

March 2003

**MEDICARE  
PROVIDER  
ENROLLMENT**

**Opportunities to  
Enhance Program  
Integrity Efforts**





Highlights of GAO-03-185, a report to the Senate Committee on Finance, the House Committee on Energy and Commerce, and the House Committee on Ways and Means

### Why GAO Did This Study

Staffing companies that contract with physicians to staff hospital departments—including emergency departments—are not permitted to bill Medicare. In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Congress directed GAO to assess the program integrity implications of enrolling these companies and allowing them to bill Medicare. GAO reviewed about 2.8 million emergency department claims for 2000 from five states and assessed whether contractor physicians retained by staffing companies billed Medicare comparably to other emergency department physicians. GAO also evaluated how the lack of information on staffing companies affects efforts to assure Medicare program integrity.

### What GAO Recommends

GAO suggests Congress consider permitting the reassignment of benefits to staffing companies that retain contractor physicians and requiring these companies to seek enrollment in Medicare. GAO also recommends that CMS seek such legislative authority. CMS agreed that legislation was needed.

[www.gao.gov/cgi-bin/getrpt?GAO-03-185](http://www.gao.gov/cgi-bin/getrpt?GAO-03-185).

To view the full report, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz (312) 220-7600.

## MEDICARE PROVIDER ENROLLMENT

### Opportunities to Enhance Program Integrity Efforts

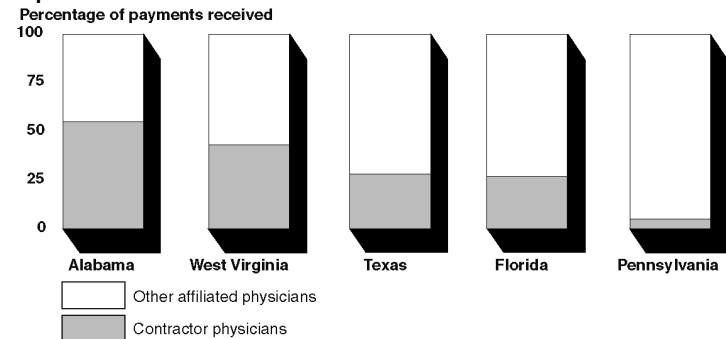
#### What GAO Found

Contractor physicians associated with staffing companies billed Medicare for complex and costly, higher-level emergency department services at rates similar to emergency department physicians with other affiliations, such as those practicing in partnerships, medical groups, or employee-based staffing companies. In addition, the patients treated by contractor physicians received diagnostic tests, were admitted to the hospital, and used ambulance transport at rates similar to patients treated by other emergency department physicians.

Staffing companies that retain contractor physicians remain largely invisible to the oversight efforts of the Centers for Medicare & Medicaid Services (CMS) because these companies are not enrolled in Medicare. Although CMS has information on the individual physicians, it has no information on the companies themselves. This may hinder oversight because contractor physicians provided a significant share of emergency care to Medicare beneficiaries. For example, in four of the five states studied, 27 to 58 percent of the physicians with substantial emergency department practices were contractor physicians retained by staffing companies.

CMS does not permit the enrollment of staffing companies that retain contractor physicians because, under current law, these companies may not be reassigned Medicare benefits. This limits CMS's ability to monitor claims. CMS cannot identify claims submitted by these companies on behalf of their contractor physicians nor can it subject the claims to the same systematic scrutiny given to enrolled groups. Consequently, it cannot evaluate the billing patterns of specific companies nor assess the aggregate impact of these companies on Medicare program integrity.

**Contractor Physicians Receive a Significant Share of Medicare Payments for Emergency Department Services**



Source: GAO.

Note: Percentages are based on payments to physicians with substantial emergency department medical practices in 2000. This information is based on GAO's analysis of 2000 Medicare claims data.

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# Contents

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<b>Letter</b>		<b>1</b>
	Results in Brief	5
	Background	6
	Contractor Physicians Billed Similarly to Their Counterparts for Emergency Department Services	8
	Despite Representing a Significant Share of Billings, Staffing Companies That Retain Contractor Physicians Are Practically Invisible to Oversight	11
	Conclusions	14
	Matters for Congressional Consideration	15
	Recommendation for Executive Action	15
	Agency Comments	15
<b>Appendix I</b>	<b>Scope and Methodology</b>	<b>16</b>
	State Selection Criteria	16
	Method for Distinguishing Contractor Physicians Associated with Staffing Companies from Physicians with Other Affiliations	17
	Methods for Comparing Billing Patterns	18
<b>Appendix II</b>	<b>Comments from the Centers for Medicare &amp; Medicaid Services</b>	<b>20</b>
<b>Appendix III</b>	<b>GAO Contact and Staff Acknowledgments</b>	<b>22</b>
	GAO Contact	22
	Acknowledgments	22
<b>Related GAO Products</b>		<b>23</b>
<b>Tables</b>		
	Table 1: Percentage of Higher-Level E&M Services Billed by Physician Type and State for Medicare Beneficiaries, in 2000	9
	Table 2: Percentage of Medicare Beneficiaries Who Received Higher-Level E&M Emergency Services and Who Also Received Selected Services by State, in 2000	10

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Table 3: Number of Emergency Department Physicians, Percentage of Contractor Physicians, and Percentage of Related Medicare E&M Payments, in 2000	12
Table 4: Use of Medicare Emergency Department E&M Service Codes in Selected States, in 2000 (Percentage)	17
Table 5: Emergency Department Physicians Billing Medicare by Staffing Arrangement and State, in 2000	18

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## Figure

Figure 1: Hypothetical Example of Variations in Contractor Physician Billing	13
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### Abbreviations

CMS	Centers for Medicare & Medicaid Services
E&M	evaluation and management
PIN	provider identification number

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United States General Accounting Office  
Washington, DC 20548

