day period, the hospital's social service notes show many contacts with the patient's relatives trying to get the relatives to help arrange nursing home care, but with little results. After the 19 days had elapsed, the physician adviser instructed the review coordinator to give the relatives 2 more days to obtain help or to get the patient's name on the waiting lists of two skilled nursing homes. After the 2 days expired, 1 additional grace day was granted. The 21 days of approved hospital care were categorized as a delay in discharge not due to hospital. The review coordinator informed us that if the patient's relatives had placed her on waiting lists for two skilled nursing facilities when requested by the hospital, then the PSRO would have certified the patient for continued stay at the hospital under the category "unable to transfer to skilled nursing facility" until such care became available.

The second category provided extensions for patients who received no acute care and were not awaiting the availability of a bed in a lower level of covered care. For example, one patient had 3 days of hospital care certified in the "other" category because her physicians could not agree on what to do with her and the patient's daughter

lived in another State. After the 3 days elapsed, the PSRO reviewer certified another 5 days under the delay in discharge category. After the 5 days elapsed, Medicare benefits were denied except for 3 grace days.

The PSRO officials maintain that these two categories may have been misused by the review coordinators and may represent valid certifications if properly documented by the physician adviser. This point is discussed in more detail in the PSRO's comments on this report and our evaluation of those comments. (See app V.)

PSRO officials said they prescribed the 15 categories to help identify incorrect extensions; however, they have not used them in this manner. For example, in 1978 one delegated hospital we visited accounted for nearly 20 percent of the 6,700 days that the PSRO had recorded in the discharge delay category. The PSRO's March and August 1979, monitoring reports which cover 1978 and the first seven months of 1979 did not question the heavy use of this category and stated the hospital had fully complied with criteria for extensions and had recorded them in the appropriate categories.

Discharge planning adequate, but some extended stays inappropriately certified

Some PSRO officials believe they should have more authority over discharge planning because hospitals do not adequately plan postdischarge care. However, the 39 hospitals we visited appeared to be adequately planning for the postdischarge care of Medicare and Medicaid patients.

Discharge planning is a hospital function which includes discussing the patient's needs with the patient and family and locating an available bed in an appropriate setting. The law and regulations do not require PSROs to monitor individual cases or perform hospital discharge planning. HHS requires review coordinators to notify the appropriate hospital officials if Federal patients appear to need discharge planning for transfer to another facility, such as a skilled nursing facility.

In the 39 hospitals visited, nurses or social workers planned postdischarge care. They usually learned of patients who needed discharge planning through reviews of admission notices and medical charts or referrals from attending physicians, nurses, or review coordinators.

Of the 809 patients included in our review, 99 had their stays extended a total of 1,351 days after physician advisers determined that hospital care was no longer needed. These extensions did not, however, appear to be the result of poor discharge planning. Seventy-five patients' stays were correctly extended for 1,127 days for periods where discharge planners had determined and documented that no suitable bed was available in covered facilities. In most of the other cases, the discharge planners were actively involved, but the physician advisers incorrectly certified extensions totaling 224 days

--75 days for six patients whose transfers were delayed because they or their families were uncooperative.

--126 days for 14 patients who were awaiting transfer to noncovered postdischarge care.

--23 days for four patients who were awaiting transportation or appointment of a legal guardian.

For example, three patients' transfers from one hospital to skilled nursing facilities were delayed because the patients or their families were uncooperative in seeking placement. The reviewers certified 63 days for these patients without having documentation to show that nursing home beds were unavailable

The reviewers at three other hospitals certified a total of 64 days for nine Medicare patients awaiting transfers to intermediate care facilities or private homes. Medicare pays for patients awaiting transfer to skilled nursing facilities, but not for those awaiting transfer to intermediate care facilities or elsewhere.

In one of the three cases, the physician adviser on August 25, 1978, incorrectly extended the hospital stay of a Medicare patient scheduled for discharge to her home. She remained in the hospital because her husband felt he could not properly care for her at home, but he said he would take her home on August 29. The physician adviser certified the continued hospital stay contrary to HHS criteria. On August 29, the husband again refused to take his wife home because home care was too expensive, and he had promised not to put her in a nursing home.

Finally, the patient's physician requested the PSRO physician adviser to deny further benefits, and the denial letter was issued on August 31. The adviser certified 7 days to cover the delay from August 25 through August 31, which he attributed to poor discharge planning. We believe the adviser's incorrect certification action, not discharge planning, was responsible for charging 7 medically unnecessary days of care to the Medicare program. PSRO review at this hospital was being performed on a delegated basis. The PSRO's monitoring reports noted unexplainable delays in transfers to nursing homes, but characterized the problem as a delay in the hospital's discharge planning process.

Reviewers at another of the three hospitals--also delegated--initially certified 12 days of care for a Medicare patient awaiting transfer to an intermediate care facility because they were not aware that Medicare is not supposed to pay for hospital days spent awaiting transfer to an intermediate care facility. Later, the reviewers at this hospital also incorrectly certified 14 days of care for four other Medicare patients because they were not aware that the patients were awaiting transfer to intermediate care facilities. Eventually, they retrospectively denied 22 of the 26 incorrectly certified days. These days were still paid by Medicare. In its monitoring reports during this period, the PSRO attributed delays in patient discharges to poor discharge planning, but did not note that the hospital's reviewers were unaware of Medicare coverage provisions or of the type of facility to which the patients were being transferred.

In our opinion, performance of the discharge planning function by PSROs could result in increased program costs without an offsetting reduction in the discharge delays. However, HHS could reduce Medicare and Medicaid program costs by assuring, through educational and assessment procedures, that PSRO physician advisers understand and comply with regulations and related instructions on certified stays for patients awaiting discharge.

DELAYS IN PERFORMING CONCURRENT REVIEW

Delay in performing concurrent review was another cause of payment for medically unnecessary days. Actions were not always completed before patients' previously assigned stays expired. According to HHS regulations, PSROs must either approve or deny extensions by the end of the previously assigned stay.

