Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SUMMARY OF OIG ACTIVITIES ON MEDICARE

JUNE 1993 OEI-12-93-00010

EXECUTIVE SUMMARY

PURPOSE

This report consolidates information obtained during the course of Office of Inspector General (OIG) reviews of the Medicare program and offers solutions to long standing problems. This is not an assessment of the Health Care Financing Administration's (HCFA) effectiveness in managing Medicare. We focus on problems which have not been resolved. As policymakers consider ways to reform the health care system, lessons drawn from the Medicare program can be instructive.

BACKGROUND

Medicare is a large and rapidly growing program. In 1992, Medicare had 36 million elderly and disabled beneficiaries. It issued $129 billion in payments. The number of beneficiaries has almost doubled since 1967. Current Medicare expenditures are almost triple the entire nation's health care spending in 1967.

Medicare is a complex program. Paying for medical care is complicated by the multifaceted nature of medicine. Additionally, paying for health care is a three step process. First, beneficiaries are treated by health care providers. Second, those providers describe their services on claims they submit for payment (593 million claims were processed in 1991). Finally, 81 private insurance companies (under contract to the Government) determine how much should be paid and make the payments.

ISSUES

The Medicare program must ensure that payments to providers are fair while reducing administrative burdens. Three basic problems cause excessive payments: inaccurate claims, payment rates, and other insurers not paying their share. The challenge of reducing administrative burden while ensuring that payments are accurate is a substantial one, discussed more fully in the OIG report, "Electronic Data Interchange: Issues and Challenges."

- *Inaccurate Claims:* Medicare can lose money when claims submitted by providers do not accurately reflect the services they performed. The coding systems (which identify medical services) are gamed via unbundling (submitting separate bills for each component of a service). Medical services are sometimes exaggerated through upcoding. Actual charges are misrepresented through the waiver of coinsurance and deductibles. In other situations, the coding systems do not accurately reflect the service performed.

- *Payment Rates:* When Medicare started, it paid most health care providers their reasonable charges or costs. New rate setting methods for a variety of providers have been established. While these changes have been an

improvement, some payments are still too high. Many of the adjustments and exemptions to the hospital payment methodology are not justified by higher hospital costs. Additionally, the new physician fee schedule does not properly reflect the overhead costs of efficient providers of medical services.

- *Other Insurers:* Finally, other insurers bear primary responsibility to pay for the health care of some Medicare beneficiaries. Some of these beneficiaries are covered through employee health plans (if they or their spouse are still working), and automobile insurance (if they are accident victims). In many cases, the contractors that Medicare hires to handle its claims are the insurance companies that are liable as primary insurers. We found that billions of dollars were being wasted because the secondary payer statute was not being properly implemented.

The Medicare program must ensure that the services provided to beneficiaries are necessary, appropriate, and high quality. Inconsistent coverage decisions, lack of controls, and limited quality oversight hamper the program's ability to fulfill this responsibility.

The Medicare program must address financial conflicts of interest which may lead to abuse. Financial conflicts of interest exacerbate concerns about the quality and cost of services. Physicians can profit from referring patients to facilities or other providers in which they have a financial interest. Providers can be offered kickbacks, or seek them, in exchange for patient referrals. We reported on this issue in 1989 and 1991. We have also opened over 850 investigations on kickback issues and have obtained close to 570 convictions, settlements and other sanctions, and almost $16 million in recoveries.

The Medicare program must examine its payment systems to ensure that they are not vulnerable to fraud and abuse. Medicare's reliance on private insurance carriers carries with it inherent conflicts of interest and opportunities for problems. Additional reliance on computer systems and the electronic submission of claims may create new vulnerabilities to fraud, waste, and abuse.

RECOMMENDATIONS

As discussed in this report, the problems and challenges facing the Medicare program are substantial. During the course of our audits, inspections, and investigations in the Medicare program, we have made numerous specific recommendations for change. Many of these recommendations have been accepted by the Health Care Financing Administration and some have not. Some require legislative changes; others can be accomplished through administrative action.

All significant unimplemented OIG recommendations are included in one of two documents. The Office of Inspector General Cost-Saver Handbook (the Red Book) is a compendium of recent OIG recommendations to reduce unnecessary spending by

the Department through administrative or regulatory change, or by the Congress and Administration through legislative change. The Office of Inspector General Program and Management Improvement Handbook (Orange Book) contains recent recommendations for strengthening program and management efficiency and effectiveness. For our readers' convenience, we have reproduced our listing of recommendations to improve the Medicare program in the appendices to this report.

To reduce the level of fraud, waste, and abuse in Medicare, policymakers should:

- improve coding systems,
- base fee schedules on the reasonable costs of efficient providers,
- aggressively enforce the secondary payer statute,
- identify and eliminate unnecessary and inappropriate coverage variations,
- ensure the quality of medical services,
- discourage financial conflicts of interest,
- strengthen Medicare systems, and
- develop payment alternatives.

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INTRODUCTION

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BACKGROUND

While the private sector finances most health care, public spending is substantial as well. In 1992, the Federal government accounted for 30 percent of health spending. Payments for the 36 million Medicare beneficiaries (this program finances health care for the elderly and disabled) were $129 billion. The Federal share of Medicaid payments (this program finances health care for low-income persons) was $70 billion. The HCFA runs both of these programs and absorbed 12 percent of the Federal budget in Fiscal Year (FY) 1991.

The enormous size of the Medicare system could have barely been foreseen by its creators. In 1967, Medicare covered 20 million people. National health spending was $51 billion, a third of what Medicare alone now pays out for health care. The number of providers doing business with Medicare has increased dramatically. In 1975, 2,254 home health agencies billed the program. In 1992, that number was 5,963. In 1975, almost 3,000 independent laboratories did business with the program. In 1992, that number was 7,509. In 1975, there were no end stage renal disease (ESRD) facilities billing the program. In 1992, 2,211 ESRD facilities were billing Medicare.

