BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Health And Human Services

Opportunities To Reduce Medicare Payments For Prosthetic Lenses While Enhancing Nationwide Uniformity Of Benefits

Inadequate guidance to Medicare's claims processing contractors has resulted in unnecessary expenditures for prosthetic lenses and related professional services used after the removal of cataracts and inequitable benefits for Medicare beneficiaries.

GAO estimates that improved guidance by the Department of Health and Human Services could have resulted in a reduction in Medicare allowed charges of at least $7.4 million during 1982 in areas served under 7 of the program's 49 claims processing contracts. Significantly greater amounts could have been saved nationally and more equitable administration of benefits would have resulted.

GAO recommends that the Department develop and implement guidance to improve controls over payments for prosthetic lenses and related professional services.

GAO/HRD-85-25
JANUARY 10, 1985

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

HUMAN RESOURCES
DIVISION

B-217228

The Honorable Margaret M. Heckler
The Secretary of Health and
Human Services

Dear Madam Secretary:

Each year, Medicare pays for a large number of cataract surgeries and for the prosthetic (artificial) lenses which perform the function of the removed natural lens of the eye. This report discusses two opportunities for reducing Medicare payments associated with prosthetic lenses and assuring that beneficiaries throughout the nation are provided consistent benefits. We estimate that Medicare allowed charges could have been reduced by between $7.4 million and $16.2 million through uniform screening limits for the number of replacement lenses that Medicare will pay for and more reasonable payment screens for lenses and related professional services for prescribing and fitting them.

This report contains recommendations to you. As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the four above-mentioned Committees; the Director, Office of Management and Budget; your Inspector General; and the Administrator of the Health Care Financing Administration.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY OF
HEALTH AND HUMAN SERVICES

OPPORTUNITIES TO REDUCE MEDICARE PAYMENTS FOR PROSTHETIC LENSES WHILE ENHANCING NATIONWIDE UNIFORMITY OF BENEFITS

D I G E S T

When the lens of the eye becomes cloudy or loses its transparency--a condition known as cataracts--vision is impaired and can be lost. In fact, cataracts are the second leading cause of blindness in the United States. Cataract-related blindness can usually be corrected, however, by surgically removing the affected lens and using an artificial (prosthetic) lens in its place. There are three types of prosthetic lenses: cataract eyeglasses; cataract contact lenses; and intraocular lenses, which are surgically implanted in the eye.

Cataracts are particularly common among the elderly, almost all of whom are eligible for Medicare. It was estimated that over 600,000 cataract surgeries were performed in 1982, most of them on the elderly. Because of the many Medicare beneficiaries who have cataract surgery and later obtain prosthetic lenses, GAO reviewed Medicare's policies regarding payments for such lenses. GAO concentrated on the policies related to cataract eyeglasses and cataract contact lenses because these types of prosthetic lenses can involve continuing expenses, whereas intraocular lenses normally represent a one-time expense when they are implanted.

GAO reviewed payments made in 1982 for prosthetic lenses by seven carriers--insurance companies under contract with the Health Care Financing Administration (HCFA) to process and pay Medicare claims. GAO identified two opportunities to reduce Medicare payments for prosthetic lenses that would also help assure that beneficiaries throughout the nation are consistently treated. These opportunities are (1) establishing uniform screening for the number of replacement lenses that Medicare will pay for and (2) determining payment amounts separately for the lenses themselves and for the related professional services.

Tear Sheet

GAO/HRD-85-25
JANUARY 10, 1985

The results of GAO's review of a random sample of beneficiaries who received prosthetic lenses, when projected to the universe of such beneficiaries at the seven carriers, indicate that Medicare allowed charges would have been reduced by $7.4 million to $16.2 million if such policies had been in effect in 1982.

UNIFORM SCREENING NEEDED ON THE NUMBER OF COVERED REPLACEMENT LENSES

Medicare regulations and guidelines do not establish specific limits on the number of replacement lenses for which Medicare will pay. Instead, HCFA allows each carrier to establish reasonable limits on the number of lens replacements that Medicare will pay for. (See pp. 6 and 7.)

The seven carriers reviewed had replacement limits that varied from relatively stringent limits to none at all. For example, limits on replacements of lost or torn soft or extended-wear contact lenses ranged from no replacements allowed to unlimited replacements. Consequently, one carrier would reject claims for any such replacement lenses, whereas another carrier would pay for an unlimited number of replacements. In our worst case example, one carrier paid for 40 contact lenses in 20 months for one Medicare beneficiary. (See pp. 8 to 11.)

To determine the potential impact of establishing a uniform policy for replacement lenses, GAO randomly selected a sample of beneficiaries from the universe of those receiving prosthetic lenses at the seven carriers. GAO applied the following replacement policy to the claims history of these beneficiaries:

--one replacement each year for cataract eyeglasses and

--one original and two replacement cataract contact lenses for each eye during the first year after surgery and two replacements for each eye for each subsequent year. (See pp. 11 and 12.)

This replacement policy was more stringent than that used by four of the seven carriers, similar to that used by two others, and less stringent than one of the carriers. GAO's test policy was also somewhat more liberal than one recommended to HCFA by the American Academy of Ophthalmology, which would limit replacements of cataract lenses to one per eye per year after the first year. (See pp. 7 to 9.)

About 4 percent of the beneficiaries in GAO's sample received more replacement lenses than would have been allowed under the policy outlined above. The average total amount of allowed charges per beneficiary exceeding the test limits was $311. (See p. 12.)