In 21 of the 39 hospitals we visited, PSRO reviewers did not deny the extensions of 81 patients' hospital stays until after their previously assigned stays had expired. A total of 148 days elapsed between the end of these patients' previously assigned stays and the denial actions. These hospitals and patient days were categorized as follows: 15 hospitals accounting for 92 days were delegated, and 6 hospitals accounting for 56 days were nondelegated. The reviewers at these hospitals either certified or retrospectively denied the elapsed days. Retrospectively denied days are payable under Medicare by a waiver and in one of the States we reviewed are payable under Medicaid.

Some of the delays in reviewing extensions were unavoidable, but others were caused by correctable PSRO requirements or hospital practices as in the following examples:

- One PSRO required the physician adviser at a non-delegated hospital to be from the medical staff of another hospital. At one of this PSRO's nondelegated hospitals, the physician adviser was frequently unavailable. During January and February 1979, he was available to look at cases on only 10 of the 42 working days for 1 or 2 hours a day. Consequently, 11 of the 25 denial letters we reviewed were issued from 1 to 8 days after the patients' previously assigned stays had expired, and 22 days were retrospectively denied. In addition, because of delays in reviewing four admissions, the physician adviser retrospectively denied another 6 days as medically unnecessary. After we pointed out these delays to PSRO officials, they appointed another adviser who was to visit the hospital 5 days a week.
- According to one delegated hospital's review plan, adverse determination letters could be issued up to 2 days after the previously assigned stay ended. Under its practice, the hospital did not usually begin its review until the last certified day. Because of delays in completing reviews of 4 of 10 patients' stays we reviewed, the physician adviser retrospectively denied 5 days for one patient, 2 days for each of two patients, and 1 day for another patient.

* We examined the monitoring reports prepared by the PSROs for the 15 delegated hospitals and found no indication that the PSRO was aware that extensions at these hospitals were not being acted upon by the end of the previously assigned stay as required by HHS regulations

INCONSISTENCIES BETWEEN PSRO AND
MEDICARE PAYING AGENT PROCEDURES

Incorrect payments also occurred because one PSRO used a method of counting allowed days that was different from the method used by the fiscal intermediary that paid the patient bills for Medicare. At this PSRO, two of the three hospitals we visited received payment for 12 days of care that they were not entitled to.

This PSRO certified patient days in 24-hour periods. For example, a stay of 5 days might last from noon January 1 to noon January 6, when the patient was discharged. Under its procedures, the PSRO reviewer would certify the patient's stay from the 1st to the 6th.

This PSRO requirement normally caused no problems because paying agents paid for the day of admission but not the day of discharge. Thus, they would pay for 5 days if a patient was admitted January 1 and discharged January 6.

Discrepancies occurred, however, when an adverse determination was issued and patients stayed longer than their assigned grace days. If a patient admitted at noon January 1 received an adverse determination at noon on January 6, the reviewer would still intend certification from the 1st to the 6th to mean 5 days and could assign up to 3 grace days. However, if the patient stayed beyond the date his or her grace days expired, the agents would pay the hospital for 6 certified days and the assigned grace days because no discharge day was involved. Thus, Medicare would pay the hospital for 1 more day than the PSRO intended.

We pointed out the inconsistencies to PSRO and Medicare intermediary officials, who discussed but did not resolve the issue. Accordingly, we brought the issue to the attention of HHS regional officials, who in January 1980 issued instructions, which if properly implemented, should resolve the problem.

CONCLUSIONS

More comprehensive project officer monitoring and HHS assessments of PSRO and delegated hospital concurrent review are needed to assure that PSROs effectively monitor delegated hospitals and effectively review patient admissions and extensions of stays at nondelegated hospitals. Because of inadequate project officer monitoring and HHS assessments, HHS officials were not aware of the guidance and technical assistance that PSROs and delegated hospitals needed to minimize noncompliance in concurrent review.

RECOMMENDATION

Accordingly, we recommend that the Secretary of HHS direct the Administrator of HCFA to require that periodic PSRO assessments and project officers' monitoring emphasize the extent that concurrent review activities comply with HHS coverage and procedural requirements, including

- PSRO requirements and hospital practices for extending patients' hospital stays,
- compatibility of PSRO and hospital certification procedures with the paying agents' payment procedures,
- PSRO and hospital promptness in approving and denying extensions of patients' stays, and
- PSRO monitoring of delegated hospitals.

HHS COMMENTS AND OUR EVALUATION

HHS concurred with our recommendation. (See app. IV.) In its comments HHS said that it has already proposed a revised PSRO performance monitoring system which includes a review of the PSROs' delegated hospital review system.

Although HHS agrees with our recommendation and is taking corrective action, its comments state that it believes that our review was slanted because as we had indicated on page 4, 12 of the 13 PSROs that we reviewed were included in HCFA's January 1979 PSRO program evaluation and 9 were found to be in the bottom 50 percent under that measure of effectiveness. HHS further states that our review was slanted

because the 809 cases we reviewed involved patients who received determinations denying payment for hospital days of care because of a lack of medical necessity.

Our reasons for selecting cases involving adverse determinations are explained on pages 4 and 5 of this report. With respect to our selecting 9 PSROs that were in the bottom 50 percent of HCFA's evaluation, we believe that the disclosure of this condition is necessary to identify possible limitations on the scope of our review. On the other hand, we believe that HHS may be placing an undue weight on HCFA's evaluation as it relates to the effectiveness of individual PSROs. For example, according to HCFA's evaluation, one of the PSROs we selected ranked 74th out of the 96 included in HCFA's evaluation and 11th out of the 13 in its HHS region. In contrast, HCFA regional officials have informed us that in their judgment this PSRO is the best in its region.

Regarding discharge planning, HHS believes that PSROs should have more authority to monitor a hospital's discharge planning efforts and to be able to deny hospital days, if they have evidence that the hospital is not making a good faith effort to place patients. According to HHS, PSROs do not, nor should they have responsibility for the discharge planning for individual patients.