Medicare contracts with private health insurance companies called fiscal intermediaries and carriers to handle day-to-day claims processing and related operations. Fiscal intermediaries process claims under Part A of the program, which includes hospitals, nursing homes, home health agencies and other institutional providers. Intermediaries processed 92 million claims in 1991, at a cost of $1.64 per claim. Carriers process claims under Part B of the program, which includes physicians, laboratories, and other noninstitutional providers. Carriers processed 501 million claims in 1991, at a cost of $1.13 per claim. The HCFA has introduced major changes to the claims processing system and plans more. A new electronic bridge links all Medicare systems and allows for cross checks of eligibility and payment information. In order to encourage electronic submission of claims by providers, which reduces administrative costs of handling the claim, new payment rules allow HCFA to pay electronic claims more quickly than paper files. The HCFA plans to reduce the number of carriers that process claims for durable medical equipment, prosthetics and orthotics supplies, in order to obtain more control over payment for these claims. Finally, and perhaps

most significantly, HCFA has proposed the development of a standard Medicare Transaction System, replacing the 14 different systems currently used by Medicare contractors.

In addition to having their claims processed by different contractors, different types of providers are paid based on different payment methodologies. Initially, all providers were paid based on their "reasonable and customary" charges. This gave providers very little incentive to be prudent and their charges frequently bore little relationship to the cost of delivering services. Hospitals were reimbursed for their "reasonable costs" and physicians received their "reasonable charges." Beneficiaries were given incentives to control costs in the form of coinsurance, deductibles, exclusions, and the responsibility to pay for any charges above what Medicare determined to be reasonable.

Since the inception of the program, several new approaches to pricing Medicare payments for health care services have been developed. The prospective payment system (PPS) for inpatient hospitals was introduced in 1984. It pays a predetermined amount for treating beneficiaries with specific illnesses. Hospitals report the diagnosis of the patient and procedures performed; based on this information, a diagnosis-related group (DRG) is assigned. Medicare pays the hospital based on the DRG assigned and makes adjustments which take the hospital's location, patient mix, and other factors into account. Because the amount per patient is fixed and known in advance, hospitals have an incentive to be efficient in serving patients. In the past, efficiency could have cost the hospital money, since the more services it provided the more it was paid.

The Medicare program has instituted fee schedules for a number of other services. For example, a fee schedule was implemented for medical equipment and supplies in 1989 which prescribed a set range of acceptable payments that could be made for various types of medical equipment and supplies. Carriers then retained some flexibility to pay suppliers differently depending on past practice and geographic considerations, but variation in payment amounts was reduced to a fixed range. This fee schedule was based on average historical charges of medical equipment and supply providers.

The most extensive fee schedule implemented to date is for physician services. This new system will be phased in over time and began in 1992. The new Medicare Fee Schedule is based on extensive efforts by researchers at Harvard University to identify the amount of work involved in physician services. Before the implementation of the Medicare Fee Schedule, we and other analysts frequently identified overpriced services. Congress would respond by passing legislation to mandate reductions in payment rates. The new resource-based physician fee schedule attempts to correct past mistakes by basing fees on the resource costs of providing a service rather than on past charges, which tended to overcompensate surgeons and encourage high-tech procedures.

The HCFA plans future reforms in payment methodology. Since 1986, HCFA has been working on developing methods to reimburse outpatient surgery facilities in a prospective manner. Currently, hospital outpatient departments are reimbursed largely on costs. Developing an appropriate methodology for the reimbursement of outpatient surgery in hospitals and free-standing facilities is important to the program because more services than ever are being provided on an outpatient basis.

Role of the Office of Inspector General

The OIG's mandate is to protect the integrity of the United States Department of Health and Human Service's (DHHS) programs and the beneficiaries of those programs by reducing fraud, waste, and abuse and by promoting the effectiveness and efficiency of the department's programs. About one-third of our resources are devoted to oversight of the Medicare program.

The OIG accomplishes its mission through a series of audits, evaluations (inspections) of program operations, and investigations of possible criminal or civil violations. The OIG also reviews all regulatory and legislative proposals developed by the Department to assess their effect on fraud, waste, and abuse.

During the past four years the OIG has issued more than 187 audit and inspection reports on the Medicare program identifying more than $20 billion in potential savings.[1] We have recommended numerous improvements in program operations. In FY 1991, we were involved in 1,238 successful criminal and civil health care actions against those who defrauded or abused the Medicare and Medicaid programs.

METHODOLOGY

The issues presented in this report are based on inspection, audit and investigative work of the OIG.

Rather than present findings, as we normally do, this report describes the challenges facing the Medicare program. We describe how program managers must determine the appropriate payment for services and supplies, must ensure that care provided to beneficiaries is necessary and appropriate, must face the increasing problem of financial conflicts of interest for providers, and must improve systems.

ISSUES

PREVENTING AND IDENTIFYING EXCESSIVE PAYMENTS

The Medicare program must ensure that payments to providers are fair while reducing administrative burdens.

Three basic problems cause excessive payments: inaccurate claims, inappropriate payment rates, and other insurers not paying their share. Each of these are discussed below. The challenge of reducing administrative burdens is discussed in a separate OIG report, "Electronic Data Interchange: Issues and Challenges."

▸ ***HCFA must ensure that claims submitted for services are accurate.***

The Medicare program loses money when providers submit inaccurate claims that don't reflect the services actually performed or the supplies actually delivered. Providers can also be disadvantaged by being paid too little when inaccurate claims are submitted.

Hospitals' billings must be scrutinized to ensure that proper diagnosis, which determine the DRG payment, are reported to the program. In addition, the cost reports of home health providers and nursing homes must be audited to ensure that only proper amounts are included and reimbursed.

For noninstitutional providers, the task of ensuring appropriate billings is even more difficult, although less total dollars are at stake. In 1991, $45 billion was paid for 501 million medical claims submitted by about 600,000 health care providers and suppliers. Seven thousand procedure codes were used by physicians and 3,000 codes were used by suppliers. Procedure codes identify the specific services or items provided and are used by Medicare to determine payments. Medicare uses computerized prepayment edits to identify potential problems before claims are paid. Postpayment reviews help carriers recover improper payments by identifying possible fraud, waste, and abuse. However, "gaming" by providers, as described below, still costs the program millions of dollars each year.

Gaming can take the form of unbundling (submitting separate bills for each component of a service, rather than one claim for the overall procedure or item) and upcoding (billing for a more intensive service than the one actually delivered). Other fraudulent activities, such as the routine waiver of coinsurance and deductibles, contribute to overuse of services. Finally, loopholes in the coding system may allow or even encourage inaccurate claims.