PROSTHETIC LENS PAYMENTS SHOULD BE SEPARATED FROM PAYMENTS FOR SERVICES

Practitioners--physicians and optometrists--were almost universally billing Medicare "comprehensive service fees" that covered both the prosthetic lenses and the related professional services. In comparing the typical cost of a prosthetic lens to the Medicare allowed charges for the comprehensive service procedure, GAO found that practitioners were receiving overly high payments for the professional services compared to allowed charges for other similar procedures. (See pp. 15 to 18.)

For example, an extended-wear prosthetic contact lens may cost a physician about $55, but the carriers GAO reviewed had prevailing charges for comprehensive service fees ranging from $212 to $350 for initial extended-wear lenses and from $75 to $350 for replacements. However, carrier information GAO obtained showed that the allowed charge for an office visit by an established patient for an intermediate ophthalmologic examination and evaluation (involving substantially the same professional services as replacing a cataract contact lens) ranged from $15 to $56.

GAO estimated the savings that could be obtained by separating payment determinations for the prosthetic lenses and the related professional services. To develop this estimate GAO compared the allowed charges for the comprehensive service procedure to the charges that would have been allowed if payments were determined on the basis of the cost of the prosthetic lens and allowed charges for ophthalmologic professional services. The results indicate that separating the payment determinations in this manner would have reduced the seven carriers' allowed charges by about $54 per beneficiary. (See pp. 19 and 20.)

GAO believes that HCFA has the authority under the inherent reasonableness criteria of Medicare law and regulations to separate these payment determinations. The American Academy of Ophthalmology has recommended to HCFA that comprehensive service fees should not be used for contact lens replacements. Moreover, basing payment for prosthetic lenses on the cost to the practitioner plus a reasonable handling fee would be in line with the American Medical Association's statement that a doctor is not a commercial enterprise and should not profit from the resale of products or from the work of others. (See pp. 20 and 21.)

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO recommends that the Secretary direct the Administrator of HCFA to develop and implement

--uniform screens on the number of replacement prosthetic lenses for which Medicare will pay (see p. 14) and

--guidelines to require cost-based reimbursements for prosthetic lenses and separate reasonable allowances for the related professional services (see p. 23).

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ILLUSTRATIONS

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

CHAPTER 1

INTRODUCTION

Within the eye, immediately behind the pupil, is the lens, which focuses light on the inner back surface--the retina. Any opacity (cloudiness or loss of transparency) of the lens, which interferes with the light coming into the eye, is called a cataract.

Cataracts are the second leading cause of blindness in the United States. However, cataract-related blindness can usually be corrected by surgically removing the opaque lens and using prosthetic lenses to focus light on the retina. Cataract surgery results in a condition known as aphakia, which means the natural lens of the eye is absent. To restore the function of the natural lens, a physician may prescribe cataract eyeglasses, cataract contact lenses, or surgically implant an intraocular lens. The use of an intraocular lens establishes a condition known as pseudophakia.

Cataract surgery occurs most frequently among persons aged 65 and older--the Medicare population. Recent technological changes in the methods of performing cataract surgery, greater acceptance of intraocular lenses, and increases in the average longevity of Americans have contributed to significant increases in the frequency of cataract surgeries and in Medicare payments for the correction of cataract-related blindness. It is estimated that more than 600,000 cataract surgeries were performed in 1982, representing nearly a 50-percent increase in the estimated number of such surgeries since 1979.[1]

This report discusses opportunities for improvements in the administration of payments under Medicare for prosthetic lenses. These improvements could result in significant savings to Medicare and more equitable treatment of beneficiaries.

MEDICARE COVERAGE OF CATARACT-RELATED SERVICES

Medicare is a federal program which pays much of the health care costs of eligible persons--generally those aged 65 or over. The program was established with the enactment of title XVIII of the Social Security Act and became effective on July 1, 1966.

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[1]See Walter J. Stark, M.D., et al., "Trends in Cataract Surgery and Intraocular Lenses in the United States," American Journal of Ophthalmology, Vol. 96, No. 3, Sept. 1983, pp. 304-310.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is responsible for administering the Medicare program.

Medicare provides protection under two parts. Part A--the hospital insurance program--covers inpatient hospital care, home health care, and inpatient care in skilled nursing facilities. HCFA administers part A with the contracted assistance of intermediaries--usually Blue Cross plans or commercial insurance companies, such as Aetna.

Part B--the supplemental medical insurance program--covers physician services, outpatient hospital services, certain home health care, and other medical and health services. HCFA administers part B through contracts with various health insurance companies called carriers. These carriers make part B payments for physicians' services and supplies. These payments generally are based on reasonable charges.

Part B generally covers 80 percent of the reasonable charges for covered services and/or supplies in excess of a $75 annual deductible. The beneficiary must pay the deductible and the remaining 20-percent coinsurance.

Medicare pays for cataract-related services under both parts A and B. Part A pays for the inpatient hospital services provided to cataract surgery patients, including reimbursement for intraocular lenses when implanted on an inpatient basis. Part B pays for physicians' services and supplies, including not only prosthetic lenses but also the professional fees charged for cataract surgery performed on an inpatient or outpatient basis, and related office visits and examinations.

Part B pays for certain combinations of prosthetic lenses, if determined by a physician to be medically necessary to restore useful vision to the aphakic beneficiary. Also, part B pays for adjustments to prosthetic lenses, required by wear or a change in the beneficiary's condition, when ordered by a physician and for the replacement of lost or irreparably damaged prosthetic lenses with or without a physician's order. In addition, part B pays for conventional eyeglasses prescribed for patients with cataract contacts or intraocular lenses to provide refractive corrections. The matters discussed in this report deal exclusively with part B payments.