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March 17, 2003

The Honorable Charles E. Grassley  
Chairman  
The Honorable Max Baucus  
Ranking Minority Member  
Committee on Finance  
United States Senate

The Honorable W.J. "Billy" Tauzin  
Chairman  
The Honorable John D. Dingell  
Ranking Minority Member  
Committee on Energy and Commerce  
House of Representatives

The Honorable William M. Thomas  
Chairman  
The Honorable Charles B. Rangel  
Ranking Minority Member  
Committee on Ways and Means  
House of Representatives

In 2000, Medicare—the federal health insurance program that serves the nation’s elderly and disabled—paid for about 16 million visits to hospital emergency departments. Although hospitals may employ individual physicians to provide care, they can rely on other staffing arrangements to ensure adequate physician coverage in their emergency departments. Some hospitals rely on medical groups, such as physician partnerships, to ensure this coverage, while others utilize staffing companies to provide physician services. Staffing companies are businesses that recruit physicians, verify medical credentials, and provide physicians to staff hospital departments, including emergency departments. Some staffing companies are small and serve local or regional markets, while others are large and provide physicians to hospitals nationwide. Some staffing companies employ the physicians that they provide to hospitals and others retain physicians on a contractual basis.

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The Centers for Medicare & Medicaid Services (CMS), the agency responsible for administering the Medicare program, determines, consistent with Medicare law, when and under what arrangements physicians can enroll<sup>1</sup> in, and therefore directly bill, the program for services. Medicare law generally allows individual physicians and physician partnerships to file claims for payment. Medicare law also permits physicians to “reassign” their right to payment to certain other entities, such as the hospitals or other facilities where services were performed, or to their employers. CMS’s interpretation of this provision has had the effect, however, of prohibiting companies that retain physicians on a contractual basis from receiving reassigned benefits. As a consequence, such staffing companies have not been permitted to enroll in—and therefore submit claims directly to—Medicare. Claims for services supplied by contractor physicians must be submitted to Medicare either by the physicians themselves or the facilities where the services were furnished. This determination applies to companies that retain contractor physicians to staff hospital emergency departments, as well as those providing physician services for other medical specialties, such as radiology and anesthesiology.

Although staffing companies that retain contractor physicians cannot directly bill Medicare, they nonetheless indirectly receive Medicare funds. These staffing companies submit claims to Medicare on behalf of their contractor physicians, who are entitled to direct payment for their services to Medicare beneficiaries. The Medicare payments are deposited in the contractor physicians’ individual bank accounts. However, the staffing companies have typically made arrangements with these physicians to transfer their payments for these Medicare claims to the staffing companies. Depending upon the contract provisions, the companies and contractor physicians then share these funds.

The fiscal integrity of the Medicare program is partially dependent on CMS’s ability to effectively identify and investigate aberrant billing patterns among providers to hold these providers accountable. Contractor physicians are individually responsible for the billings submitted on their behalf. Because staffing companies that use contractor physicians are not

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<sup>1</sup>“Enrollment” is CMS’s term for its formal process of accepting medical providers, including physicians, into the Medicare program. The enrollment process helps ensure that only qualified and eligible individuals and entities can participate in the program and receive payment for services furnished to beneficiaries. Providers that are not enrolled cannot directly receive payment for Medicare services.

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enrolled in Medicare, CMS typically has little information on these companies and cannot readily associate the billings of individual contractor physicians with specific staffing companies. If CMS is unable to recoup overpayments from contractor physicians, it does not have the recourse to recoup these funds from staffing companies. As a result, these staffing companies may have less incentive than enrolled providers to ensure that the program is billed properly.

Recent legislation required that we study the Medicare provider enrollment process as it relates to contractor physicians with a particular emphasis on hospital-based physicians, such as those retained by emergency department staffing companies.<sup>2</sup> Among other things, it specifically directed us to assess the program integrity implications of enrolling staffing companies that retain contractor physicians. As agreed with the committees of jurisdiction, we examined emergency department billings and focused this report on (1) whether staffing companies' contractor physicians bill Medicare similarly to emergency department physicians with other affiliations, such as those practicing in partnerships, medical groups, or employee-based staffing companies, and (2) how CMS's ability to monitor Medicare billings has been affected by the lack of information linking contractor physicians to their staffing companies.

To conduct our study, we examined Medicare emergency department evaluation and management (E&M) services because they are an essential component of care provided to Medicare beneficiaries by emergency department physicians. E&M services involve a physician taking a patient's medical history, performing a physical examination, and making decisions regarding diagnosis and treatment. Medicare payments for E&M services vary based on several factors, including the patient's status and presenting diagnosis and the level of the physician's medical decision making and counseling exercised during the patient's examination. We analyzed about 2.8 million claims for emergency department E&M services paid in 2000 for beneficiaries in Alabama, Florida, Pennsylvania, Texas, and West Virginia—or about 20 percent of Medicare emergency department E&M services paid in 2000 nationally.

To determine which physicians were contractors associated with—that is, retained by—staffing companies, we identified physicians with common

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<sup>2</sup>The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, App. F, § 413, 114 Sta. 2763, 2763A-515.

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payment addresses who were not enrolled in Medicare as part of a medical group. For purposes of comparison, we placed all other physicians, including those who were members of partnerships, medical groups, or employees of hospitals or staffing companies, in a separate category.<sup>3</sup> To determine if contractor physicians associated with emergency department staffing companies billed Medicare for more complex services at higher rates than physicians with other affiliations, we compared the proportions of each group's E&M billings that were billed at the two highest levels. We also compared information from Medicare claims about other services that patients served by each group received at the time of their emergency department visits to assess whether the groups were caring for comparable patients. It was not feasible to obtain patients' medical records that would allow a more complete comparison of the two groups' patients. Our findings cannot be generalized or projected to staffing companies that retain contractor physicians in other specialties, such as radiology or anesthesiology, nor can our findings be projected to other states.