Unbundling: Unbundling allows providers to inflate charges far above the appropriate levels. Instead of billing for a complete service or item, the provider bills for all of the subcomponent parts. As an example, an OIG audit of physician claims in

Pennsylvania estimated that there were potentially $12.2 million in such questionable payments annually in that State alone. Procedures were unbundled or in some cases physicians billed for mutually exclusive procedures.[2] Medicare is paying more than twice as much as physicians for some clinical laboratory tests because it is paying for test "profiles" or "batteries" on an al-a-carte basis.[3] Another OIG review found physicians receiving $12 million in overpayments for biopsies and/or explorations which were a part of another surgical procedure.[4]

HCFA has developed a limited number of edits for carriers to use in identifying and dealing with unbundling. As an illustration, one of these edits is designed to prevent payment for both a total abdominal hysterectomy and removal of the ovaries at the same time because, by definition, the first procedure includes the second. Additional edits may well be needed. Some private payers have as many as 3,000 edits in their claims processing systems, as compared to about 300 in the Medicare payment system.

Upcoding: Under Medicare's prospective payment system (PPS) for hospitals, hospitals benefit financially from billing for more intensive and costly diseases. An OIG study of 1985 medical records found 21 percent of hospital claims were improperly coded, generally to the favor of hospitals and resulting in a $308 million overpayment.[5] We recently replicated this study and found as many underpayments to hospitals as a result of errors as overpayments.[6] As a general matter, this means that Medicare paid the right amount to hospitals as a group for services they provided to Medicare beneficiaries. However, some individual hospitals may be paid too much or too little.

A 1989 OIG report showed wide discrepancies in the way that physicians bill for evaluation and management visits and recommended numerous coding reforms.[7] This variation in coding suggests that some physicians may have been upcoding their claims, claiming a higher level of service was performed than was correct. In implementing the new Medicare Fee Schedule, HCFA has drawn samples of claims to determine the accuracy of claims submitted and to educate physicians on proper reporting. The new fee schedule will not accomplish its goals if physicians inaccurately report their services and claim that services were performed when they were not.

Routine Waiver of Coinsurance and Deductibles: For some types of services, beneficiaries must pay at least 20 percent of Medicare's allowed amount for the services they receive. They must also pay an annual deductible before Medicare usually pays anything. The purpose of the coinsurance and deductibles is to involve beneficiaries in health care decisionmaking and provide an incentive for the prudent purchasing of services and supplies.

The importance of this safeguard can be illustrated by a study in which the OIG identified provider abuse in selling medically unnecessary seat lift chairs to Medicare beneficiaries. Sixty percent of the recipients of seat lift chairs we surveyed said that the suppliers told them they wouldn't have to pay anything for the chairs. Sixty-nine

percent said they never made payments for the coinsurance or deductibles.[8] Clearly, providers are more able to convince vulnerable beneficiaries to purchase their services and equipment, even if it is of marginal or no value, by telling them that they have nothing to lose by placing an order. Many of our investigations have shown that the routine waiver of coinsurance and deductibles is a key element in scams to bill for unnecessary or undelivered services and items. To highlight this problem, we issued a special fraud alert on routine waivers to over 800,000 health care providers.[9] The alert describes what types of waivers are illegal and asks providers to report violators.

Imprecise Coding Systems: The Part B fee schedules tie payments to procedure and supply codes. For physician services, HCFA relies on a coding system developed and maintained by the American Medical Association for physician services. For durable medical equipment and supplies HCFA and representatives of the insurance industry have developed separate codes. These coding systems must differentiate between services and supplies with significantly different resource costs. This is not always the case. Some codes lump together vastly different services. Other codes do not accurately reflect the service performed or the item delivered. For example:

- The procedure codes for some ultrasound services included vastly different procedures.[10 11 12] Included under the same procedure codes were: (1) one hour long procedures with $300,000 machines that provided color images of body parts, and (2) the use of a $300 "pocket doppler" that took only 5 minutes and provided audio feedback only on the flow of bodily fluids.

- A study of liver biopsy procedures found that there was no accurate procedure code for needle biopsies that involve surgical incisions.[13] Physicians used a code that implied that they had performed a surgical biopsy.

- Suppliers sometimes provide foam rubber mattresses to beneficiaries and submit claims for more expensive "air fluidized beds." These devices "use warm air under pressure to set small ceramic beads in motion which stimulate the movement of fluid" and can be useful for patients with serious skin problems. The coding manual contains no description of "air fluidized beds."[14] Another Medicare manual provides a detailed description of the type of air flotation mattress that is covered by Medicare but the coding manual's lack of detail makes it difficult to support criminal fraud convictions of suppliers.

We recently completed field work on a study to evaluate the success of the coding system in preventing fraud, waste, and abuse. We reviewed previous audits, studies and other analysis performed by the OIG and others, and interviewed representatives of the physician societies and carriers to gain a better understanding of the systems' strengths and weaknesses. We have concluded that legitimate confusion, as much as provider abuse, can lead to inaccurate claims. Approximately 20 percent of physician respondents believe at least one-quarter of the codes have inadequate definitions; 40 percent of coders and HCFA officials believe that to be true.[15]

- ***The HCFA must ensure that payment rates are fair.***

As discussed earlier, the Medicare program started with very weak cost controls, paying providers on the basis of their costs and charges. Such methodologies provided little incentive for providers to deliver care efficiently. Although the program has made much progress in this regard, problems remain in the reimbursement for inpatient hospitals, outpatient facilities, physician services, and supplies.

Inpatient Hospitals: When Medicare implemented PPS, a number of adjustments and exemptions were included in the law. We analyzed those adjustments and suggest reforms.

- The law gave teaching facilities an add-on payment amount called indirect medical education payments. We extensively analyzed the payment rates to, and the profit rates of, teaching facilities. We found that teaching hospitals were making excessive profits. Legislation in 1987 reduced the add-on to 7.6 percent and $1.1 billion was saved in FYs 1989 through 1991.[16] Additional analysis lead us to recommend that the indirect medical education payment be further reduced.[17] The FY 1992 budget request recommended gradually reducing the indirect medical education add-on further to 3.2 percent. If enacted this would have saved more than $1 billion in FY 1992.