OBJECTIVES, SCOPE, AND METHODOLOGY

We initiated a review of Medicare payments for cataract-related services because of the increasing frequency of cataract surgery. The main objective of our review was to determine if

HCFA had provided adequate guidance to carriers to effectively administer Medicare reimbursements for prosthetic lenses. Specifically, we wanted to determine if part B reimbursements for cataract eyeglasses and contact lenses have been unnecessarily high or inequitably administered.

We reviewed the administration of Medicare reimbursements for prosthetic lenses by seven carriers. These carriers, which cover all or portions of seven states, included:

--Blue Cross and Blue Shield of Florida (all of Florida except Dade and Monroe Counties),

--Transamerica Occidental Life Insurance Company (seven southern California counties),

--Aetna Life and Casualty Insurance Company (Arizona),

--Blue Cross and Blue Shield of Alabama (Alabama),

--EDS-Federal Corporation (Illinois),

--Prudential Insurance Company of North America (North Carolina), and

--Wisconsin Physicians Service (Wisconsin).

We selected Florida, Illinois, and California because they are among the 10 states with the highest elderly population and also have relatively high ratios of eye care specialists (ophthalmologists and optometrists) per 100,000 population compared to many states. We included Alabama, North Carolina, Wisconsin, and Arizona to determine if carriers' administration of prosthetic lens reimbursements varied within HCFA regions.

At each carrier, we determined the procedures followed in handling, controlling, and paying claims for prosthetic lenses. We also identified the steps followed to

--ascertain that each beneficiary is eligible for the prosthetic lens(es) billed,

--limit the number of replacement prosthetic lenses for which Medicare pays, and

--identify duplicative claims.

We obtained from each carrier the universe of beneficiaries having one or more claims for prosthetic lenses during calendar year 1982--the most recent data available at the time of our

review. From each universe, we obtained a random sample of beneficiaries and reviewed the paid claims history of each to determine

--the number of prosthetic lenses billed to Medicare during calendar year 1982,

--the amounts allowed and paid for each prosthetic lens, and

--whether claims for conventional eyeglasses were included.

We used the random samples to estimate savings if Medicare reimbursements were limited to (1) a maximum number of prosthetic lens replacements and (2) the cost of the prosthetic lenses, plus reasonable fitting and handling fees, for those lenses allowed. In addition, we estimated the savings to the Medicare program should HCFA discontinue coverage for conventional eyeglasses worn by aphakic patients. Additional information regarding our statistical sampling methodology is in appendix I.

At HCFA regional offices in Atlanta, Chicago, and San Francisco, we reviewed manuals, correspondence, and other guidance to carriers about the administration of prosthetic lens reimbursements. We also discussed with regional officials our objectives and tentative observations regarding improvements needed and the potential for fraud and abuse in this area.

We visited several ophthalmologists and optometrists to obtain their views on current trends in the practice of cataract surgery. In some instances, we requested explanations regarding numerous replacement prosthetic lenses provided to beneficiaries within relatively short time periods.

Our review primarily covered claims for prosthetic lenses provided to Medicare beneficiaries during calendar year 1982 and our fieldwork was conducted from May 1983 through June 1984. We made our review in accordance with generally accepted government auditing standards.

PRIOR REPORT RELATED TO PROSTHETIC LENSES

Medicare law generally excludes coverage of conventional eyeglasses; however, HCFA allows coverage of such eyeglasses for Medicare beneficiaries who have cataract contact or intraocular lenses. These patients usually wear conventional eyeglasses in front of cataract contacts or intraocular lenses to provide further refractive correction of the vision restored by the

prosthetic lenses. The seven carriers included in our review allowed charges of about $7.8 million--representing Medicare payments of about $6 million--for such conventional eyeglasses in calendar year 1982.

In a March 7, 1984, report (GAO/HRD-84-44) to the Administrator, HCFA, we recommended that coverage of conventional eyeglasses be discontinued for prosthetic lens wearers because these conventional eyeglasses perform the same function as those worn by Medicare beneficiaries who still have the natural lenses of their eyes. On April 11, 1984, the Administrator responded that our recommendation appeared to have merit and that HCFA would consider changing the current policy. HCFA had not changed this policy as of November 1984.

CHAPTER 2

TIGHTER CONTROLS NEEDED OVER PAYMENTS FOR PROSTHETIC LENSES

HCFA regulations authorize reimbursements for the replacement of lost or irreparably damaged prosthetic devices, including prosthetic lenses. However, HCFA has no regulations or guidelines which limit the number of replacement prosthetic lenses[1] for which reimbursement should be made, but instead allows individual carriers to impose such limits. Carrier-imposed limits vary significantly or do not exist. As a result, Medicare funds have been expended for excessive lens replacements, and beneficiaries have not been treated equitably because of the different replacement limits used by the carriers.

If the lens replacement limits which we developed had been used, charges allowed for lens replacements would have been reduced by an estimated $3.2 million during calendar year 1982 in the areas served by the seven carriers we reviewed. This represents potential Medicare savings of $2.5 million in these seven areas--Medicare pays 80 percent of allowable charges. Significantly greater amounts could be saved if HCFA developed national limits on the number of lens replacements for which Medicare will pay. National limits on lens replacements would also result in more equitable treatment of Medicare beneficiaries.