In addition to our claims analysis, we interviewed CMS officials to discuss Medicare enrollment policies and procedures as well as the program integrity implications of enrolling staffing companies that retain contractor physicians in Medicare. We also discussed these matters with representatives from several of the claims administration contractors that CMS relies on to help administer the program.<sup>4</sup> We obtained the views of officials from staffing companies that employ physicians, as well as those that retain physicians on a contractual basis and several organizations representing emergency department physicians. Included among those officials interviewed at CMS and staffing companies were several physicians who have experience working in hospital emergency departments. Finally, we reviewed applicable laws, regulations, and other guidance concerning Medicare enrollment and claims processing. We performed our work from March 2001 through February 2003, in

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<sup>3</sup>We excluded a small number of physicians from our analysis who appeared to practice emergency medicine as solo practitioners. They did not appear to be members of partnerships or medical groups or employees of hospitals or staffing companies and did not have payment addresses in common with other physicians. Less than 1 percent of the physicians who provided emergency services in the five states in 2000 were excluded.

<sup>4</sup>The claims administration contractors that process Part A claims—those covering inpatient hospital, skilled nursing facility, hospice, and certain home health services—are known as fiscal intermediaries. Contractors processing Part B claims—covering physician services, diagnostic tests, and related services and supplies—are referred to as carriers.



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accordance with generally accepted government auditing standards. (See app. I for more information on our scope and methodology, including our criteria for selecting the states examined.)

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## Results in Brief

In four of the five states we studied, contractor physicians retained by staffing companies billed Medicare for the higher-level emergency department E&M services similarly to other physicians. These staffing company physicians billed the higher-level E&M services at rates comparable to emergency department physicians with other affiliations, such as those associated with partnerships, medical groups, or employee-based staffing companies. In the fifth state, contractor physicians associated with staffing companies billed the higher-level services substantially less often than other physicians. Our analysis also indicated that the patients each group served were generally similar, at least in terms of receiving services typically associated with an emergency department visit, such as ambulance transportation, hospital admission, and diagnostic testing. Patients treated by contractor physicians received slightly more of these services in four of the five states we examined. A more comprehensive comparison of the similarities of patients of the two groups of physicians was not feasible.

Contractor physicians associated with staffing companies provided a substantial amount of emergency department care to Medicare beneficiaries in four of the five states we reviewed. For example, in these four states, contractor physicians received from 27 percent to 55 percent of the emergency department E&M payments made by Medicare on behalf of beneficiaries in these states. Despite their strong presence, the staffing companies are practically invisible to CMS's oversight. CMS does not have information on which physicians may be contracting with different staffing companies. Although CMS can identify the billings of individual physicians or groups and assess whether their billings are markedly different from the billings of their peers and hence merit more extensive review, it cannot conduct such oversight of claims submitted by the contractor physicians associated with a particular staffing company. In the aggregate, emergency department contractor physicians billed similarly to other affiliated physicians, but differences in the billing patterns of contractor physicians retained by specific companies cannot be detected because the companies cannot be identified. Given the share of Medicare payments associated with these staffing companies in the states studied, it would be prudent if CMS could improve its ability to screen claims by requiring such staffing companies to enroll in Medicare and identify the physicians with which they have contracted.

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To enhance program integrity, we suggest that Congress may wish to amend the Social Security Act to permit the reassignment of benefits to staffing companies that retain contractor physicians to treat Medicare beneficiaries, and require these staffing companies to seek enrollment in Medicare. We are also recommending that the CMS Administrator seek such legislative changes. CMS agreed that a legislative amendment was needed to permit the reassignment of benefits.

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## Background

Beneficiaries are generally the only parties under Medicare statute who are entitled to receive Medicare payments for physician services.<sup>5</sup> However, they can “assign” their rights to payment to physicians, other providers, and suppliers who directly deliver the care or service and then submit claims to Medicare. These physicians as well as other providers and suppliers must meet criteria for enrollment in the Medicare program. To bill Medicare, CMS requires that physicians, other providers, and suppliers use a standardized, five-digit coding system on the claim forms to identify the medical services and procedures that were provided.<sup>6</sup> These billing codes describe the type of medical, surgical, and diagnostic service rendered. For E&M services, these codes also designate the level—or intensity—of care provided. Emergency department E&M codes range from 99281 to 99285.<sup>7</sup> Typically, the higher the E&M code, the more complex the consultation, or level of care involved, and the higher the Medicare payment.

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<sup>5</sup>Section 1842(b)(6) of the Social Security Act provides that payments for Part B services, including payments for physicians’ services, generally may be made only to the individual who received the services. 42 U.S.C. § 1395u(b)(6) (2000). The law provides exceptions, however, permitting payment to a physician’s employer or to a facility, such as a hospital, in which the services were provided. Part A services paid under section 1814(a) of the Social Security Act include inpatient hospital, skilled nursing facility, hospice, and certain home health services, and generally may be made only to providers. 42 U.S.C. § 1395f(a) (2000).

<sup>6</sup>The Health Insurance Portability and Accountability Act of 1996 required the Secretary of Health and Human Services to adopt standard code sets for describing health-related services in connection with financial and administrative transactions, such as filing claims for payment. Pub. L. No. 104-191, Title II, Stat. F, 110 Stat. 1936, 2021 (codified at 42 U.S.C. §§ 1320d-1320d-8 (2000)). For more information, see U.S. General Accounting Office, *HIPAA Standards: Dual Code Sets Are Acceptable for Reporting Medical Procedures*, [GAO-02-796](#) (Washington, D.C.: Aug. 9, 2002).

<sup>7</sup>There are about 8,000 codes that identify all types of medical services, such as anesthesia, laboratory, medicine, pathology, radiology, and surgery.