- Medicare pays for most hospital capital costs on a pass-through basis. A 10 year phase-in to prospective payment rates for these procedures has been enacted. Extensive audits show that past costs have been inflated by the inclusion of inappropriate items. We've estimated that excluding those inappropriate amounts could reduce payment rates by as much as $920 million annually.[18]

- Medicare compensates hospitals for the bad debts caused by beneficiaries who fail to pay their coinsurance or deductibles. Hospitals have little incentive to collect bad debts because Medicare will cover the loss. Audits have found inadequate collection efforts. Medicare could save $400 million annually by eliminating this policy. The HCFA agrees with the OIG's option to include a bad debt factor in DRG rates. This will require legislative action.[19]

- Medicare could reduce its costs by selectively contracting for certain procedures (such as coronary artery bypass graft surgery.) An OIG review found that hospitals and surgical teams that perform a high volume of these procedures offered packages to health maintenance organizations that combined hospital and physician charges and were substantially less than Medicare's payment. We concluded that there is a need for legislation that will allow the negotiation of fixed-price, package agreements with preferred providers so that high quality of care can be obtained at costs significantly less than the program is currently paying. The HCFA has selected four sites to serve as demonstration projects

to test our thesis. The results will be evaluated and serve as the basis for future legislation. We estimate that this approach could save $192 million annually.[20]

Outpatient Facilities: As discussed earlier, a growing proportion of medical services are being performed in outpatient settings. Hospital outpatient services were not included in the prospective payment system and they continue to be reimbursed (at least partially) on a "reasonable cost" basis. Medicare pays more for services in hospital outpatient departments than it does for the same services in ambulatory surgical centers, which sometimes perform the same services. Several OIG reports have shown differing reimbursement amounts to different types of facilities for providing the same services.[21] [22] [23] Yet, we found no significant difference in the type of patients these facilities treat or in the quality of care delivered.[24] Differentiation in payment according to place of service may not encourage delivery of services in the most cost-effective setting.

Physician Services: Although we applaud the work done so far to rationalize physician payments on the basis of resource costs, we and others recognize significant problems remain. The work of the Harvard team which developed the resource based, relative value system did not include estimates of the practice cost, or overhead, required to support each type of procedure. As a result, payments for practice expenses are still tied to historical costs. In addition, overhead costs are spread evenly among all of the procedures performed by a specialty. This is an important weakness because practice expenses are almost half of the cost of providing physician services. Both HCFA and the Physician Payment Review Commission are studying ways to identify and reimburse practice costs.

A further challenge for HCFA is to assign relative values to services which were not studied by the Harvard team, or to update the relative values that have been assigned. We will be scrutinizing this process in the future to ensure that appropriate methodologies have been established and are being followed to maintain the validity of the fee schedule.

Another area which has been extremely difficult for HCFA to address is the identification and assessment of new technologies. We have pointed out that Medicare carriers make decisions about technologies differently, and consequently arrive at different decisions about what is covered or not covered. We have also pointed out that no system exists for ensuring that payments for new technologies decrease in response to decreasing costs for delivering an item or service.[25] We plan to conduct a follow-up review to assess the effectiveness of recent changes made to HCFA's coverage and pricing process to determine if these vulnerabilities remain.

Durable Medical Equipment and Other Items: The coverage and pricing for durable medical equipment, prosthetics, orthotics, and supplies has received a great deal of attention from the OIG and HCFA over the past several years. This may seem odd, since total allowed charges for these items are a modest portion of the total Medicare

budget, only $3.3 billion in 1991. Yet we have documented flagrant and consistent abuses in this area over time.

The legislation that was enacted in 1990 to mandate national floors and ceilings for prices narrowed the variations in pricing among carriers. It also mandated specific reduction in payments for some types of equipment and supplies that the OIG had identified as overpriced. However, additional refinement of the fee schedule may well be needed because the schedule was not based on the cost of manufacturing an item but on historical charge data. Examples follow:

- We found that Medicare was overpaying for intraocular lenses and recommended a reduction in payments to $200 per lens.[26] [27] HCFA implemented our recommendation in some settings and $60 million was saved.[28] Subsequent work has found many providers paying less than $200 for lenses and we've recommended that HCFA drop its reimbursement rate to $150 or less.[29] This recommendation could save $100 million annually.[30] We are now conducting another review of intraocular lens purchase costs.[31]

- Supplying oxygen to Medicare beneficiaries accounts for almost half of Medicare's durable medical equipment expenditures. In 1987, we compared Medicare reimbursement for home oxygen and oxygen equipment with amounts paid by non-Medicare payers. We found that all 122 Veterans Administration hospitals paid less for each type of oxygen equipment than Medicare.[32] We re-evaluated payment rates in 1991, after implementation of the fee schedule, and found that Medicare was still paying 178 percent more than the Veterans Administration for oxygen services.[33] The Department is seeking legislative authority to move to a competitive bidding system for the delivery of oxygen services (and other durable medical equipment) in large urban areas.

- Despite congressionally-mandated reductions in the price of transcutaneous electrical nerve stimulation (TENS) devices, the 1993 fee schedule amount is $429. Some of these devices can be purchased wholesale for $35. We have previously testified on our concerns about the cost of these items and the amount paid by Medicare in testimony before the Congress.

Other areas also need attention. For example, a study of rapidly rising payments for ambulance services found that the reasonable charge methodology for controlling increases in supplier charges had been ineffective.[34] Although HCFA technically has the authority to reduce payment amounts when they are inherently unreasonable, this authority is rarely used.

- ***The HCFA must ensure that other insurers pay their share of the cost of services for Medicare beneficiaries.***

Medicare contractors are responsible for ensuring that a Medicare payment is made as a secondary source to certain types of private insurance coverage. The Medicare program initially paid for most health services provided to beneficiaries. Beginning in 1980, however, the Congress began enacting legislation that made Medicare the secondary payer in certain cases. By 1987, legislative changes had been enacted that made Medicare the secondary payer to Employer Group Health Plans for those beneficiaries who are working aged, disabled, or have end stage renal disease.

We have issued numerous reports on Medicare secondary payer (MSP) issues. Our reviews continue to show a need to recover past overpayments, avoid future overpayments, and expand the definition of MSP to more beneficiaries.

Recover Past Overpayments: We have issued six reports that describes the need for adequate resources and financial management systems to ensure that all past MSP mistaken payments (estimated to be approximately $961.6 million) are recovered.[35 36 37 38 39 40] As of September 1992, HCFA reported about $961.6 million in past MSP overpayments that had not been collected. About $681.6 million of this total were backlogged claims.