MEDICARE REGULATIONS DO NOT LIMIT PROSTHETIC LENS REPLACEMENTS

The law (42 U.S.C. 1395x(s)(8)) authorizes Medicare coverage of certain prosthetic devices and their replacements. Section 2130 of the Medicare Carriers Manual provides implementing guidance for coverage of all prosthetic devices and includes coverage of replacements by reference to section 2100.4, which relates to the replacement of durable medical equipment. Generally, section 2100.4 authorizes carriers to replace "equipment" (including prosthetic lenses) in cases of loss or irreparable damage without a physician's order and in cases of wear or a change in the patient's condition when supported by a current physician's order. Carriers are expected to investigate cases

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[1]As used in this chapter, replacement limits refer to screens used by carriers to determine when replacement lenses will be paid for by Medicare. Any replacement lenses above the limit would have to be justified to be eligible for Medicare payment.

suggesting malicious damage, culpable neglect, or wrongful disposition and to deny claims where, under the circumstances, program payment would be unreasonable.

HCFA has provided no supplemental guidance to carriers regarding what maximum limits should be placed on prosthetic lens replacements. HCFA's Bureau of Quality Control and the American Academy of Ophthalmology have previously recommended that HCFA establish limits on prosthetic lens replacements. However, HCFA has chosen to maintain its current policies--leaving it to carrier discretion to question frequent replacements of lenses.

In a November 1982 report on prosthetic lenses, the Bureau of Quality Control recommended that HCFA's Bureau of Program Policy determine whether limiting the number of lenses the program will pay for was desirable or feasible. Program Policy officials rejected the recommendation and suggested that carriers be reminded of the current Medicare policy provisions. As discussed above, these provisions contain no specific limits.

On September 20, 1983, the American Academy of Ophthalmology, Governmental Relations Committee, recommended that HCFA establish guidelines for Medicare reimbursement of prosthetic lens services and materials. The Committee recommended that

> ". . . Reimbursement for spectacle prosthesis for aphakia generally should be limited to:
>
> "(a) One pair of temporary spectacles when indicated and one pair of aphakic spectacle lenses during the first year after cataract surgery. (Bifocals and/or separate near and distance).
>
> "(b) One pair of aphakic spectacle sunglasses when medically indicated as necessary the first year after surgery.
>
> "(c) One pair or one lens change per year after the first year following surgery (2nd year and beyond). The change would have to be greater than one-half diopter in power or ten degrees in cylinder axis, and certified as such by the prescriber.
>
> ". . . Reimbursement for the contact lens prosthesis for aphakia generally should be limited to:
>
> "(a) Two contact lenses per aphakic eye during the first year following cataract surgery. There shall be only one comprehensive contact lens service fee with the first lens or pair of lenses. . . .

"(b) One contact lens replacement per eye per year for subsequent years following cataract surgery. . . ."

. . . . .

"(e) When contact lenses are fitted, one pair of aphakic bifocals during the first postoperative year should be covered. Replacements of aphakic spectacles for patients with an aphakic contact lens shall be the patient's responsibility."

In early August 1984, HCFA advised Academy representatives that HCFA had no plans to distribute these or any other mandatory or suggested lens replacement limits to part B carriers. HCFA officials believed that HCFA does not have authority to establish maximum limits on the number of services, including number of replacement lenses, Medicare will pay for, but rather must pay for any medically necessary covered service. We believe that HCFA has authority to establish and require the carriers to use replacement limit payment screens. Any replacements exceeding the screens would have to be justified before payment could be made. In response to a previous GAO recommendation,[2] HCFA recently required carriers to institute specific prepayment utilization screens, such as four podiatry visits per year and one comprehensive physical examination, and stipulated that any services exceeding the screens must be shown to be medically necessary before payment is made. Those screens are similar to what we envision for replacement lenses.

Current carrier replacement limit policies

Carriers independently choose whether or not to set limits on the number of lenses for which reimbursement will be made. As a result, carrier administration of this benefit varies widely, ranging from relatively stringent limits to none at all. For example, the carriers we visited used the following reimbursement limits for prosthetic contact lenses:

--Carriers in Arizona, Florida, and Illinois would pay for unlimited contact lens replacements without restrictions on the reasons for replacement.

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[2]Improving Medicare and Medicaid Systems to Control Payments for Unnecessary Physicians' Services (GAO/HRD-83-16, Feb. 8, 1983), in which we recommended that HCFA require all carriers to institute certain cost-effective prepayment utilization screens. In October 1984, HCFA revised its Carriers Manual to require the use of specific prepayment medical necessity screens.

--The Wisconsin carrier would pay for two replacements for each aphakic eye each year.

--Until July 1983 the North Carolina carrier would pay for two hard or soft contact lens replacements or one extended-wear lens replacement for each aphakic eye each year. In July 1983, this carrier changed its limits to two replacements of any type, either or both eyes, each 18 months.

--The Alabama carrier would pay for one replacement for each aphakic eye each year but would allow exceptions to the limit when medically justified.

--The California carrier would pay for unlimited replacements of any contact lenses before November 1983. This carrier's new limit is one replacement of soft or extended-wear contact lenses each year, for each aphakic eye for medical reasons and additional lenses, if justified. However, this carrier does not pay for the replacement of lost or torn soft or extended-wear contact lenses.

The Florida carrier's policy manual established a limit of three replacements per year for prosthetic contact lenses, unless medical necessity is documented, but carrier representatives stated this limit was not being enforced because of the carrier's uncertainty regarding its authority to establish such limits. Therefore, in effect, the Florida carrier had no limit on replacements.

The following table shows the 1982 paid claims history of one case from a randomly selected sample of beneficiaries in Florida. This is a worst case example of what can happen in the absence of replacement limits.