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CMS has delegated the authority for enrolling physicians and other entities into the Medicare program to its claims administration contractors—the fiscal intermediaries and carriers—that help it manage the Medicare program. As carriers are responsible for the administration of Part B services, they are therefore tasked with managing the enrollment of physicians in Medicare. Before enrolling individual physicians and other entities, the carriers determine whether applicants meet Medicare eligibility criteria and assess, based on information provided, whether they appear to pose a potential threat to program integrity. For example, applicants are required to disclose their legal business names and ownership, adverse legal actions, and outstanding Medicare debt from previous enrollment along with copies of their medical licenses. The carriers also have the authority to request additional documentation to validate information included in the enrollment application, such as articles of incorporation and partnership agreements. In addition to verifying the required information, the carriers may access several national databases to identify adverse reports on applicants that may affect their ability to become enrolled in Medicare.<sup>8</sup> Once physicians are enrolled, the carriers assign each physician an individual provider identification number (PIN), which serves as a unique identifier. Similarly, entities that are eligible to enroll in Medicare and therefore directly bill the program—such as physician partnerships or staffing companies that employ physicians—obtain group PINs.

As specified by law, physicians can only “reassign” their payment rights to certain other entities, such as the hospitals or other facilities where services were performed or to their employers. Emergency department staffing companies generally do not own the facilities where services are performed and those that retain contractor physicians are not considered the physicians’ employers. As a result, Medicare payments cannot be reassigned to emergency department staffing companies that retain contractor physicians, and these companies are not permitted to enroll in and directly bill Medicare or be assigned group PINs. However, these

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<sup>8</sup>Claims administration contractors compare the names of providers, managing directors, and owners with at least 5 percent ownership interest to those listed on several databases, specifically the (1) Department of Health and Human Services Office of Inspector General list of excluded providers, (2) General Services Administration debarment list, (3) Healthcare Integrity and Protection Data Bank, (4) Fraud Investigation Database, and (5) ChoicePoint—a private research service that verifies medical providers’ personal and business information. For related information see U.S. General Accounting Office, *Medicare: HCFA to Strengthen Medicare Provider Enrollment Significantly, but Implementation Behind Schedule*, [GAO-01-114R](#) (Washington D.C.: Nov. 2, 2000).

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staffing companies may submit claims on behalf of their contractor physicians, using the physicians' individual PINs. Although the physicians are ultimately responsible for the claims submitted on their behalf, they may not be aware of how the staffing companies code the services billed to Medicare.

Carriers may use an individual or a group PIN to facilitate their program integrity activities. PINs allow carriers to link the individual physicians who actually rendered the services and the entities with which they are affiliated. Carriers are then able to monitor billing patterns and compare billings of both individual physicians and groups. By analyzing the billing patterns associated with both the PINs of individual physicians and these entities, carriers can identify meaningful differences and detect potential instances of improper payments or fraud. Because staffing companies that retain contractor physicians may not be reassigned benefits and cannot enroll in Medicare, they do not receive group PINs. Consequently, they are not identified on Medicare claim forms and are not subjected to such scrutiny.

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## Contractor Physicians Billed Similarly to Their Counterparts for Emergency Department Services

Our comparison of the billings by contractor physicians retained by staffing companies to other affiliated physicians—such as those practicing in partnerships, medical groups, and employee-based staffing companies—showed that contractor physicians and those with other affiliations both billed for higher-level E&M services at comparable rates in four of the five states we reviewed and at a lower rate in the fifth state we reviewed. Moreover, the rates at which other services—such as ambulance transportation, hospital admission, and diagnostic testing—were rendered in conjunction with the higher-level E&M services were similar for contractor physicians and those with other affiliations, providing an indication that the patients of both types of physicians were comparable.

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## Higher-Level E&M Services Billed at Similar Rates

Comparing the emergency department E&M billings of contractor physicians with other affiliated physicians showed that physicians involved with the two types of staffing arrangements billed Medicare for the higher-level services at similar rates in four of the five states we reviewed. The payment amounts for the higher-level services—codes 99284 and 99285—are, on average, about three times greater than the average payment amounts for lower-level services—codes 99281, 99282,

and 99283.<sup>9</sup> As table 1 shows, contractor physicians in Alabama, Florida, Pennsylvania, and Texas billed nearly the same proportion of higher-level E&M services as their counterparts in those states. The largest difference we identified was in West Virginia, where contractor physicians associated with staffing companies billed the higher-level services 55 percent of the time while other affiliated physicians billed for these services 74 percent of the time. We were unable to determine the cause of this variation.

**Table 1: Percentage of Higher-Level E&M Services Billed by Physician Type and State for Medicare Beneficiaries, in 2000**

State	Contractor physicians associated with staffing companies	Other affiliated physicians
Alabama	57	57
Florida	69	64
Pennsylvania	57	58
Texas	66	64
West Virginia	55	74

Source: GAO.

Note: We calculated these rates by dividing the number of higher-level (codes 99284 and 99285) billings by the total number of emergency department E&M services billed by physician type. This information is based on our analysis of carrier data.

### Patients of Contractor Physicians and Other Affiliated Physicians Received Similar Services

Regardless of whether emergency department patients were treated by contractor physicians or other emergency department physicians, those receiving higher-level E&M services received other services at similar rates in the five states we reviewed. To determine the comparability of patients treated by both types of physicians, we examined the rates at which patients had been transported by ambulance to the emergency department, received diagnostic tests, or were admitted to the hospital within 24 hours of the emergency department visit. As table 2 shows, patients generally received ambulance, hospital admissions, and

<sup>9</sup>During 2000, the national payment amounts for Medicare emergency department E&M services were as follows: \$20.14 for 99281, \$31.49 for 99282, \$64.07 for 99283, \$98.49 for 99284, and \$154.88 for 99285. Actual payment amounts are higher or lower, depending on the labor cost adjustment for the geographic location.

diagnostic testing services at similar rates when higher-level E&M services were billed, regardless of the physicians' staffing arrangements.<sup>10</sup>

**Table 2: Percentage of Medicare Beneficiaries Who Received Higher-Level E&M Emergency Services and Who Also Received Selected Services by State, in 2000**

Service <sup>a</sup>	Alabama physicians		Florida physicians		Pennsylvania physicians		Texas physicians		West Virginia physicians	
	Contractor	Other affiliated	Contractor	Other affiliated	Contractor	Other affiliated	Contractor	Other affiliated	Contractor	Other affiliated
Ambulance	38	35	38	42	48	46	41	39	39	37
Admission	59	53	64	65	75	66	63	61	63	53
Diagnostic testing	92	91	89	91	96	95	95	93	90	86

Source: GAO.