To recover past MSP overpayments we recommend that HCFA take the following actions: (1) ensure that contractors resources are sufficient and instruct contractors to recover improper primary payments, (2) insure that contractors take sufficient action to preclude the loss of backlogged MSP cases (i.e., claims where contractors are more than one quarter behind in sending a demand letter) because the recovery period lapsed, (3) implement financial management systems to ensure all overpayments (receivables) are accurately recorded, and (4) pursue alternative strategies such as contingent contracts, demonstration and incentive programs, or fund collection activities from recovery proceeds.

During FY 1992, HCFA provided the contractors an additional $20 million in administrative funding to reduce the MSP backlog, however, the backlog continues. The HCFA has also developed a MSP overpayment tracking system. However, it is not considered a financial management system. In addition, DHHS submitted a FY 1994 legislative proposal to establish a payment safeguards revolving fund to provide smoother and more certain funding levels which could result in more consistent and efficient contractor MSP operations. HCFA will consider the question of demonstration projects in the department's legislative development process.

Improve Future Collection Efforts: Collection of accurate and timely information on other primary payers is needed to reduce Medicare overpayments in the future which result from unidentified MSP cases and help the recovery process for overpayments. We have issued four reports that describes the need for collection of accurate and timely information to reduce Medicare overpayments by $900 million per annum in

future years.[41 42 43 44 45] Identification of MSP situations occurs through a variety of means: beneficiary questionnaires, provider identification of coverage when services are provided, and the statutorily authorized Data Match Project with the Social Security Administration and the Internal Revenue Service.

The HCFA should: (1) revise the justification for a FY 1990 legislative proposal, which would require insurance companies, underwriters and third-party administrators to periodically submit Employer Group Health Plan (EGHP) coverage data directly to HCFA, and resubmit it for FY 1994, (2) require that employers report EGHP coverage on the Wage and Tax Statement (W-2), (3) revise all Medicare claims forms to require a positive or negative response pertaining to other health insurance coverage, (4) request that the Social Security Administration maintain beneficiary spousal information in it's Master Beneficiary Record system for use by HCFA, (5) establish a national data bank system containing primary insurance information, and (6) assure compliance with all first claim development procedures and collect health insurance information for disabled beneficiaries during the required disability waiting period.

The HCFA is considering these recommendations and supports the establishment of a national clearinghouse of health insurance information as an alternative to some of our recommendations. Implementation plans and policies have not been developed and corrective action has not been implemented. Legislative action is required.

Expand Definition of MSP: Medicare should be the secondary payer for all State and local government employees hired before April 1, 1986. This proposal has been included in previous Presidential budgets. Although this proposal was not enacted, we continue to advocate this legislation. As an alternative HCFA could seek legislation making Medicare the secondary payor for retirees of exempt State and local agencies. These include additional Medicare program cost savings of about $2 billion per year that could be achieved, if certain provisions of the legislation were expanded.

We have issued two reports that promote additional cost savings if the MSP provisions were extended to include beneficiaries with end-stage renal disease (ESRD) without limitation and those retirees of exempt State and local entities.[46 47] While legislation extended the ESRD provision from 12 to 18 months, we continue to believe that legislative action is appropriate. In the 102nd Congress, H.R. 11 (as passed by the Senate) continued a provision to extend the MSP ESRD provision from 18 to 24 months. However, this provision was not enacted.

ENSURING QUALITY OF CARE

The Medicare program must ensure that the services provided to beneficiaries are necessary, appropriate, and high quality.

For the sake of the program's financial integrity and beneficiaries' protection, the Medicare program has a responsibility to ensure that care it pays for is necessary and appropriate. Inconsistent coverage decisions, lack of controls, and limited oversight of quality hamper the program's ability to fulfill this responsibility.

Inconsistent Coverage: Medicare delegates most coverage decisions to local carriers, which leads to inconsistencies in coverage. We have repeatedly pointed out that this delegation causes services to be covered in one jurisdiction but not covered in another, duplication of efforts by carriers to collect and analyze the information necessary to make coverage decisions, and provider confusion. HCFA believes that this diversity is consistent with congressional intent and that it is usually appropriate. We have issued several reports on this issue:

- Medicare carriers surveyed for a 1990 report[48] found that carriers perceived numerous problems with Medicare's coverage decisionmaking process. They sought additional guidance from HCFA. HCFA maintained that they were solving these problems through ongoing administrative reforms.

- Another OIG study shows that carriers have been inconsistent in deciding when to withdraw coverage of obsolete technologies.[49]

- A recent case study of one procedure (transcranial dopplers) found that carriers continue to make inconsistent coverage decisions, base their decisions on questionable criteria and sometimes fail to implement the decisions that they do make.[50] We are concerned that HCFA's efforts to improve the coverage decisionmaking process have not been successful. We are planning additional work on this issue.[51]

Unnecessary Services: It is difficult for any payer to determine whether services rendered by a medical professional are necessary. Such decisions are made implicitly by all payers in determining the extent of the coverage afforded to beneficiaries. However, even within the coverage guidelines set by any payer, providers may engage in abuse. While individual cases of ordering or providing medically unnecessary services may be difficult to demonstrate, systems can either encourage or discourage providers in this regard. It is one of the significant problems associated with fee for service medicine, in which the more services a physician supplies the more he or she is paid.

A key way for Medicare to avoid paying for unnecessary services is strict adherence to coverage decisions. We have not always found that Medicare adheres to its own rules. For example, a random sample of medical records (primarily cataract surgeries) found

that many monitored (or local) anesthesia services did not meet Medicare's coverage guidelines and that other insurance carriers had more restrictive coverage policies for this procedure.[52] A more recent study, in which we examined payments made for total parenteral nutrition (TPN), found that half of the $148 million paid out in 1991 was for services that did not meet the coverage guidelines. This is especially troubling since only two carriers process claims for TPN, the coverage guidelines are quite strict and specific, and a certificate of medical necessity is required in order for a claim to be paid. Further, TPN therapy is extremely invasive and should only be administered in specific instances of demonstrated need. Our findings suggest that carrier specialization and use of certificates of medical necessity or other documentation of medical need, by themselves, will not assure proper payment.