We do not disagree with HHS' position as to the appropriate role of PSROs in this function. PSROs do have the authority to monitor a hospital's discharge planning efforts and should deny payment to hospitals for all days of care that are not medically necessary. This includes days of care incurred because appropriate arrangements for postdischarge care have not been made. However, PSROs often do not deny payment for days of care that are not medically necessary under HHS' criteria. In addition, for cases where days of care are being justified as medically necessary on the basis of hospital documentation that appropriate nursing home beds are not available, if PSRO monitoring finds that this documentation is not based on good faith efforts the PSRO should notify the fiscal intermediary. The fiscal intermediary has the authority to rebut waiver of liability for "alternate care" days inappropriately certified as necessary when an appropriate bed was available.

- - - -

Comments from the PSRO whose activities are discussed on pages 9 through 11 are discussed in appendix V.

CHAPTER 3

PAYMENTS TO PHYSICIANS FOR MEDICALLY UNNECESSARY

DAYS OF HOSPITAL CARE ARE NOT LARGE

Many hospital officials believe paying physicians but not hospitals for medically unnecessary days of hospital care is inequitable because physicians, not hospitals, have the authority to discharge patients who no longer need such care. PSRO and HHS officials told us that denying physicians' charges for inpatient services would provide the doctors with an incentive to discharge patients when hospital care is no longer necessary and, thus, reduce the number of days that Medicare and Medicaid patients are hospitalized. In addition, savings would be realized to the extent that payments for unnecessary physician services are denied

Based on available information, however, the amounts involved do not appear large enough to result in significant cost savings nationwide. In addition, denial of payment for physician services under Medicare could place the financial burden on the beneficiary, and the physician could be paid anyway

PAYMENTS TO PHYSICIANS FOR SERVICES ON MEDICALLY UNNECESSARY DAYS OF HOSPITAL CARE

Most doctors were not billing for hospital services provided to patients on days when hospitalization was medically unnecessary, and the average amount billed for each such patient was about \$10. Among the 809 hospital claims involving adverse determinations that we examined, physicians were paid \$8,000--an average of \$10 per case--or an average of \$4.50 per day--for hospital services provided on days that the hospital was denied reimbursement, because the PSRO had determined that hospital care was not medically necessary. These payments were primarily for daily visits made by the patients' physicians.

For surgical patients, physicians generally do not bill for daily visits because postsurgical care is usually included as a part of the fee for the operation. For the 809 claims, the hospitals were denied and did not receive payment for

1,779 days. We were able to identify only 128 claims where physicians were reimbursed \$8,000 for services provided on 522 of these days. Although these amounts are not statistically projectable because our selection of hospitals was directed to facilities with the larger numbers of adverse determinations, we believe that it fairly represents the low realm of activity of physicians' billings in this area.

During the first half of 1979, about 4.8 million Medicare and Medicaid hospital admissions were subject to PSRO review. Of these, about 49,000 cases (1 percent) involved denials of all or part of the hospital bills because PSROs had determined that some hospital days were not medically necessary. Thus, assuming \$10 per claim, the payments for physicians' services applicable to these denials would amount to about \$490,000 or the equivalent of \$1 million annually.

In 1979, Medicare reimbursements alone for physicians' services were about \$5.8 billion of which about 60 percent (\$3.5 billion) involved physician services provided in a hospital setting. During the same period, we estimate that denials of Medicare payments for physicians' services on the basis that such services were not necessary amounted to over \$100 million. Thus, viewed in perspective the potential additional savings that might result from focusing on payment for physicians' services for PSRO denied days of hospital care seems rather limited nationwide.

On the other hand, denying such physician payments could alleviate the basis for the hospitals' concern that they rather than the physicians are being inequitably penalized for care ordered by the physicians. Also for the individual PSRO that generates relatively large numbers of adverse determinations, such a focused review could be productive.

PROGRESS TOWARD REVIEWING PHYSICIANS' HOSPITAL SERVICES

The 1972 amendments to the Social Security Act require PSROs to review physicians' and hospitals' professional health care for medical necessity, quality, and appropriateness. HHS issued interim guidelines for review of hospital care

in November 1974; however, it did not establish draft instructions for review of physician services until November 1978 and April 1979

In the memorandum transmitting the April 1979 instructions, HHS directed PSRO officials to immediately establish informal arrangements with fiscal agents responsible for Medicare or Medicaid payments to physicians to inform them of physicians providing hospital care to patients to whom adverse determinations apply. As of June 1979, at least 8 of the 13 PSROs we reviewed had not arranged to advise Medicare paying agents (carriers) of the physicians' fees for inpatient

services that should be considered for nonpayment. In July 1979, HHS' Medicare Bureau instructed Medicare paying agents to immediately arrange to receive and consider PSRO adverse determinations on physician services. Although these determinations would not be binding on physician payments until formal arrangements were established, paying agents were to "strongly consider" them.

At least three Medicare carriers we visited started reviewing claims for physicians' inpatient services before HHS' April 1979 draft instructions. Only one of these carriers considered PSRO determinations of the need for hospital care. This carrier, however, reviewed physician services only for patients hospitalized for more than 30 days. The other two Medicare carriers independently determined the medical necessity of some physicians' inpatient services, but did not check their determinations with the PSROs before paying the physicians.

In addition, two of the eight State Medicaid agencies visited--California and Maryland--had instructed physicians not to bill the programs for days on which the PSRO determined that hospital care was medically unnecessary. These instructions were issued in February 1975 and May 1977, respectively.

Based on our review of two Maryland PSROs, it does not appear that this instruction has been effective in preventing physicians in those areas from claiming and being paid for hospital services provided on days that the PSRO determined were medically unnecessary for hospital care. However, the amounts being overpaid do not appear to be significant. Our sample of six hospitals in Maryland included 15 Medicaid patients who had a total of 64 days of hospital care denied.

