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BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ON

OPPORTUNITIES TO REDUCE MEDICARE PAYMENTS RELATED TO CATARACT SURGERIES WHILE ENHANCING NATIONWIDE UNIFORMITY OF BENEFITS

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today, to discuss our report entitled Opportunities To Reduce Medicare Payments For Prosthetic Lenses While Enhancing Nationwide Uniformity of Benefits (GAO/HRD-85-25, January 10, 1985).

Our testimony, which is based on our report, centers on opportunities for reducing Medicare payments associated with cataract contact lenses and eyeglasses and assuring that

beneficiaries nationwide are treated equally. It reflects work we performed in Alabama, Arizona, California, Florida, Illinois, North Carolina, and Wisconsin.

Recent reports and news articles have raised questions about unnecessary cataract operations, overcharges for intraocular lenses and physician services, and kickbacks from lens manufacturers to physicians who use their lenses. Early in our review, we identified situations where physicians were being offered questionable inducements to purchase intraocular lenses from manufacturers. We turned this information over to the Department of Health and Human Services' Inspector General's Office so that it could be included in their ongoing investigation. Consequently, our January 1985 report does not address fraud and abuse, but focuses on opportunities to change reimbursement policy which, if implemented, will reduce Medicare expenditures related to cataract surgeries.

UNIFORM SCREENING NEEDED ON THE NUMBER OF COVERED REPLACEMENT LENSES

Medicare regulations authorize reimbursements to physicians for the replacement of lost or irreparably damaged prosthetic lenses worn by cataract patients. Payments for such lenses are administered under Medicare part B with the contracted assistance of various health insurance companies called carriers. Regulations and guidelines do not establish specific limits on the number of replacement lenses for which Medicare will pay. Instead, each carrier is allowed to establish reasonable limits on the number of lens replacements.

We found that carrier administration of this benefit varied widely, ranging from relatively stringent limits to none at all. For example, carriers in Arizona, Florida, and Illinois paid for unlimited contact lens replacements, while the Wisconsin carrier paid for two replacements for each eye each year. The California carrier we visited paid for one replacement of soft or extended-wear contact lenses each year for each eye for medical reasons and additional lenses, if justified. However, this carrier did not pay for the replacement of lost or torn soft or extended-wear contact lenses.

Because of these differences, one carrier would reject claims for some replacements, whereas another carrier would pay for an unlimited number of replacements. In our view, Medicare funds have been paid for an excessive number of lens replacements, and beneficiaries are treated differently depending on where they reside because of the different replacement limits used by the carriers. In our worst case example, one carrier paid a physician for 40 contact lenses in 20 months for one Medicare beneficiary.

To determine the potential savings which might result from establishing a uniform policy for replacement lenses, we randomly selected a sample of beneficiaries from the universe of those receiving prosthetic lenses at the seven carriers we visited. We 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.

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. It was also less stringent than one recommended to the Health Care Financing Administration (HCFA) by the American Academy of Ophthalmology, which would limit replacements of cataract lenses to one per eye per year after the first year.

About 4 percent of the beneficiaries in our 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. If the lens replacement limits that 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 based on the 80 percent Medicare reimbursement rate.

In our January 1985 report, we concluded that the lack of controls over payments for replacement prosthetic lenses results in unnecessary expenditures of Medicare funds and inequitable treatment of Medicare beneficiaries. We recommended that the Secretary of HHS direct the Administrator of HCFA to develop and implement uniform payment screens covering the number of replacement prosthetic lenses to be paid by Medicare. Replacements exceeding the screens should require medical

justification before payment is made. The Secretary agreed with our recommendation and stated in her June 20, 1985, comments on our report that such screens will be implemented by October 1, 1985.

PROSTHETIC LENS PAYMENTS SHOULD BE SEPARATED FROM PAYMENTS FOR SERVICES

Physicians generally charge a single comprehensive fee covering both the lens and its handling and fitting when billing Medicare or its beneficiaries for prosthetic lenses. The carriers we visited limited Medicare reimbursements of such fees to the prevailing charges[1] for all physicians in an area. Considering the typical cost of lenses, however, we found that the comprehensive fee paid by Medicare results in physicians receiving excessive amounts for the services they provide.

For example, an extended-wear cataract contact lens may cost a physician about $55, but the carriers we reviewed used prevailing charges for single comprehensive fees ranging from $212 to $350 for initially fitted extended-wear lenses and from $75 to $350 for replacements. However, carrier information we obtained showed that the allowed charge for an office visit which involves substantially the same physician services as replacing a cataract contact lens, (i.e., an intermediate ophthalmologic examination and evaluation for an established patient) ranged from $15 to $56.

We estimated that because of the single comprehensive fee method, the total charges allowed by the seven carriers in 1982

[1]An amount high enough to cover 75 percent of the customary charges of all physicians in an area.

were approximately $8.6 million more than would have been allowed if the lenses and office visits had been paid separately. Because Medicare generally pays 80 percent of allowed charges, this represents Medicare payments of about $6.9 million.

We believe that HCFA has the authority to require separate billings. The American Academy of Ophthalmology has recommended to HCFA that single comprehensive fees not be used for reimbursing 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 stated policy that a physician is not a commercial enterprise and should not profit from the resale of products or from the work of others.

Our January 1985 report recommended that the Secretary of HHS direct the Administrator of the HCFA to develop and implement guidelines to require cost-based reimbursement for prosthetic lenses and separate reasonable allowances for the related professional services.

In her June 20, 1985, comments, the Secretary stated that reducing reimbursement for lenses to actual acquisition costs and directing carriers to reimburse separately for the lens and the examination and fitting would be considered. She stated that in the next three to six months, carriers will be advised to apply "inherent reasonableness" criteria in determining reimbursement for lenses.

This concludes my prepared statement. We will be happy to answer any questions you may have.