When a service is covered, it is more difficult to assess if the service was medically unnecessary in the particular case at hand. For example, claims for outpatient clinical laboratory services account for about 25 percent of all Part B line items but less than 10 percent of allowed charges. Total payments for clinical laboratory tests have been rising rapidly despite reductions in per service payments. Many inappropriate factors (such as defensive medicine) encourage the ordering of lab tests. The sheer volume and small dollar amount of these tests renders utilization review cost ineffective. In this case, we believe that the current reimbursement system encourages overuse of laboratory services. Beneficiaries have little incentive to curtail their utilization of these tests because they do not pay coinsurance or deductible amounts on clinical laboratory tests. We have recommended that HCFA study ways to prospectively pay for (or roll-in) clinical laboratory services through payments for physician office visits.[53] We estimate that reductions in inappropriate utilization, administrative costs, and the collection of coinsurance would result in savings of over $12 billion in 5 years.[54] One large medical laboratory chain recently plead guilty to two felony counts because they performed and billed for tests that physicians considered unnecessary. The company will pay $110 million in fines and restitution.

Durable medical equipment has also been a concern to us in this regard. We have documented many instances where medically unnecessary medical equipment or supplies were provided to Medicare beneficiaries. In our work on seat lift chairs, discussed earlier, we found that many seat lift chairs were not being used for medical purposes, that 85 percent of the beneficiaries were initiating the request for the item, and that most were learning of these items through aggressive mass marketing.[55] Similar problems were identified with oxygen,[56] TENS devices,[57] and power-operated vehicles.[58] Subsequent legislation withdrew coverage of seat-lift chairs and reduced payment rates for TENS. Legislation also required the use of certificates of medical necessity, filled out by the physician rather than the supplier, in order to better ensure the medical necessity of these items. We will be reviewing the success of this initiative in ensuring that only medically necessary medical equipment and supplies are provided to Medicare beneficiaries.

Quality Concerns: The Medicare program relies on Peer Review Organizations (PROs), survey and certification, accreditation and licensing to ensure the quality of care provided to Medicare beneficiaries. Over time, we have expressed concern about the effectiveness of PRO review and the system "gaps" which leave many settings unregulated. For example:

- In one study, we reviewed a random sample of Medicare hospital discharges and found that 6.6 percent of the patients received poor quality care.[59] This compared to the PROs' finding that only 0.8 percent of cases presented quality of care concerns. We recommended strengthening the PRO program and issuing regulations to implement a 1985 law giving PROs the authority to deny Medicare reimbursement for patients receiving substandard medical care. This regulation has still not been published.

  PROs have reviewed millions of inpatient medical records to confirm the necessity, quality, and appropriateness of care rendered to Medicare beneficiaries. The law requires PROs to refer cases to the OIG for sanctions. This rarely occurs. Only 12 cases were referred to the OIG in fiscal year 1992.[60]

- We have identified quality of care problems when physicians travel to small rural hospitals to perform surgery. These "itinerant" surgeons are typically not available for follow-up care. Our contract physicians found poor quality care 26.6 percent of the time.[61]

- Many surgeries are now being performed in physician offices. We reviewed a sample of these procedures and found that medical records did not document reasonable quality of care for 20 percent of the surgeries.[62]

- Medicare has no quality standards for independent physiological laboratories that perform ultrasound, cardiac monitoring and other non-invasive tests. In many states these facilities are not regulated. We found that concerns about the quality of these tests is pervasive.[63] We recommended that HCFA promote stronger quality assurance but HCFA declined, believing that we did not present convincing evidence of poor quality.

- In recent years, we among many others have expressed concern about the quality of laboratory testing. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) significantly expanded Federal oversight of laboratory testing. The responsibility for implementing CLIA falls to HCFA along with the Public Health Service. We plan a series of studies to assess the impact of CLIA on laboratory testing and HCFA's enforcement of the statute.

ADDRESSING FINANCIAL CONFLICTS OF INTEREST

The Medicare program must address financial conflicts of interest which may lead to abuse.

Physician ownership of and compensation from entities to which they make referrals is a practice that has received increasing attention and concern. In 1989, in the first national study of its kind, we reported that patients of referring physicians who own or invest in independent clinical laboratories receive 45 percent more clinical laboratory services than all Medicare patients in general.[64] Another OIG report identified suspect financial arrangements between hospitals and hospital-based physicians.[65] We found that some hospitals are requiring kickbacks from these hospital-based physicians because they depend on hospitals for their referral of patients. Inappropriate incentives can also be present in the financial arrangements between different physician specialties such as optometrists and ophthalmologists.[66]

Some steps have been taken to curtail these financial conflicts of interest and more have been proposed. Legislation has banned Medicare payment for clinical laboratory services ordered by physicians with financial ties to the laboratory. Legislation has been proposed to extend this ban to other types of providers.

Under the Medicare and Medicaid anti-kickback statute, section 1128B(b) of the Social Security Act, it is illegal to offer or pay a profit distribution to physicians to deliberately induce them to refer business payable under Medicare or any State health care program. Since 1987, we have received more than 1,300 allegations of violations of the anti-kickback statute, and have opened over 850 cases. Close to 570 convictions, settlements, and exclusions have been obtained as a result of our investigations, as well as almost $16 million in recoveries. As an illustration, our office initiated civil proceedings against three limited partnership laboratories and its principals in The Inspector General v. The Hanlester Network, et. al. In this case, for the first time, it has been established that a joint venture scheme can violate the anti-kickback statute.

In 1991, the OIG promulgated final "safe harbor" regulations. These regulations define for health care providers specific non-abusive business arrangements that will not be subject to prosecution under the anti-kickback statute. These safe harbors may lead to a restructuring of many joint ventures. We are in the process of sampling a variety of entities to identify the effect of this regulation on their ownership and referral patterns.[67]

IMPROVING MEDICARE PAYMENT SYSTEMS

The Medicare program must examine its payment systems to ensure that they are not vulnerable to fraud and abuse.

Medicare's payment systems, implemented by a network of contractors, lead to some of the problems cited above. Other examples bring home this point. In one study, we found that carriers were failing to properly verify the credentials or identity of providers billing Medicare and that some ineligible providers were receiving Medicare reimbursement.[68] [69] We recommended that HCFA:

- specify a minimum framework for provider number assignment to be followed by all carriers;
- consider implementation of a system of user fees to defray the costs of provider number assignment and maintenance;
- expand the Physician Registry to include nonphysician practitioners;
- require the Physician Registry to provide feedback to carriers concerning all active practice records;
- ensure carrier implementation of HCFA provider number assignment directives;
- require carriers to update files regularly, deactivate all provider numbers without current billing history, and establish adequate controls to assure that providers not legally authorized to practice are identified and their provider numbers deactivated.