We requested physician payment information for these 15 patients from the Maryland Department of Health and Mental Hygiene. We learned that the physicians for nine of these patients were reimbursed a total of \$473 for services provided after the patients' hospital stays were denied by the PSRO. For example, the PSRO denied reimbursement to the hospital after one patient's 16th day of care. The patient remained in the hospital for another 8 days. The patient's physician billed Medicaid a total of \$156, which included \$8 a day for each of the 8 denied days. The State agency said it would try to obtain repayments from this physician and the other physicians who were paid the \$473.

HHS officials informed us that they are now pilot testing a computer software package to assist PSROs in reviewing physicians' inpatient care.

PATIENTS' LIABILITY FOR PHYSICIAN SERVICES UNDER MEDICARE

Under Medicare, the patient is protected from financial liability for unnecessary physician services, including those provided in a hospital, when the physician accepts assignment for the services he or she is providing--the physician has agreed that his or her total charge for a service will be the Medicare reasonable charge excluding deductible and coinsurance amounts. When the physician does not take assignment, the patient is responsible for paying the physician, and Medicare simply reimburses the patient for allowable and medically necessary services based on 80 percent of Medicare's reasonable charges.

About half of physician services are provided on a non-assigned basis. Denial of inpatient physician services provided to Medicare patients can, therefore, result in placing a financial burden on the beneficiary.

We discussed this problem with HSQB officials, who said they were drafting proposed regulations that would remove this burden from the patient by having Medicare reimburse the patient even though the services were found to be not medically reasonable and necessary.

Adoption of such regulations could serve as an additional disincentive for physicians to accept assignment, and the Congress has indicated concern with the fact that more and more Medicare claims are unassigned and that this trend is increasing the financial burden placed on Medicare patients

In our opinion, adoption of such regulations could serve as a disincentive for physicians to accept assignment because, if a case were not under assignment, and the PSRO or Medicare paying agent found certain physician services to be not medically reasonable and necessary, the physician could still bill the patient for the services, and the patient would be reimbursed by Medicare. However, if the case were under assignment and certain physician services were found to be not medically reasonable and necessary, the physician would not be reimbursed--thus, the disincentive to accept assignment.

CONCLUSIONS

We believe that significant savings cannot be expected from denying payment for physician services provided to hospitalized patients for days when the stay has been determined to be medically unnecessary. HSQB statistics show that, during the first half of 1979, only about 1 percent (49,000 patients) of the 4.8 million acute care patient admissions, subject to PSRO review, involved denials of hospital stays.

Our review of 809 denied cases showed that physicians were reimbursed for an average of about \$10 per case for services provided to hospitalized patients whose days of hospital care were being denied as not medically necessary. We could only confirm that physicians were paid for services on these days in 128 (16 percent) of the cases. Therefore, the potential to reduce payments to physicians for hospital services provided to patients whose hospital care has been denied as medically unnecessary appears to be limited, and the potential to encourage physicians to have their patients discharged earlier by not reimbursing them for services provided on denied days of hospital care also appears to be limited.

HHS COMMENTS AND OUR EVALUATION

HHS stated that it was not clear whether we were recommending that (1) physicians services under Part B of Medicare not be reviewed or (2) there should not be any linkage between the determination of medical necessity of the hospital stay and the need for physician services during that stay.

We were recommending neither. Our review was directed to finding out the extent that physicians were being paid for inpatient care on days that payment for hospital care was

denied and whether there would be significant savings if Medicare paying agents systematically identified, reviewed, and perhaps denied such payments.

We concluded that it would be unrealistic to expect to reduce program payments significantly on a nationwide basis by focusing on reviews of payments for physicians' services provided on PSRO denied days, based on (1) HSQB statistics that showed that the PSRO denials involved only about 1 percent of hospital admissions and (2) our review of 809 denials which identified physician payments totaling \$8,000 relating to only 16 percent of such denials. Therefore, we could not support a recommendation to establish such a system nationwide

In this connection, Medicare Part B paying agents (carriers) process about 130 million claims a year at a cost of about \$3 a claim using highly automated claim processing systems, and we believe that the costs of identifying the relatively few claims relating to about 100,000 PSRO denials should also be considered before proposing that the systems be modified to focus carrier reviews on such claims

CHAPTER 4

CONTROLLING HOSPITAL REVIEW COSTS

HHS did not propose regulations to effectively control delegated hospitals' costs for performing PSRO review until May 1979, more than 6 years after enactment of the 1972 amendments to the Social Security Act.

NEED AND PROGRESS TO CONTROL HOSPITAL REVIEW COSTS

Concern regarding the cost of PSRO hospital review has been expressed by HHS, the Office of Management and Budget, and the Congress. For example, the House Appropriations Committee, in its report on the fiscal year 1979 Labor and Department of Health, Education, and Welfare Appropriations Bill, expressed concern about the costs of the PSRO program and stated that it is imperative that the program demonstrate that it can operate at a lower cost and within a prescribed budget.

Responding to these concerns, the HHS' Office of Professional Standards Review Organizations has established the objective of reducing the average cost of reviewing the care provided to each hospitalized Medicare/Medicaid patient from an average of about \$13 in 1977 to \$8.70. HHS plans to meet this objective primarily by requiring that concurrent reviews be concentrated on areas where improved utilization or quality of health care is needed instead of reviewing all patient admissions and extensions of care.

Presently, HHS is implementing regulations that should give individual PSROs the authority they need to ensure that hospitals performing delegated review limit their reviews and expenditures to the extent necessary to meet this \$8.70 goal.

PSROs have not had adequate control over expenditures for PSRO review by delegated hospitals. In March 1977, HHS issued guidelines requiring delegated hospitals to submit, to their PSRO, estimates of the future cost for performing concurrent review. These estimates are to be submitted 60 days before each Medicare cost reporting period. PSROs were required to approve an interim cost per review for each delegated hospital and to furnish copies of the approved rate to the hospital and the Medicare intermediary. The intermediaries periodically reimburse the delegated hospitals at

the approved rates. These amounts are paid from the Medicare trust fund.