Note: This information is based on our analysis of carrier data.

<sup>a</sup>We used beneficiary claims data to identify whether ambulance, hospital admission, and diagnostic services were delivered in conjunction with a higher-level E&M service (99284 and 99285). The most frequently ordered diagnostic tests were chest x-rays, echocardiograms, computerized axial tomography scans, and automated blood count tests. Contractor physicians and other affiliated physicians ordered such tests 37 percent and 40 percent of the time, respectively.

Patients treated by contractor physicians in Alabama, Pennsylvania, Texas, and West Virginia had slightly higher ambulance, hospital admissions, and diagnostic testing rates than patients treated by other physicians. However, as noted earlier, these physicians did not bill for higher-level services at rates significantly greater than physicians with other affiliations in these four states. The opposite pattern occurred only in Florida. There, contractor physicians treated patients who received fewer other services, but billed higher-level E&M services slightly more often. In Florida, these physicians billed Medicare for higher-level services

<sup>10</sup>Under both types of staffing arrangements, across all five states, from 1 to 6 percent of patients did not receive at least one of the three services. Although carrier officials told us that most patients who received higher-level E&M services were transported to the hospital by ambulance, admitted to the hospital, or received some diagnostic tests, our initial analysis showed that some patients who received higher-level E&M services did not receive any of these services. We therefore asked carriers to review the claims of a sample of these patients. Carrier analysis revealed that some claims contained data entry errors that prevented them from associating these services with a particular E&M service. They also identified other claims that were paid in 2001, after our survey period. However, for about a third of the patients in their sample, carrier officials could not explain why one of the three types of services had not been rendered. Consequently, carrier officials could not discount the possibility that the higher-level E&M codes were improperly billed.

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69 percent of the time as compared to 64 percent by other affiliated physicians.

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## Despite Representing a Significant Share of Billings, Staffing Companies That Retain Contractor Physicians Are Practically Invisible to Oversight

In four of the five states we examined, a substantial percentage of the physicians providing emergency department care were contractor physicians associated with staffing companies. These physicians also received a significant share of Medicare payments for these services. However, because the staffing companies are not subject to the enrollment procedures that the carriers routinely conduct for physicians and medical groups before they are allowed to bill Medicare, CMS does not collect critical information that would enable it to identify claims that are submitted by staffing companies on behalf of their contractor physicians. Without such information, CMS cannot routinely link the claims that these companies submit on behalf of their physicians to assess the billing patterns of physicians contracting with specific staffing companies compared to the billing patterns of other physicians.

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## Contractor Physicians Account for Significant but Variable Share of Medicare Billings

Our five-state analysis of Medicare emergency department claims data and physician payment information showed that contractor physicians with staffing company affiliations accounted for a significant share of billings overall, but this varied by state. In four of the five states studied, from 27 to 58 percent of the physicians with substantial emergency department practices were contractor physicians associated with staffing companies.<sup>11</sup> As table 3 shows, in Alabama, 58 percent of the 351 physicians we identified as having substantial emergency department practices were contractor physicians. Though the percentage of these physicians was lower in Florida, Texas, and West Virginia, they still provided a significant portion of emergency care for Medicare beneficiaries in those states and received a proportionate share of Medicare E&M payments for their services. In contrast, a considerably lower percentage of Pennsylvania physicians were contractors associated with staffing companies. We were unable to determine why contractor physicians had a relatively small presence in this state.

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<sup>11</sup>We defined a substantial emergency department practice as one in which at least 50 percent of the physician's practice involved emergency department E&M services and at least \$20,000 in Medicare payments for E&M services were paid to the physician in 2000.

**Table 3: Number of Emergency Department Physicians, Percentage of Contractor Physicians, and Percentage of Related Medicare E&M Payments, in 2000**

<b>State</b>	<b>Number of physicians with substantial emergency department practices</b>	<b>Percentage of contractor physicians with substantial emergency department practices</b>	<b>Percentage of E&amp;M payments to contractor physicians with substantial emergency department practices</b>
Alabama	351	58	55
Florida	1,240	27	27
Pennsylvania	1,122	4	5
Texas	1,258	29	28
West Virginia	253	44	43

Source: GAO.

Note: This information is based on our analysis of carrier data.