Table 2.1

Medicare Allowances for Cataract Contact Lenses Provided to One Florida Beneficiary in 1982

Claim	Number of contact lenses claimed	Dates provided	Elapsed days	Amount billed	Amount carrier allowed
A	4	01/06/82	–	$ 325	$ 250
		01/28/82	22	325	250
		02/17/82	20	325	250
		02/25/82	8	325	250
B	3	03/16/82	19	325	250
		04/20/82	35	325	250
		05/12/82	22	325	250
C	5	05/26/82	14	325	250
		06/10/82	15	325	250
		06/21/82	11	325	250
		07/13/82	22	325	275
		07/28/82	15	325	275
D	9	08/11/82	14	300	275
		08/20/82	9	300	275
		09/07/82	18	300	275
		09/22/82	15	300	275
		10/09/82	17	300	275
		10/19/82	10	300	275
		10/29/82	10	300	275
		11/09/82	11	300	275
		11/18/82	9	300	275
E	2	12/13/82	25	300	275
		12/29/82	16	300	275
Total for calendar year 1982	23		357	$7,200	$6,075

The table shows the provider replaced one of this beneficiary's contact lenses an average of every 15.5 days, with a range of from 8 to 35 days. Also, the table shows contact lenses during calendar year 1982 only; the beneficiary's history disclosed he obtained a total of 40 contact lenses, 2 pairs of cataract spectacles, and 3 pairs of trifocal eyeglasses during the 20 months from October 1981 through May 1983.

Although the above is a worst case example, it was not unique. We randomly selected 34 eye care providers in Florida and reviewed the 1982 profile of each. Twenty-seven of these providers dispensed lenses to 311 Medicare beneficiaries. Five providers dispensed lenses to 27 beneficiaries clearly in excess of our suggested limits discussed below. Nine providers (including two of the five above) dispensed lenses which may have exceeded our suggested limits for 15 beneficiaries, but carrier records did not show whether these beneficiaries had cataract surgery in one or both eyes.

One of the above providers received reimbursement for 14 replacement contact lenses for one patient within 6 months--between February and July 1982. This provider received reimbursement during 1982 for five or more contact lens replacements--more than two for each eye--dispensed to each of eight beneficiaries.

POTENTIAL SAVINGS IF HCFA LIMITS LENS REPLACEMENTS

In the absence of specific HCFA criteria about what constitutes excessive replacements, we developed the following criteria from our analysis of limits already being used by carriers in North Carolina and Wisconsin and from discussions with carrier medical consultants:

--For cataract eyeglasses--one replacement each year.

--For cataract contact lenses--one original and two replacements per eye the first year after surgery, two replacements per eye each subsequent year.

These limits may not be the optimum, nor are we recommending them for use by HCFA. However, several carrier representatives, medical consultants, and representatives of the American Academy of Ophthalmology contacted during our review indicated that these limits would be fair or generous. Also, as shown on pages 8 and 9, our sample limits were not as stringent as those some carriers are currently using.

To determine potential savings to the Medicare program if HCFA implemented uniform limits for prosthetic lens replacements, we applied the above limits to random samples of beneficiaries at each of the seven carriers. Our stratified random sample contained 1,436 beneficiaries from a total universe of 158,547 beneficiaries. We found that in calendar year 1982, 45 of our sample beneficiaries (or a weighted 3.7 percent of our universe) received prosthetic lens replacements in excess of the maximum limits we used. The average total amount of allowed charges per beneficiary exceeding the test limits was $311.

Sixteen beneficiaries who had cataract surgery on one eye received more than two contact lens replacements in calendar year 1982. Eight beneficiaries who had undergone surgery on both eyes for cataracts received more than four contact lens replacements. Of these, one received 11 replacements and one received 8 in a 1-year period. Twenty-four beneficiaries received more than one pair of cataract eyeglasses in calendar year 1982. One of these received five pairs during that period with three pairs claimed on the same date. We projected that the carriers allowed charges totaling about $3.2 million for such "excessive" replacements, with 95-percent confidence that actual allowances were within plus or minus $3.04 million. The table on the following page shows our projections and confidence limits for each carrier reviewed.

Table 2.2

Estimated Allowances for Replacements in Excess of Suggested Limits

Carrier's service area	Estimated allowances for excessive replacements	95-percent confidence limits	
		Lower	Upper
Alabama	$ 10,365	$ 330	$ 23,993
Arizona	35,052	8,096	62,008
California (seven southern counties)	323,198	45,292	601,104
Florida (excluding Dade and Monroe Counties)	2,618,194	9,232	5,645,968
Illinois	160,557	41,602	279,513
North Carolina	6,912	173	16,187
Wisconsin	22,663	337	48,718
Weighted total	$3,176,941	133,841	6,220,041

Note: The 95-percent confidence limits of some states and of the combined seven-state group are broad because of the small number of sample cases which exceeded our criteria. All other sample cases had a zero value in the sampling error calculations, which gives a large sampling error. However, the upper and lower limits are the extreme outside values to which the true total could range.

INEQUITABLE TREATMENT OF BENEFICIARIES

HCFA's policy which allows each carrier to independently set limits, if any, on the number of replacement prosthetic lenses for which Medicare will pay causes inequitable treatment of beneficiaries. For example, based on the various limits shown on pages 8 and 9, a beneficiary wearing a cataract contact lens on one eye who loses four extended-wear contact lenses within a year could get reimbursement for one replacement in Alabama and North Carolina, none in California, two in Wisconsin, and all four in Florida, Arizona, and Illinois.