At the end of their cost reporting periods--usually 12 months--delegated hospitals were required to report to the Medicare intermediary their actual direct costs for PSRO review. The intermediary was required to examine each hospital's report and determine if the costs were reasonable and allowable. The intermediary then adjusts the reimbursement to equal actual reasonable and allowable costs which could be more or less than the original estimate approved by the PSRO. Under this system, HHS and the PSROs had little control over the amounts that delegated hospitals spent on PSRO review.

In April 1979, HHS issued instructions which should have helped to strengthen PSROs' control over the amounts delegated hospitals spent. The instructions required delegated hospitals to justify all costs over those approved at the beginning of the period. The PSRO was to review and comment on the hospitals' costs. The intermediary was required to consider the PSROs' comments when deciding the reasonableness of the hospitals' review costs.

To gain more adequate cost control, HHS proposed regulations in May 1979 that would give each PSRO a budget for hospital review. These regulations would require PSROs to develop budgets for nondelegated hospital review and to negotiate budgets and review plans with delegated hospitals. These regulations were published in final form on October 10, 1980. If properly implemented the regulations should give HHS better control over PSRO hospital review costs.

Furthermore, in April 1980 the Committee on Interstate and Foreign Commerce reported to the House of Representatives, H.R. 4000, "Medicare and Medicaid Amendments of 1980," which included an amendment aimed at increasing HHS and PSRO control over the cost of delegated reviews.

According to the Committee report (Rept. No. 96-589, part 2), under present law PSROs are to consider only effectiveness and timeliness of review in making decisions to delegate PSRO review to hospitals. The Committee was concerned that, although individual hospitals may be able to demonstrate effectiveness and timeliness, they may not be able to undertake

these review activities as economically (on a cost per review basis) as the PSRO serving the hospital's area. Where this is the case, the Committee stated that the PSRO should undertake the review activities. Accordingly, the Committee proposed adding the word "efficiently" to the statutory standards that a hospital must meet to continue conducting delegated reviews.

The Omnibus Reconciliation Act of 1980, Public Law 96-499, included this provision at section 925.

CONCLUSIONS

The October 10, 1980, regulations should, if properly implemented, provide HHS and PSROs with adequate control over hospital review costs. Also, the addition of the statutory language in to Omnibus Reconciliation Act of 1980 should give PSROs additional control over the costs of delegated reviews.

BART GIBBONS FLA., CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT

J J PICKLE TEX
CHARLES B RANGEL N Y
FORTNEY H (PETE) STARK CALIF
JAMES R JONES OKLA
HAROLD FORD TENN
RICHARD A GEPHARDT MO

PHILIP M CRANE, ILL
L A (SKIP) BAFALIS FLA
JAMES G MARTIN N.C

EX OFFICIO
AL ULLMAN OREG
BARBER B CONABLE JR N Y

COMMITTEE ON WAYS AND MEANS

U S HOUSE OF REPRESENTATIVES

WASHINGTON DC 20515

SUBCOMMITTEE ON OVERSIGHT

NINETY-FIFTH CONGRESS

AL ULLMAN OREG., CHAIRMAN
COMMITTEE ON WAYS AND MEANS

JOHN M MARTIN JR CHIEF COUNSEL
J P BAKER ASSISTANT CHIEF COUNSEL
JOHN K MEAGHER MINORITY COUNSEL

SUBCOMMITTEE STAFF
PAMELA PECARICH STAFF DIRECTOR
LAWRENCE J ROSS COUNSEL

November 8, 1978

Mr Elmer B. Staats
Comptroller General
General Accounting Office
441 G Street, N.W.
Washington, D.C.

Dear Mr Staats

The Ways and Means Oversight Subcommittee has for some time been concerned with the efficiency and effectiveness of the PSRO program. Unfortunately, there continue to be real questions as to whether this program is achieving its Congressionally stated purpose. In this context, let me note that the General Accounting Office has provided very valuable assistance to the Subcommittee and the Congress by GAO's past audits in the PSRO area. The Subcommittee intends to continue its review of the PSRO program and, thus, we would appreciate the further assistance of the General Accounting Office.

Public Law 92-603 requires PSROs to delegate review of hospital services to the provider hospital when the provider is able and willing to perform the review. Nonetheless, PSROs are required to monitor delegated review to insure its ongoing effectiveness. We would like the General Accounting Office to conduct an audit of this monitoring function and the delegation requirements generally in order to determine if maximum effectiveness and efficiency are promoted by the present scheme, or if legislative changes would be advisable. In this connection, special attention should be paid to the role and influence of the HEW budget. Since budget problems related to Bureau allocations may have a substantial impact on either the present or any future legislative standard, a complete assessment of the budget effect appears necessary.

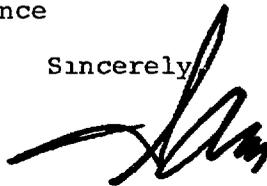
We would also hope that GAO could, at the same time, review PSRO monitoring of hospital conducted discharge planning. Does giving the discharge planning function exclusively to hospitals, with loose PSRO monitoring, assure efficient expenditure of resources? Would it be advisable to strengthen the

the PSRO monitoring role, or to transfer to PSROs direct responsibility for the discharge function? We would like the General Accounting Office to address these important policy questions

Finally, we would also hope that at the conclusion of GAO's review in this area that the Subcommittee would be able to hear testimony from GAO on the general comparative efficiency of delegated review status versus non-delegated status. I would suggest that GAO project personnel work out how to proceed on this issue with members of the Oversight Subcommittee staff. Specifically, I think a meeting would be appropriate after the results of the most recent OPEL PSRO evaluation are known. The Subcommittee is planning to have a PSRO hearing in the latter part of August, 1979. It is at that time that we would hope to hear testimony from GAO on the topics mentioned above.

In order to set up a convenient meeting time and if there are any questions, please have your staff call either Mark Wincek or Sam Deramo of the Subcommittee staff (225-2743). Thank you for your continuing assistance.