As a result of our reports, HCFA has developed an action plan to improve its management of the provider number system. We will be scrutinizing this process to ensure that actions taken address the problems identified in these reports.

A further concern to us is the network of carriers and intermediaries itself which process claims on behalf of the Medicare program. Through our work on the Medicare secondary payer issue, and oversight of claims processing environment, we believe that this system carries with it inherent conflicts of interest. For example, a recent report we issued on contractors' for-profit subsidiaries documents the practice of contractors requiring the use of their subsidiaries' systems for the submission of claims to their private side of business, thereby disadvantaging other competitors marketing other systems for use in billing the Medicare program.[70] In many MSP situations, the proper payer is the contractors' private side of business, thereby reducing the incentive for the Medicare contractor to identify the proper primary payer.

The performance of Medicare contractors is key to the success of the Medicare program. Thus, HCFA's oversight of its contractors is one of its highest priorities. Yet, as discussed in this report, we have documented numerous instances in which guidelines established by HCFA have not been adhered to. A report discussed earlier, in which we found half of the money paid out for total parenteral nutrition to have been improperly paid, is an example.[71] Yet it is worth repeating that in this instance only two carriers are responsible for processing the claims and certificates of medical necessity are required to establish the medical need for the therapy. Here carrier personnel flagrantly ignored the coverage guidelines and authorized payments when the certificates of medical necessity were incomplete, contradictory, or clearly established need outside of the coverage guidelines. Despite these and other examples, the rating of Medicare contractors according to established performance indicators are almost always extremely high. We plan future work to assess the performance reviews of Medicare contractors.

Most providers are now submitting claims electronically and new incentives now make electronic submission of claims more attractive to providers. While we agree that the electronic submission of claims will reduce administrative burden and speed payment to providers, it may also create new opportunities for fraud and may make the detection and prosecution of fraud more difficult. When erroneous payments are made they can now be repeated with lightening speed. We will not have the original documents to prove a case, but rather a copy of the electronically-generated form. Admissability of this form in court, as well as manipulation of the form, may cause legal difficulties. More information on this subject can be found in our report, "Electronic Data Interchange: Issues and Challenges."

Finally, providers may find ways to use the current fragmented system to their advantage. When deciding where to submit their claims, some medical equipment suppliers have shopped among the various Medicare carriers to find the highest reimbursement rates or the most lax medical necessity standards. Medicare allows suppliers to submit claims wherever they receive the order. By using call forwarding and other techniques providers can locate their home office wherever they wish and bill the carrier of their choice. A 1991 report found that this policy cost Medicare at least $22 million in 1989.[72] That report's analysis was limited to a small portion of durable medical equipment. HCFA agreed with our recommendations and will base pricing and coverage decisions on the beneficiary's residence.

RECOMMENDATIONS

As discussed in this report, the problems and challenges facing the Medicare program are substantial. During the course of our audits, inspections, and investigations in the Medicaid program, we have made numerous specific recommendations for change. Many of these recommendations have been accepted by the Health Care Financing Administration and some have not. Some require legislative changes; others can be accomplished through administrative action.

All significant unimplemented OIG recommendations are included in one of two documents. The Office of Inspector General Cost-Saver Handbook (the Red Book) is a compendium of recent OIG recommendations to reduce unnecessary spending by the Department through administrative or regulatory change, or by the Congress and Administration through legislative change. The Office of Inspector General Program and Management Improvement Handbook (Orange Book) contains recent recommendations for strengthening program and management efficiency and effectiveness. For our readers' convenience, we have reproduced our listing of recommendations to improve the Medicare program in the appendices to this report.

To reduce the level of Medicare fraud, waste, and abuse, the following initiatives should be prominent on policymakers' lists:

- ***Improve coding systems***

  The coding systems for physician services, medical equipment and suppliers must accurately reflect the services or items provided and effectively combat gaming strategies such as unbundling.

- ***Base fee schedules on the reasonable costs of efficient providers***

  - Reduce or eliminate adjustments to hospital payments that are not warranted by higher costs.

  - Implement a prospective payment system for outpatient facility services.

  - Base the practice cost portion of the physician fee schedule on the current overhead costs of efficient providers.

  - The durable medical equipment fee schedules should be based on the cost of efficiently providing items, not historical charges.

- ***Aggressively enforce MSP statue***

  - Provide more funding for secondary payer activities.

- Improve data collection on spousal employment.
- Authorize and mandate additional data matching programs.
- Provide incentive programs for contractors to seek primary payers.

- ***Identify and eliminate unnecessary and inappropriate coverage variations***

  Coverage decisions should be more consistent. There is little reason to leave most decisions to local carriers. This is a duplication of effort. It can lead to inequities in coverage for beneficiaries as well as inappropriate payments.

- ***Ensure the quality of medical services***

  When existing Federal and State regulations do not ensure that Medicare beneficiaries are receiving high quality medical services, HCFA should take steps to assure quality.

- ***Discourage financial conflicts of interests***

  When beneficiaries are being referred for additional medical care, the beneficiary needs to know that the reason for that service is their true medical need and that the physician has no financial incentive to order unnecessary services. In choosing where to refer patients, beneficiaries need to know that physician judgements will not be affected by financial conflicts of interest.

- ***Strengthen Medicare systems***

  The HCFA is considering implementation of a new claims processing environment, which we support. The current system may have fit the environment of the 1960s, but it needs to be revisited in light of technological changes which allow for electronic submission, adjudication, and payment, and medical advances which have reduced variations in medical practices.

- ***Develop payment alternatives***

  Medicare must aggressively pursue ways of financing care that create more incentives for the provision of only necessary and appropriate care. Among the methods chosen might be managed care, prospective payments, and payments for care conducted within established practice guidelines.