Also, the table on page 10 shows where one beneficiary received 23 contact lenses in calendar year 1982. Medicare payments totaling at least $4,800 (80 percent of allowed charges minus $75 deductible) were made for this beneficiary for contact lenses. In comparison, had this beneficiary lived in Wisconsin or North Carolina, no more than $800 would have been paid on his behalf (80 percent of $1,000 allowed for the first four lenses).

Medicare payments totaling $2,800 were made, during 1982, for replacement of lost or damaged soft contact lenses for another Florida beneficiary. The California carrier would not have paid for the replacement of these lost or damaged lenses.

In our opinion, the Medicare program, to the maximum extent possible, should be uniformly administered for all eligible beneficiaries. HCFA can enhance the equity of benefits administration for Medicare beneficiaries by establishing maximum limits on program coverage of prosthetic lens replacements.

CONCLUSION

HCFA's policy of allowing each part B carrier to independently choose whether or not to establish limits on the number of prosthetic lens replacements for which Medicare will pay causes significant differences in the administration of reimbursements for such lenses. Under this policy, some carriers allow reimbursements for frequent replacements, while others have relatively restrictive limits.

We believe the lack of controls over payments for replacement prosthetic lenses results in unnecessary expenditures of Medicare funds and inequitable treatment of Medicare beneficiaries. Significant savings and more equitable benefits could be realized if HCFA established replacement screens for use by all carriers.

HCFA has the authority to require that carriers establish uniform lens replacement payment limit screens and require justification for any lens replacements exceeding the limits before payment is made. HCFA used this authority in October 1984 to require carriers to institute specific prepayment utilization screens for physician services, and we believe HCFA should require screens for replacement lenses.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to develop and implement uniform screens for the number of replacement prosthetic lenses for which Medicare payment will be made. Replacements exceeding the screens should require justification before payment is made.

CHAPTER 3

REIMBURSEMENTS FOR PROSTHETIC LENSES SHOULD BE SEPARATED FROM CHARGES FOR RELATED PROFESSIONAL SERVICES

Physicians generally use comprehensive service procedure codes which cover both the prosthesis and its handling and fitting when billing Medicare or its beneficiaries for prosthetic lenses. However, we found that if physicians were paid separate fees for their services and for the cost of the prosthesis provided, Medicare could save a substantial amount--between $5.8 million and $8 million at the seven carriers we reviewed based on 1982 payments. The common procedure coding system which all carriers are required to use by July 1985 includes codes which would enable payment on this basis. Also, in our opinion, HCFA has authority under section 1842 of the Social Security Act (42 U.S.C. 1395u) and Medicare regulations (42 C.F.R. 405.502) to implement a payment system along these lines.

HOW MEDICARE REASONABLE CHARGE LEVELS ARE DETERMINED

Medicare normally bases its payments for physician services on reasonable charges. The reasonable charge is defined as the lowest of

--the actual charge made by the physician,

--the physician's customary charge for the service (that is, an amount high enough to cover the physician's charges 50 percent of the times the service was rendered), or

--the prevailing charge for the area (that is, an amount high enough to cover 75 percent of the customary charges of all physicians in the area).

Customary and prevailing charge levels are computed for each type of service based on the prior charges. Each type of service is represented in Medicare's data by a procedure code which is either reported on the bill by the physician or coded by the carrier based on the physician's narrative description of the service provided.

Under HCFA's common procedure coding system, which all carriers must implement by July 1985, physician services related to providing and fitting cataract eyeglasses and contact lenses can

be reported by either (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability or (2) separate codes for the lenses and for the physicians' services.[1] At all of the carriers we reviewed, physicians normally submitted bills based on the comprehensive service code. The allowed charges for these codes varied widely among the carriers, but in general appeared to be high.

Prevailing charges at the carriers we visited ranged from $212 to $350 for comprehensive services related to the initial provision of an extended-wear cataract contact lens and from $75 to $350 for replacing such a lens. These prevailing charge screens, shown in the following table, were used by the carriers in determining whether submitted charges were reasonable.

Table 3.1

Prevailing Charge Screens Used by Selected Carriers for Extended-Wear Contact Lenses

Carrier's service area	Prevailing charge screens for an extended-wear contact lens[a]	
	Initial lens	Replacement lens
Alabama	$212	$100
Arizona	250	100
California (seven southern counties)	300	125
Florida (excluding Dade and Monroe Counties)	350	150
Illinois	250 - 350[b]	250 - 350[b]
North Carolina	275	100
Wisconsin (charge allowed)	250	75

[a]Prevailing charge screens for Arizona and southern California were those effective in July 1983. Screens for replacements in Wisconsin were changed effective in November 1982. Screens for all other areas were those effective in July 1982.

[b]In Illinois, the carrier had separate prevailing charge screens of $325, $350, and $250 for ophthalmologists, optometrists, and optical shops, respectively, in each of 16 designated areas.

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[1]Procedure coding systems the carriers used before adopting HCFA's common procedure coding system also normally provided these options for reporting services.

SEPARATING PAYMENT FOR LENSES AND THE RELATED PHYSICIAN SERVICES WOULD LOWER MEDICARE COSTS

Because of the wide variation in allowed charges for comprehensive service fees among the carriers and because the cost of lenses to patients following cataract surgery was considerably higher than to noncataract patients, we tested an alternative to allowing comprehensive service fees for the provision of cataract eyeglasses and contact lenses. To estimate the typical cost to the physician for prosthetic lenses, we obtained wholesale price lists from a number of wholesalers and physicians and held discussions with these persons. This information showed, for example, that extended-wear prosthetic contact lenses cost from about $19 to about $62 with a usual cost of about $55. Comparing this amount to the prevailing charges in the table on the previous page indicates that the allowable charges for the physician services component of the comprehensive services fee for an extended-wear contact lens ranged from $157 to $295 for an initial service and from $20 to $295 for a replacement service.