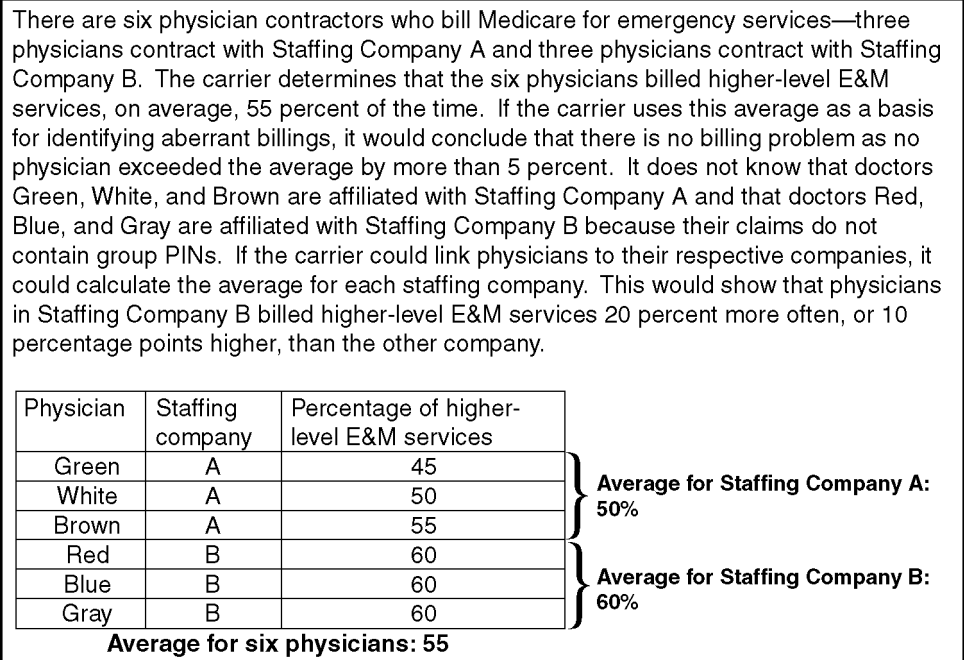
## Program Safeguards Hindered by Lack of Information

Despite the significant share of Medicare payments for emergency department E&M services made to contractor physicians, the staffing companies that retain these physicians are not subject to the screening or systematic scrutiny that carriers impose on other entities that are eligible to enroll in Medicare. During the enrollment process, carriers obtain substantial information about providers that can be used to identify applicants who may be more likely to submit improper billings. Because staffing companies that retain contractor physicians may not be reassigned benefits and cannot enroll in the program, they are not assigned PINs and such information about them is not collected. Medicare cannot identify which physicians are associated with a specific company.

For entities that are enrolled in Medicare, carriers can track the billings of specific providers associated with an entity over time, compare the billings of similar provider types, and examine claims submitted by physicians affiliated with different entities. These analyses allow the carriers to spot billing patterns that are markedly different from the norm, which could suggest potential improper billing. The carriers cannot perform this analysis for staffing companies that retain contractor physicians because these companies do not have group PINs that would enable carriers to link physicians' billings to the companies. As our hypothetical example contained in figure 1 demonstrates, important differences in billing practices across companies can be missed when the carriers cannot identify company affiliation.



**Figure 1: Hypothetical Example of Variations in Contractor Physician Billing**



Source: GAO.

If a carrier determines that a medical group’s billings differ significantly from other similar providers, the carrier may review the entity’s claims to identify the reasons for the variance. If the review finds improper bills, the carrier can take corrective action, including an assessment of amounts paid in error that must be repaid to Medicare. For repeated billing abuses, the carrier can take steps to further protect the Medicare program. For example, it can delay payment of some or all claims, pending more intense screening. When the group is enrolled in Medicare, the carrier may hold accountable, not just the physicians responsible for the improper billings, but the group, partnership, or entity employing those physicians as well. For example, if the physician stops billing Medicare before the amount of the overpayment can be withheld from subsequent payments or if the physician is unable to return the amount of the overpayment, plus applicable penalties and interest, the carrier may be able to recover the funds from a partnership or staffing company that employed the physician. Such steps cannot be taken against staffing companies that retain contractor physicians. Because staffing companies that retain contractor physicians may not be reassigned benefits and are not enrolled in Medicare, CMS has no information on these companies and cannot

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associate the billings of individual contractor physicians with specific staffing companies.

Under current law, CMS lacks the capability to readily identify contractor physicians and the staffing companies with which they associate. We engaged in a time-consuming and labor-intensive process that is not routinely performed by CMS or its carriers. We had to extract and match physician information from multiple sources, including Medicare emergency department claims data, Medicare cost reports, a staffing company database voluntarily provided by one staffing company, and hospitals we contacted in the five states we reviewed.

CMS officials acknowledge the limitations in the current reassignment and enrollment policies and the lack of information on staffing companies that retain contractor physicians. They explained that although Medicare statute expressly provides for certain types of entities—such as medical groups and health care delivery systems—to enroll and have group PINs, that law does not have comparable provisions for staffing companies that retain contractor physicians. CMS officials, therefore, maintain that they lack the authority to change CMS policy to permit the enrollment of these staffing companies and assignment of group PINs to them.

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## Conclusions

Across the five states, contractor physicians billed Medicare similarly to other affiliated physicians. While these similarities were observed at an aggregate level, contractor physicians associated with specific companies may nonetheless have billing patterns that differ markedly from the norm. This, coupled with the significant share of Medicare payments that these staffing companies receive, albeit indirectly, for emergency services in four of the five states we studied, suggests that it is important for CMS to be able to monitor the billing practices of individual companies using contract physicians. However, the law prohibiting staffing companies from being reassigned Medicare payments—with the result that they are not permitted to enroll in Medicare and receive group PINs—has limited CMS's ability to conduct oversight. CMS's carriers cannot identify claims submitted by these staffing companies and, therefore, cannot subject them to same systematic scrutiny as those of other groups. Although our work did not include an analysis of billings by contractor physicians who specialize in the provision of other medical services, such as radiology or anesthesiology, these companies remain as invisible to CMS's oversight as those providing emergency department care.

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## Matters for Congressional Consideration

In order to enhance Medicare's program integrity, Congress may wish to amend the Social Security Act to (1) permit the reassignment of benefits to staffing companies that retain contractor physicians to treat Medicare beneficiaries so that CMS may enroll these companies if they meet appropriate criteria and (2) require these staffing companies to seek enrollment in Medicare.

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## Recommendation for Executive Action

To facilitate improvements in program integrity, the CMS Administrator should propose legislation permitting the reassignment of benefits to staffing companies that retain contractor physicians to treat Medicare beneficiaries and requiring that these companies seek enrollment in Medicare.