Sincerely,



Sam M. Gibbons, Chairman
Subcommittee on Oversight

PSROs VISITED

1. Alabama Medical Review, Inc., Birmingham, Alabama.
- 2 Greater Southern Arizona PSRO, Inc., Tucson, Arizona.
3. California PSRO Area XXIII, Torrance, California.
4. Kern County PSRO, Inc., Bakersfield, California.
5. PSRO of Santa Barbara and San Luis Obispo Counties
Santa Barbara, California
- 6 Dade Monroe PSRO, Inc., Miami, Florida.
7. Chicago Foundation for Medical Care, Chicago, Illinois
8. Quad River Foundation for Medical Care, Joliet,
Illinois.
9. Baltimore City PSRO, Inc., Baltimore, Maryland.
10. Prince George's Foundation for Medical Care, Inc.,
Riverdale, Maryland.
11. South Carolina Medical Care Foundation,
Columbia, South Carolina.
12. Northern Virginia Foundation for Medical Care,
Falls Church, Virginia.
- 13 Wisconsin Professional Review Organization, Madison,
Wisconsin.

APPROVED EXTENSIONS OF STAY FOR ONE PSRO 1978

<u>Category</u>	<u>Use</u>	<u>Special instructions</u>	<u>Days of hospital care approved</u>
1	Change in diagnosis	Physician documentation indicates the original diagnosis is no longer the primary reason for continued certification because of acute medical necessity	64,592
		A new diagnosis has been identified and is the primary focus of treatment	
2	Patient not responding to treatment	Physician documentation indicates there is little or no favorable reaction to drugs, treatments or therapies	123,658
3	Complications requiring additional medical care	A complication is an added medical difficulty, complex state, disease, or accident superimposed without being specifically related yet affecting or modifying the primary diagnosis Physician documentation reflects the presence of a complication	58,002
		Considerations when using this reason --Severity of complications --Treatment of original diagnosis continues and is still the primary reason for patient's hospitalization --May be necessary to change to multiple diagnosis if treatment has more than one focus	
4	Delay lab/x-ray reports	Physician documentation indicates that reports are not available and this is the only reason for the patient's continued stay	451
		Other certified days Physician adviser consult necessary	
5	Scheduling problems with surgery	Physician documentation that surgery cannot be scheduled due to distance, surgeon not available, the anesthetist not available, or the schedule is full	558
		Other certified days Physician adviser consult necessary	
6	Scheduling problems with lab/x-ray	Physician documentation that lab/x-ray procedures cannot be done due to distance, full schedule, specialist not available	371
		Other certified days Physician adviser consult necessary	
7	Unable to transfer to skilled nursing facility	Physician documentation indicates patient must remain in an acute care hospital due to lack of an appropriate bed in a skilled nursing facility	18,098
		Other certified days Physician adviser consult necessary Discharge planning should be in process	
8	Delay in discharge not due to hospital	Hospital has made all necessary arrangements, but discharge is delayed due to lack of transportation, snowstorm, admission policies of nursing homes, home care arrangements have been delayed, etc. as reflected by physician documentation	6,662
		Other certified days Physician adviser consult necessary	

	<u>Category</u>	<u>Use</u>	<u>Special instructions</u>	<u>Days of hospital care approved</u>
9	Review program delay	Timeliness of review significantly hindered because review coordinator or physician adviser absent due to illness distance holiday or weekend Review coordinator should maintain documentation	Other certified days Physician adviser consult necessary	623
10	Delay in adverse initial determination process	To be used when attending physician disagrees with decision of physician adviser and further physician reviewer consultation is not immediately available Review coordinator should maintain documentation	Other certified days Physician adviser consult necessary	53
11	Surgical procedure required	Physician documentation indicates a significant procedure (one that carries operative or anesthetic risk) has been performed	Assign length-of-stay for continued stay at 50th percentile of operation	105,771
12	Other	Use only when reasons 1 to 11 and 13 to 15 do not describe the reason for the patient to remain in an acute care hospital as indicated by physician documentation Implies no acute care is being given	Physician adviser consult necessary when no acute care is being given	2,593
13	Suspected diagnosis confirmed as primary diagnosis	Physician documentation indicates suspected, probable rule out, possible, or questionable diagnosis is confirmed Applies when initial days have been assigned under signs and symptoms	Assign extension to 50th percentile of confirmed diagnosis less days assigned under initial days If beyond 50th percentile assign to 75th percentile	16,624
14	Terminal illness	Physician has documented patient is felt to be moribund Implies acute care is being given or that adequate care is not available in a nearby nursing home	Discharge planning should be in process	6 948
15	Need for continued observation or care	Physician documentation indicates patient is progressing but is not yet well enough to be discharged or to be moved to a lower level of care or no diagnosis has yet been substantiated (as when signs and symptoms have been used for admission diagnosis)		<u>233 982</u>
	Total			<u>638,986</u>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
WASHINGTON DC 20201

OFFICE OF INSPECTOR GENERAL

JUL 31 1980

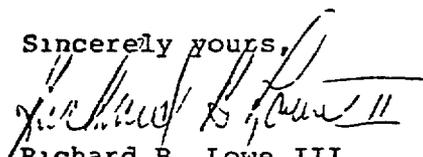
Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "HHS Should Improve Monitoring of the Operations of Professional Standards Review Organizations." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

Sincerely yours,



Richard B. Lowe III
Acting Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND
HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE
DRAFT REPORT ENTITLED, "HHS SHOULD IMPROVE MONITORING OF
THE OPERATIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS"

General Comment on GAO's Conclusions

GAO reviewed the records from 13 PSROs involving a total of 809 patients. Twelve of the 13 PSROs studied by GAO were evaluated in terms of reduction of days of care in HCFA's 1979 program evaluation and nine of these were found to be in the bottom 50 percent for that measure. One of the 13 PSROs has received a warning for possible termination for poor performance. The study was further slanted in that all of these patients had received determinations denying some part of their hospital stay because of a lack of medical necessity.

Additionally, during the period of this study, monitoring of PSRO review decisions was performed by Medicare fiscal intermediaries. Since the GAO report does not state whether its findings were also identified in the intermediary monitoring reports, it is difficult to determine if the cited failure of the Health and Human Services (HHS) regional officials to be aware of these compliance problems stemmed from a parallel weakness in intermediary monitoring or to a failure in the use of available information.