APPENDIX A

UNIMPLEMENTED OIG RECOMMENDATIONS: COST SAVERS

	ANNUAL SAVINGS MILLIONS
Medicare Reimbursement	
▸ Tighten Medicare Coverage of Noninvasive Tests of the Lower Limbs	$ 14
▸ Limit Medicare Part B Reimbursement for Hospital Beds	10
▸ Allow Payment for Nonemergency Advanced Life Support Ambulance Services Only When Medically Necessary	16
▸ Apply 190-Day Lifetime Limit for Medicare Inpatient Psychiatric Care and a 60-Day Annual Limit	48
▸ Reduce Payments for Unnecessary and Poor Quality Upper GI Endoscopies and Colonoscopies	55
▸ Reduce Payments for Unnecessary and Poor Quality Cataract Surgeries, and Associated Tests	51
▸ Reduce Monitored Anesthesia Care Payments	28
▸ Recover or Adjust Medicare Credit Balances in Skilled Nursing Facility Accounts	13*
▸ Increase Fair Hearing Threshold	10
▸ Raise the Medicare Entitlement Age to 67	Billions**
Medicare Secondary Payer	
▸ Recover Past MSP Overpayments	962*

**One-time recovery of savings.*

*** Savings would be first realized in the year 2003.*

- Avoid Future MSP Overpayments 900
- Expand MSP Provisions . . . . . More than $1 billion

Hospitals

- Consider Hospital Profitability in the Fourth Year of the Medicare Prospective Payment System 610*
- Reduce Hospital Capital Costs 800
- Reduce the Prospective Payment System Adjustment Factor for Indirect Medical Education Costs . . . . . More than $1 billion
- Deny Medicare Reimbursement for Patients Who Receive Substandard Medical Care 110
- Modify Payment Policy for Medicare Bad Debts 400
- Limit Prospective Payment System Reimbursement for Hospital Admissions Not Requiring an Overnight Stay 210
- Reduce Medicare Payments for Hospital Outpatient Department Services 90
- Review Admissions for Hospital Stays for Selected Diagnoses 183
- Recover Medicare Payments Made for Beneficiaries Eligible for Other Government Health Insurance 40*
- Recover Unallowable Hospital General and Administrative and Fringe Benefit Costs 2*

Physicians' Reimbursement

- Adjust Physician Fee Schedule Payments Based on Site of Service Differentials 177
- Establish Mandatory Prepayment Edit Screens for Medicare and Medicaid 13
- Eliminate Fragmented Physician Claims 13

**One-time recovery of savings.*

- Roll Reimbursement for Lab Services Into Charge for Physician Office Visit . . . . . More than $1 billion

End-Stage Renal Disease

- Further Reduce Medicare's End-Stage Renal Disease Rates 22
- Disallow Bad Debts Reported by National Medical Care, Inc 3
- Eliminate Inappropriate Payments for Total Parenteral Nutrition 71
- Reduce the Reimbursement Rate for Epogen 28

Procedures and Use of Technology

- Change the Way Medicare Pays for Clinical Laboratory Tests 426
- Selectively Contract for Coronary Artery Bypass Graft Surgery 192
- Exclude Medicare Coverage of Conventional Eye Wear for Beneficiaries Having an Intraocular Lens Implant 72
- Revise Reimbursement Rates for Low-Cost Ultrasound 4

APPENDIX B

UNIMPLEMENTED OIG RECOMMENDATIONS: PROGRAM IMPROVEMENTS

Medicare Contractor Operations

- Prevent Duplicate Payments
- Review the Current Preprocedure Review Process to Determine Whether It is Cost-Effective
- Substitute a Targeted, More Intensive Review for the Mandatory Review of Cataract Surgery
- Document Medicare Part B Subcontract Procurements
- Reevaluate Procedures over Payment Safeguard Activities and Take Steps to Assure that Savings Reported Are Accurate
- Conduct a Study To Determine the Feasibility of a Reporting System which Would Distinguish Between Savings
- Conduct Demonstration Programs to Evaluate Incentives To Enhance the Recovery Medicare Secondary Payer Payments
- Target Working Spouses and the Disabled To Increase the Cost-Effectiveness of the MSP Efforts
- Strengthen Home Health Care Payment Controls

Physician and Other Services

- Require Equitable Distribution of Organs among Patients According to Established Medical Criteria
- Require Carriers To Develop and Implement a Claims Review Process To Apply Existing Monitored Anesthesia Care Coverage Instructions
- Issue Medicare Coverage Guidelines and Clarify Independent Physiological Laboratory Issues
- Initiate Demonstration Projects to Address Problems of

Noncompliance with Prescription Medications among the Ambulatory Elderly

- Develop National Guidelines for Allocating a Global Fee for Cataract Surgery and Postoperative Care

- Add Upper GI Endoscopies to the Peer Review Organization List of Recommended Review Procedures

- Intensify Review of High Volume Ophthalmologists

- Notify Hospitals and Hospital-based Physicians about Potential Legal Liability Regarding Other than Fair Market Value Agreements

Inpatient Hospital Services

- Test the Effect of the Essential Access Community Hospital Program on Access to Care

- Determine Quality of Care of Itinerant Surgery

- Recover Overpayments to Itinerant Surgeons for Postoperative Care

- Develop Quality of Care Criteria for Coronary Artery Bypass Graft Surgery

Accounting System Controls

- Obtain Guidance on Establishing a Proper Cost Allocation System

- Improve the Cost Allocation System

HCFA Administration

- Foster Greater Consistency Among Carriers on New Health Care Technologies

- Strengthen the Monetary Sanctions in PRO Program

- Exercise Greater Fiscal Accountability and Cost-Consciousness in the Kidney Acquisition System

- Prepare the Foundation for a DRG Incorporating Kidney

Acquisition and Transplantation

- Assisting States in Referring Possible Fraud Cases to Medicaid Fraud Control Units
- Establish Standards for Health Maintenance Organization Marketing and Enrollment Practices
- Require Ongoing Training of Nurse's Aides and Orderlies, Regarding Recognizing and Reporting Abuse
- Establish a Statewide Network To Resolve and Follow Up on Abuse in Nursing Homes
- Require Carriers to Periodically Review and Update Provider Records
- Develop a Disaster Recovery Plan Identifying HCRIS as a Critical Application to be Recovered
- Resubmit a Legislative Proposal to Facilitate the Collection of Medicare Secondary Payer Information
- Require Employers to Report Group Health Plan Coverage on Form W-2
- Revise Instructions and Medicare Claim Forms to Collect More Information from Beneficiaries
- Maintain Accurate Beneficiary Spousal Information for Use in MSP Activities
- Report the Noncollection of Timely and Accurate Information on Primary Insurers of Medicare Beneficiaries under MSP as a Material Internal Control Weakness
- Work with DOJ to Implement Controls To Combat Drug Diversion

APPENDIX C

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