We then compared these physician service components of comprehensive service fees to other physician service charges which we considered to be similar. Neither HCFA nor the carriers had information showing what the prevailing fees were for the procedure codes for fitting, evaluation, and short-term follow-up for prosthetic lenses because physicians almost universally billed on a comprehensive service basis. Therefore, for estimation purposes, we compared the value of professional services provided by an ophthalmologist or optometrist in fitting and handling a prosthesis, and providing necessary follow-up care to services during

- --one office visit by an established patient for an intermediate ophthalmologic examination and evaluation, if the prosthesis is cataract spectacles or a replacement contact lens and

- --two office visits by an established patient for an intermediate ophthalmologic examination and evaluation, if the prosthesis is an initial cataract contact lens.

We selected these because information obtained from carriers showed that services performed during an intermediate ophthalmologic examination are substantially the same as services described by HCFA as being covered by Medicare for ophthalmologic services for patients who have had a cataract removed. We used the follow-up ophthalmologic visit based on the assumption that the provider would have performed the cataract surgery or an initial comprehensive examination prior to fitting the prosthetic lenses.

We determined carrier-wide prevailing allowances for office visits in the areas served by carriers included in our review. These allowances ranged from $15 to $56 as shown below:

Table 3.2

Selected Carriers' Prevailing Allowances for Follow-up Office Visits

Carrier's service area	Prevailing charge for an intermediate ophthalmologic follow-up office visit
Alabama	$20
Arizona	18
California (seven southern counties)	56
Florida (except Dade and Monroe Counties)	30
Illinois	26
North Carolina	20
Wisconsin	15

We could not obtain weighted average prices for each lens because no information was available showing the relative frequency of use for each type during calendar year 1982. However, we developed a consensus list of the estimated 1982 wholesale costs for the various types of lenses commonly used. To do so, we obtained (1) price lists from optical wholesalers and providers in six states and (2) sample purchase invoices from providers in two states. We also obtained providers' and suppliers' opinions regarding the prices most commonly paid by providers for various types of prosthetic lenses during calendar year 1982. We considered information from each source in developing the estimated price list shown below.

Table 3.3

Estimated Wholesale Costs
for Selected Eye Prostheses

Type of prosthesis	Estimated 1982 wholesale cost at or below which each item was readily available
Cataract spectacle lens:	
Single vision	$20.00
Bifocal	27.50
Multidrop	40.00
Balance	15.00
Frames	30.00
Cataract contact lens:	
Regular hard	20.00
Regular soft	35.00
Extended wear (Permalens and others)	55.00

We added the estimated cost of each type of prosthetic lens to the prevailing charge for the intermediate ophthalmologic follow-up office visit (two allowances for an initial contact lens and one for a replacement) and compared the resulting amounts to the allowed charges for a sample of claims. We included one allowance if the beneficiary received eyeglasses or contact lenses for one or both eyes on the same day. However, we included no allowances, or only one allowance for an initial contact lens, if the provider had already billed for an office visit on the day that he or she provided the prosthesis.[2]

We estimate, at the 95-percent confidence level, that the seven reviewed carriers allowed charges that totaled between $7.3 million and $10 million more than would have been allowed

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[2]Although most providers included comprehensive service fees in their billings for prosthetic lenses, several providers billed, and some carriers allowed reimbursements, for office visits on the same dates that prosthetic lenses were provided. In our opinion, a separate claim for an office visit on the same date as a claim for a prosthetic lens, including a comprehensive service fee, is in effect a duplicate billing. However, we did not develop any separate estimate of such duplication because in computing the estimated excessive reimbursements for lenses, we reduced our allowance for fitting and handling fees if the provider had already billed for an office visit. Therefore, any savings available through better controls over such billings are included in the estimated savings discussed above.

based on paying cost of the lenses plus the prevailing charges for the office visits. This represents Medicare payments of between $5.8 million and $8 million because Medicare generally pays 80 percent of allowed charges. Significantly greater amounts would have been paid nationally.

The estimate is based on services to a universe of 158,547 beneficiaries--an average of $54.39 each--and relate only to those lenses which would have been allowed using the maximum limits which we used for computational purposes in the previous chapter. The following table provides a breakdown by carrier and the 95-percent confidence limits:

Table 3.4

Estimated Excessive Allowances for Prosthetic Lens Services During 1982

Carrier's service area	Excessive allowances for comprehensive services	95-percent confidence limits	
		Lower	Upper
Alabama	$ 300,239	$ 253,790	$ 346,689
Arizona	136,702	74,017	199,388
California (seven southern counties)	783,316	520,916	1,045,716
Florida (excluding Dade and Monroe Counties)	5,899,092	4,625,998	7,172,186
Illinois	1,015,525	695,014	1,336,036
North Carolina	207,928	147,587	268,269
Wisconsin	280,961	209,962	351,960
Total	$8,623,763	7,279,471	9,968,053

HCFA has authority to limit payments for prosthetic lenses

HCFA establishes or approves the procedure coding systems used by carriers for the Medicare program. The coding system defines the procedures Medicare will pay for, and the carriers determine in accordance with law and regulations the amount Medicare will recognize as the reasonable charge for each procedure.

HCFA has required all carriers to use its common procedure coding system by July 1985. This coding system includes codes for providing and fitting prosthetic lenses both on a combined basis under one code and on a separate basis with one code for providing the lenses and another for fitting and handling them. HCFA can modify this coding system to only permit separate coding or it could instruct the carriers to limit the reasonable charge for the combined codes to the total of the reasonable charges for the separate codes. Either action in effect would result in the separation of the reasonable charge determination for (1) the physicians' services for fitting and handling of the lenses and (2) the lenses themselves.