GAO reviewed the physicians' claims submitted for hospital days determined by the PSRO to be medically unnecessary and concluded that significant savings cannot be expected for this review. We question whether the study was adequate to support this conclusion. In addition, the report is not clear as to what action GAO is now recommending. Is the recommendation that physician services under Part B of Medicare not be reviewed or that there should not be any linkage between the determination of medical necessity of the hospital stay and the need for physician services during that stay?

PSRO review of physician services extends beyond the limited scope of the linkage of Parts A and B of Medicare. This review is part of the process by which physician profiles are developed so that aberrant practices may be identified and corrected. It is also a matter of continuing complaint that a hospital will be denied payment for which the physician that orders the care is apparently paid. GAO has also expressed the opinion that planned regulations concerning the liability for physicians' services under Medicare, the "without fault regulation," would serve as a disincentive to physicians to accept assignment. We disagree. This conclusion ignores the fact that the major forces influencing the assignment rate under Medicare are reimbursement levels, timeliness of payment, and the paperwork involved in making claims and not whether patients will be ultimately liable or not.

GAO Recommendation

That the Secretary of HHS direct the Administrator, Health Care Financing Administration, to require that periodic PSRO assessments and project officers' monitoring emphasize the extent that concurrent review activities comply with HHS coverage and procedural requirements including:

- PSRO requirements and hospital practices for extending patients' hospital stays,
- compatibility of PSRO and hospital certification procedures with the paying agents' payment procedures,

--PSRO and hospital promptness in approving and denying extensions of patients' stays, and

--PSRO monitoring of delegated hospitals

Department Comment

We concur.

Monitoring activities can always be improved. However, the issue of the impact of budget limitations on both the intensity of monitoring activity and program implementation must also be considered. For example, as a result of cost concerns a number of Professional Standards Review Organizations (PSROs), particularly those with small rural hospitals, are moving to alternative review systems that are retrospectively based. While retrospective review may not achieve an immediate cost savings associated with a single case, it does achieve the more important and long-term educational impact of PSRO review.

In improving the monitoring of the PSRO program, the Department is concerned with outcomes of the entire review process, coverage and procedural requirements being only two aspects.

A revised PSRO performance monitoring system is currently being designed. A draft of this proposed monitoring system was distributed for comment in March 1980. It includes a review of the PSROs' delegated hospital review system.

We also agree that greater educational and assessment procedures will improve PSRO physician advisors' understanding and compliance with regulations. In this regard, a contract was awarded in June 1980 to develop training modules for physician advisors and review coordinators. The aspect of compatibility of PSRO and hospital certification procedures with the paying agents' payment procedures will be included in the training module.

To determine PSRO compliance with HHS requirements for reviewing inpatient hospital care and for monitoring patient reviews performed by hospital personnel, GAO examined the records of 809 patients at 39 hospitals which involved adverse determinations. From this review, the GAO determined that HHS and PSROs need to more effectively monitor delegated hospitals' review activities.

The GAO based this recommendation primarily on two findings. First, that in 81 of the 809 cases the PSROs' review did not occur within the required time frame. As PSROs are required to comply with federally mandated time constraints this finding is of concern to us. However, we do not believe that this problem can be generalized to the program as a whole due to the sample size and the bias in selecting only cases involving denials.

It must also be emphasized that denials were in fact issued in these cases, and the long-term benefit from this activity is its effect on changing patterns of provider or practitioner behavior.

Second, the GAO found that in 24 of 809 cases the PSRO incorrectly certified hospital care for patients awaiting transfer to noncovered postdischarge care. Over 30 percent of the 384 days that GAO cites warranting disapproval are related to the unavailability of a bed at a lower level of care. We are familiar with the implication of GAO's study that PSROs are not aggressively issuing denials while a patient is awaiting placement in an

extended care facility. HCFA policy is that continued hospitalization may be considered medically necessary if, under Medicare, the patient needs skilled nursing care and that level of care is not available. Under Medicaid, the PSRO is required to certify medical necessity in conformance with the individual State's policy in this area. PSROs legitimately point out that there are medical and ethical objections to denying Federal reimbursement for hospital care when the predictable result is a deterioration in the patient's health. From a cost standpoint, they argue that any savings from early denials will only be illusory as the deteriorated patient will soon require hospitalization to restabilize his or her condition at greater additional expense.

Given the significant issues involved, it is understandable and proper that PSROs are cautious in denying care in circumstances where alternative arrangements are unclear or inadequate.

With respect to the desirability for PSROs to be given more responsibility for planning patient's postdischarge care, there has apparently been some misunderstanding. PSROs do not have nor should they have responsibility for the discharge planning for individual patients. Under present policy, PSROs are required to accept documentation in the medical record that alternative care is not available. It is the responsibility of the fiscal intermediary to monitor the hospitals' discharge planning efforts. We believe that the PSRO should have more authority to monitor a hospital's discharge planning efforts and be able to deny hospital days if they have evidence that the hospital is not making a good faith effort to place patients.

In addition, by limiting its examination to cases which were ultimately denied, the GAO was not able to consider whether there were hospital stays that could have been shortened if more aggressive discharge planning had occurred. Therefore, we feel that a legitimate issue for consideration is whether monitoring of the hospital discharge planning should become a PSRO function.

PSRO COMMENTS AND OUR EVALUATION

After our review, we provided the executive director of the PSRO whose activities are discussed on pages 9 through 11 with a draft copy of chapters 1 and 2 of the report so that his organization could review and comment on the material that pertains to it before issuance of the final report. We have incorporated the PSRO's comments in our report where appropriate. The PSRO's comments and our evaluation are discussed below.

PSRO comment

The 9,300 days of incorrect extensions (see p. 9) is an unwarranted projection because the classifications are made after the fact by the review coordinator and may not represent the real reasons why the physician advisers granted the extensions. GAO accountants concluded that there was incorrect certification of 9,300 patient days based on a non-representative and very limited review of workpapers, such as review coordinator worksheets, abstracts, and bills.