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## Agency Comments

In written comments on a draft of this report, CMS agreed that a legislative amendment is needed. CMS recommended that we revise the draft report to reflect that, under current law, staffing companies that retain contractor physicians are not enrolled in Medicare because they are generally not eligible to be reassigned benefits. We have revised the report to fully reflect this.

We have reprinted CMS's letter in appendix II. CMS also provided us with technical comments, which we have incorporated as appropriate.

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We are sending copies of this report to the Administrator of CMS and other interested parties. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>. We will also make copies available to others upon request.

If you or your staffs have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff members who prepared this report are listed in appendix III.



Leslie G. Aronovitz  
Director, Health Care—Program  
Administration and Integrity Issues

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# Appendix I: Scope and Methodology

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To study the billing patterns of emergency department staffing companies that retain contractor physicians, we obtained Medicare claims data paid in 2000 for beneficiaries in five states—Alabama, Florida, Pennsylvania, Texas, and West Virginia. We analyzed all the emergency department evaluation and management (E&M) claims—about 2.8 million—from the five carriers and six fiscal intermediaries that processed Medicare claims for these states during this period. These claims represented about 20 percent of all Medicare emergency department E&M services paid in 2000. We interviewed representatives from the Centers for Medicare & Medicaid Services (CMS), officials from the five Medicare carriers and several of the fiscal intermediaries serving the five states we reviewed, and three professional associations that represent emergency department physicians—the American College of Emergency Physicians, the Emergency Department Practice Management Association, and the American Academy of Emergency Medicine. Several of the officials from these organizations were also physicians who have experience working in hospital emergency departments. We also contacted hospitals in the 5 states we reviewed.

To determine how the use of staffing companies that retain contractor physicians has affected CMS's ability to monitor emergency department billings, we reviewed documentation related to the provider enrollment process. This included criteria for qualifying for an individual or group PIN and the processes for assessing their integrity. We reviewed applicable laws, CMS regulations, and program guidance. We also reviewed applicable laws and regulations on provider enrollment, Medicare cost reports, as well as reports and other relevant materials from staffing companies.

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## State Selection Criteria

We selected the five states in our study based on several factors. We chose Florida, Texas, and Pennsylvania because, according to 2000 U.S. Census Bureau data, they were among the states with the largest number of Medicare beneficiaries. Because carrier officials indicated that billing improprieties might be more likely to occur in states that exceed the national average for higher-level E&M services, we chose West Virginia as one such state. As shown in table 4, Florida and Texas also exceeded the national average in the use of higher-level codes. Finally, we selected Alabama because the carrier serving beneficiaries in that state had developed extensive experience identifying and addressing provider enrollment problems. Our results cannot be generalized to other states.

**Table 4: Use of Medicare Emergency Department E&M Service Codes in Selected States, in 2000 (Percentage)**

Service codes	Alabama	Florida	Pennsylvania	Texas	West Virginia	United States
99281	3	1	1	2	3	2
99282	13	7	9	8	9	10
99283	32	28	34	30	27	32
99284	30	30	31	31	29	32
99285	23	34	24	29	32	24
Total allowed E&M services (number)	274,660	840,247	707,385	840,193	179,908	14,318,204

Source: CMS.

Note: This information is from CMS's Part B Extract and Summary System data for 2000.

## Method for Distinguishing Contractor Physicians Associated with Staffing Companies from Physicians with Other Affiliations

We developed a method for categorizing physicians by their type of staffing arrangement, based on Medicare claims data. Our analysis was limited to physicians with substantial emergency department practices in 2000. We defined a “substantial practice” as one in which at least (1) 50 percent of the physician’s Medicare payments were for emergency department E&M services and (2) \$20,000 in Medicare payments were for emergency department E&M services. For physicians meeting these criteria, carriers provided summary data containing the physicians’ names, provider identification number (PIN), practice addresses, payment addresses, payments received, and Medicare group numbers, where applicable.

Using individual PINs, group PINs, and payment addresses, we placed physicians in one of two categories—contractor physicians and other physicians.<sup>1</sup> We used a multistep process that entailed extracting and matching information from various sources. First, we used information from Medicare claims data to place physicians whose individual PINs were associated with group PINs in the other physicians category. Second, we placed physicians who did not have group PINs into the contractor physician category if their Medicare payments were sent to addresses used by at least one other physician or if they practiced in rural areas. We used Medicare emergency department claims data, private databases, and public records to identify payment addresses and practice locations. According to CMS officials, physicians who do not have group PINs and whose payments are sent to addresses similar to another physician are likely to be contractors retained by staffing companies. Third, we

<sup>1</sup>We examined the billing patterns of these physicians in the aggregate and did not analyze individual physicians, groups, or staffing companies.

excluded physicians who did not have group PINs, payment addresses in common with another physician, or who practiced in rural locations.<sup>2</sup> Less than 1 percent of the physicians were excluded. Table 5 summarizes the results of our analysis.

**Table 5: Emergency Department Physicians Billing Medicare by Staffing Arrangement and State, in 2000**

State	Contractor physicians	Other affiliated physicians	Total physicians with substantial emergency department practice
Alabama	203	148	351
Florida	331	909	1,240
Pennsylvania	47	1,075	1,122
Texas	362	896	1,258
West Virginia	111	142	253

Source: GAO.

Note: Our method may slightly overestimate the number of physicians because they may work in more than one emergency department or staffing arrangement and have a different PIN for each practice location. This information is based on our analysis of CMS data.

## Methods for Comparing Billing Patterns

To determine whether contractor physicians retained by staffing companies bill Medicare for the higher-level services at rates comparable to other emergency department physicians, we did the following. We asked the carriers to provide us with frequency distributions of the E&M services provided by physicians in our study. We combined the less costly codes (99281, 99282, and 99283) to form a lower-level service category and the more costly codes (99284 and 99285) to form a higher-level category. Of the five procedural codes, 99284 and 99285 were claimed 56 percent of the time. The carriers derived this information from Medicare claims data.