We believe that once the reasonable charges are separated, HCFA has authority to limit Medicare payments for the lenses to their cost or something approximating their cost. Medicare regulations (42 C.F.R. 405.502(a)(7)) include as a criterion for determining what charges are reasonable: "Other factors that may be found necessary and appropriate with respect to a specific item or service to use in judging whether the charge is inherently reasonable."

Physicians normally obtain lenses from manufacturers or wholesalers and furnish them to the patient. Procedure codes for the prescription and fitting of lenses cover the services actually provided by the physician. For example, the description of code 92312 states: "Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes." The Physicians' Current Procedural Terminology, 4th edition, a procedure coding system devised by the American Medical Association on which HCFA's common procedure codes are based, states that: "The fitting of contact lenses includes instruction and training of the wearer and incidental revision of the lens." Thus, if a physician were paid based on his or her cost of the lenses and the reasonable charge for code 92312, the only physician service not covered would be the ordering and handling of the lenses, which could be covered by adding a handling fee to the cost of the lenses.

We believe that situations like that outlined above fall under 42 C.F.R. 405.502(a)(7) as other factors necessary to judge the inherent reasonableness of charges. Because the physician essentially acts as a purchasing agent for the patient, payment of more than the cost of the lenses and a handling fee would not be inherently reasonable. Such a payment methodology would also be in line with the American Medical Association's statement that a doctor is not a commercial enterprise and should not profit from the resale of products or from the work of others.

Recommendations to change payment policies for lenses have been made

In November 1982, HCFA's Bureau of Quality Control recommended that all allowances for contact lenses be restricted to the lens cost, with a separate reasonable amount for their fitting.

While the American Academy of Ophthalmology advocates the continued use of the comprehensive service fee for providing, fitting, and handling an initial contact lens, it recognizes that payment of this fee for replacements should not be allowed. The Academy recommended payment of the comprehensive fee only with the initial lens, with a smaller handling fee for replacements. In a September 20, 1983, letter to the HCFA Administrator, Academy representatives stated:

--For the contact lens patient, an additional separately billed fee should include a follow-up period of 90 days from the time of providing the lens to the patient.

--There should be only one comprehensive contact lens service fee with the first lens or pair of lenses.

--There should be a maximum of one refitting charge per year with the submission of prescription change as certified by the prescriber.

--Comprehensive service fees should not be reimbursed with each replacement lens.

--Replacement charges should reflect invoice cost plus a handling fee to cover overhead and personnel costs.

The Academy's position differs in degrees, rather than direction, from our position. We believe that both initial and replacement lenses should be reimbursed based on costs, including the handling, with separately billed fees to cover the provider's services.

CONCLUSION

HCFA could do more to make the reasonable charge methodology effective in controlling Medicare payments for prosthetic lenses and related services. Carriers' current procedures for handling such payments result in unnecessary expenditures of Medicare funds and inequitable provision of benefits. Current reimbursements are based on comprehensive fees which, in addition to covering the cost of the prosthetic lenses, include unreasonable allowances for related fitting and handling services.

We believe that prosthetic lens reimbursements should be cost-based; and separate, more reasonable allowances should be established for the related physician services. In our opinion, HCFA has authority under the inherent reasonableness criterion to require that payment for prosthetic lenses be cost-based and separate from the reasonable allowances for related professional services.

RECOMMENDATION TO
THE SECRETARY OF HHS

We recommend that the Secretary direct the HCFA Administrator to develop and implement guidance to require that carriers establish cost-based reimbursements for prosthetic lenses and separate reasonable allowances for the professional services related to fitting cataract eyeglasses and contact lenses.

STATISTICAL SAMPLING METHODOLOGY

To determine the additional cost to the Medicare program for the excessive replacement and markup of prosthetic lenses, we selected a random sample of Medicare beneficiaries in each state reviewed who received prosthetic lenses in calendar year 1982. The Medicare carriers provided the universe of beneficiaries who received one or more prosthetic lenses along with the beneficiary benefit history records for our sample cases. For each sample beneficiary, we computed the costs for what we considered excessive replacements and markup of prosthetic lenses. We used a stratified random sampling design which allowed us to compute valid estimates for each state and the seven states combined. Due to resource limitations, we only selected about 200 beneficiaries in each state.

Because we reviewed a statistical sample of Medicare beneficiaries who received prosthetic lenses, each estimate developed from the sample has a measurable precision, or sampling error. The sampling error is the maximum amount by which the estimate obtained from a statistical sample can be expected to differ from the true universe value we are estimating. Sampling errors are usually stated at a certain confidence level--in this case 95 percent. This means the chances are 19 out of 20 that if we reviewed the records of all Medicare beneficiaries in our identified universe, the results of such a review would differ from the estimate obtained from our sample by less than the sampling error of the estimate. At the 95-percent confidence level, the sampling errors for the markup of prosthetic lenses ranged from 15.5 to 45.9 percentage points for the seven states and plus or minus 15.6 percentage points for the seven states combined.

The sampling errors for excessive replacements of prosthetic lenses ranged from 74.1 to 134.2 percent for the seven states and plus or minus 95.8 percent for the seven states combined. This large sampling error occurred because only a small number of sample cases exceeded our suggested criteria. However, the upper and lower limits are the extreme outside values to which the true total could range, whereas the true total most probably approaches the sampling estimate.

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