Our evaluation of PSRO comment

These statements are not completely accurate. The 9,300 days is not a projection, but rather actual days of patient care that PSRO review coordinators categorized as shown on page 9 and in appendix III (numbers 8 and 12). We did not question the qualifications of the PSRO review coordinators regarding properly classifying extensions of hospital stays, particularly when the PSRO monitoring reports indicated that they were doing it correctly. Our conclusion that the 9,300 days are incorrectly certified as medically necessary is based on the fact that the PSRO's descriptions of and instructions for using these two categories (numbers 8 and 12 in app III) do not conform to what is allowed by Federal law, regulations, HHS instructions, and instructions from the State's department of health and social services. This is discussed in more detail in our response to the next comment.

PSRO comment

GAO's accusation that the PSRO improperly extended 9,300 patient days of care is completely unwarranted. The 9,300 days of extension represented the medical judgment of the attending and reviewing physician that medical necessity existed

for each patient extended. When a reviewing physician makes such a decision, he or she considers medical record documentation and attending physician judgment of the patient's physical, mental, social, and environmental status. The practicalities of finding a foster home for an infant, establishing legal guardianship for an incompetent individual, or a skilled nursing facility's no weekend admissions policy are considered when physician reviewers are determining the patient's need to continue in the hospital. The PSRO believes this is consistent with the PSRO law.

Our evaluation of PSRO comment

As indicated by the examples on pages 9 through 11, we believe that in granting extensions under the delay of discharge and other categories this PSRO was taking into account such factors as lack of cooperation from patients or their families which HHS instructions say should not be considered. The Medicare and Medicaid programs pay for medical care. They are not intended as a means for paying for custodial care provided to incompetent individuals or infants waiting placement in a foster home.

Federal law, regulations, HHS instructions, and instructions from the State are clear regarding what services are eligible for payment by these programs. For example, section 1814(a) of the Social Security Act states that in order for inpatient hospital services to be eligible for payment, a physician must certify that such services are required to be given on an inpatient basis or that inpatient diagnostic study is medically required and such services are necessary for such purpose. HHS instructions to PSROs (PSRO Transmittal No. 48 dated June 3, 1977) states:

"* * *the law precludes payment for covered levels of care where the reason for such care is based on other than medical needs. The PSRO must, therefore, distinguish (1) medically necessary hospital utilization from hospitalization based on such nonmedical reasons as convenience to patient, family or physician, administrative reasons, or reasons due to lack of available alternative levels of care; and (2) medically necessary covered care from medically necessary noncovered care."

The instructions provide, however, that inpatient services are eligible for payment if the patient is waiting to be transferred to a skilled nursing care facility and no bed was available in such a facility

With respect to the certification of Medicaid days of care, the memorandum of understanding between the State's department of health and social services and the PSRO provides that the goals and methods for Medicaid review will conform to the standards and guidelines established by HHS' HSQB. The memorandum further states that the goals and methods are to assure that each admission is medically necessary and that each patient stays only as long as is medically necessary

PSRO comment

There was no mention of the gross projections made in the report at the time of the exit interview, and this is the first opportunity that the PSRO has had to comment.

Our evaluation of PSRO comment

In its comments, the only thing that the PSRO refers to as a projection is the 9,300 days of inappropriate extensions. As previously indicated the 9,300 days of care represent 2 of 15 categories that the PSRO used to classify extensions of patients' hospital stays. One category (8) was designated "delay in discharge not due to hospital," and another (12) was designated "other." (See app III.)

Actually the 15 categories contain 8 categories which are designated "other" or are described as being categories for "other certified days" including category number 8. The appropriateness of days classified in these various categories was discussed during our closeout meeting with the PSRO's executive and associate directors. This fact is documented in a later memorandum prepared by the associate director.

PSRO comment

GAO auditors evaluated physician judgments respecting the medical needs of patients without the review of the medical record

Our evaluation of PSRO comment

This statement is not accurate. We did not evaluate physician judgments, with respect to the medical needs of any patient. We accepted the classification to the questioned categories as recorded by the PSRO or the delegated hospital after our review of some individual cases indicated that the classifications were accurate. Our problems with using these categories related to the (1) consideration of nonmedical factors that HHS has instructed PSROs not to consider in certifying the medical necessity of further hospital care and (2) additional granting of grace days, which in effect provides duplicate coverage for the same reasons.

PSRO comments

Our conclusions concerning the adequacy of hospital discharge planning are not supported by the PSRO's experience or the examples cited in this report (pp. 12 and 13).

Our evaluation of PSRO comment

Our conclusions concerning the adequacy of the hospitals' discharge planning function were based on our review of the activities of 39 hospitals and 809 adverse determination cases. Only three hospitals and 30 cases were applicable to this PSRO. Therefore, we would have a different perspective than the PSRO on the adequacy of the hospitals' discharge planning function and the desirability of providing PSROs with additional authority over this function. Also, we may have a narrower view of the hospitals' responsibilities for discharge planning than this PSRO. Our view was based on HCFA instructions which focus on the hospitals' supportive role to the attending physician in locating a suitable bed in an appropriate alternate facility consistent with the doctor's orders and also arranging for the transfer of patient records to assure the patient's continued care.

Our review of the cases related to the PSRO indicated that a principal problem associated with delays in patient discharges involved the uncooperativeness of the patient's family. Apparently, this PSRO believes that good discharge planning would more timely identify and overcome such problems. While the PSRO's position may have merit, we believe that for us to conclude that PSROs should have more authority over the discharge planning function would require an assumption that PSROs could better obtain cooperation from a patient's family than the local hospital. We have no basis for such an assumption.

AN EQUAL OPPORTUNITY EMPLOYER

**UNITED STATES
GENERAL ACCOUNTING OFFICE
WASHINGTON, D C 20548**

**OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, \$300**

**POSTAGE AND FEES PAID
U S. GENERAL ACCOUNTING OFFICE**



THIRD CLASS