<sup>2</sup>We relaxed the address-matching criterion for physicians in rural areas because we recognized that our selection criteria—50 percent of practice and \$20,000 in payments—might not adequately capture physicians associated with staffing companies in those locations. In rural areas where there are shortages of emergency department physicians, practices are smaller, and physicians associated with a staffing company might not have had sufficient Medicare payments to meet our selection criteria. As such, the carriers would not have identified these physicians and their Medicare payment addresses would not be available for matching with other physicians. To ensure adequate representation of rural contractor physicians, we included physicians in rural areas without group numbers in the contractor physician category. Twenty-two physicians were placed in this category as a result of this decision.

We also used Medicare claims data to determine whether patients treated by contractor physicians and those treated by other affiliated physicians received comparable services. We asked carriers to identify patients who received higher-level E&M services from physicians in both arrangements and the dates of the E&M services. We then compared this information with all Medicare claims paid from January 1, 2000, through November 30, 2000.<sup>3</sup> We did this to determine whether patients receiving higher-level E&M services were also transported by ambulance, received at least one diagnostic test, or were admitted to the hospital. Carrier officials provided us with a list of service codes that when present on a claim, indicate one of these three services. Our analysis included a search for such services delivered on the same day, 1 day before, or 1 day after the higher-level E&M service was received.

Because carrier officials told us that it would be unusual for a patient who received a higher-level E&M code to not receive any of the three selected services, we analyzed such instances. We randomly selected 15 patients in each of the five states who received a higher-level E&M service without also receiving a selected service. The carriers reviewed the patients' Medicare claims information on services rendered within 1 week before and 1 week after the date of the higher-level E&M service. We did not ask that the carriers conduct medical reviews to determine whether claims were properly coded.

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<sup>3</sup>Because billing cycles and practices vary, it is possible that some services related to an emergency department visit can be paid weeks or months after the E&M service. To reduce the influence of delayed billing on our analysis, we excluded E&M services that were performed on or after December 1, 2000. This restriction allowed us to detect admissions, ambulance, and diagnostic services that were reimbursed up to 1 month after the E&M service was rendered. There are some E&M services in our study that were paid in 2000, but performed in 1999. If some of the related admissions, ambulance, and diagnostic services were paid in 1999 and not in 2000, our cross-match would not have detected them.

# Appendix II: Comments from the Centers for Medicare & Medicaid Services




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** FEB - 7 2003

**FROM:** Thomas A. Scully   
Administrator

**TO:** Leslie G. Aronovitz  
Director, Health Care—Program  
Administration and Integrity Issue

**SUBJECT:** General Accounting Office (GAO) Draft Report, *Medicare Provider Enrollment: Opportunities to Enhance Program Integrity Efforts* (GAO-03-185)

We appreciate the opportunity to review and comment on the above-referenced report.

The General Accounting Office (GAO) reviewed about 2.8 million claims for year 2000 from five states to assess how Medicare billing by contractor physicians retained by emergency department staffing companies compared with billing by other emergency department physicians. Emergency department staffing companies are businesses that contract with physicians to staff hospital emergency departments and provide related support services. The GAO also evaluated how the lack of information on staffing companies could create Medicare program vulnerabilities that may adversely affect the Center for Medicare & Medicaid Services' (CMS) program integrity efforts. In order to enhance Medicare's program integrity, GAO recommends that Congress amend the Social Security Act (Act) to: 1) require staffing companies that retain contractor physicians and submit claims to the program to apply for enrollment in Medicare, and 2) permit CMS to enroll staffing companies that meet enrollment criteria.

The report repeatedly characterizes the current law as prohibiting staffing companies that retain contractor physicians from enrolling in Medicare. We recommend that GAO revise its report to more accurately reflect the fact that such staffing companies are not enrolled, because they are generally not eligible to receive reassigned benefits from contractor physicians under section 1842(b)(6) of the Act. An exception to this general prohibition is that staffing companies (or other entities that utilize contractor physicians) are eligible to receive reassigned benefits for services performed on premises that they lease or own. However, because emergency department staffing companies do not own or lease the space in hospital emergency rooms, this exception does not apply to them.



Page 2 – Leslie G. Aronovitz

With respect to the conclusion drawn from the findings, the recommendation and the matter for Congressional consideration, we agree with GAO’s recommendation that a legislative amendment is needed. However, CMS believes that the recommendation should be revised to say “based on the findings of GAO’s analysis, the current statutory prohibition should be revised to allow for the reassignment of benefits for services performed by contractor physicians regardless of whether those services are rendered on premises not owned or leased by the contracting organization.” Additionally, the GAO report concludes that the program is not more vulnerable for improper billing when there is a staffing company contract arrangement. Given that, CMS would prefer that the entire prohibition on reassignment by contractors be eliminated rather than trying to tailor the proposed legislative change specifically to the attributes of a staffing company.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Geraldine Redican-Bigott, (312) 220-7678

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## Acknowledgments

Enchelle D. Bolden, Shaunessye D. Curry, Richard M. Lipinski, and Craig Winslow made major contributions to this report.

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# Related GAO Products

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*HIPAA Standards: Dual Code Sets Are Acceptable for Reporting Medical Procedures.* [GAO-02-796](#). Washington, D.C.: August 9, 2002.

*Medicare Hospital and Physician Payments: Geographic Cost Adjustments Important to Preserve Beneficiary Access to Services.* [GAO-02-968T](#). Washington, D.C.: July 23, 2002.

*Medicare: Recent CMS Reforms Address Carrier Scrutiny of Physicians' Claims for Payment.* [GAO-02-693](#). Washington, D.C.: May 28, 2002.

*Medicare: HCFA to Strengthen Medicare Provider Enrollment Significantly, but Implementation Behind Schedule.* [GAO-01-114R](#). Washington, D.C.: November 2, 2000.

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