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REPORT (OF THE)
NEW JERSEY (STATE) COMMISSION OF INVESTIGATION
ON THE
PRACTICES AND PROCEDURES OF PRACTITIONER GROUPS
PARTICIPATING IN THE NEW JERSEY MEDICAID PROGRAM.

INTRODUCTION AND SUMMARY

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During the course of this investigation, staff of the Division's small Bureau of Medical Care Surveillance provided valuable assistance to the Commission. We wish to publicly express gratitude to Division Director Gerald Reilly and Surveillance Bureau Chief Rosalynn Romano for extending many courtesies and full cooperation. The New Jersey State Commissioner of Investigation also established a working liaison with the United States Senate Select Committee on Aging which is reviewing the Medicaid Program...

August 30, 1976

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INTRODUCTION AND SUMMARY

As part of its evaluative probe of the entire Medicaid program in New Jersey made at the request of Governor Brendan T. Byrne, the New Jersey State Commission of Investigation (S.C.I.) assigned one of three investigative teams to look into the area of health services encompassing providers of other than nursing home and hospital care. Among the major components of this section of the program are dentists and physicians practicing in groups or otherwise associated by virtue of sharing space at a common facility. The practitioner phase of the investigation focused upon the workings of individual medical facilities devoting at least 75% of their practice to Medicaid and bringing in substantial amounts of Medicaid money and the manner in which these facilities are administered by the New Jersey Division of Medical Assistance and Health Services (D.M.A.H.S.).

During the course of this investigation, staff of the Division's small Bureau of Medical Care Surveillance provided valuable assistance to the Commission. We wish to publicly express gratitude to Division Director Gerald Reilly and Surveillance Bureau Chief Boniface Damiano for extending many courtesies and total cooperation. The New Jersey State Commission of Investigation also established a working liaison with the United States Senate Select Committee on Aging which is reviewing the Medicaid Program-- a program under which Federal and State tax dollars are paid to providers of medical care for necessary services rendered to the indigent -- on the National level.

Evidence obtained by the Commission on some twelve sample facilities is not sufficient to dispute statements that only a small minority of practitioner groups receiving substantial Medicaid monies engage in improper or questionable conduct. However, the Commission recognizes that the potential for the abuses outlined in this report is great and accordingly, the Commission is recommending the following steps to promote program integrity, guard against unnecessary utilization and ultimately, conserve State and Federal tax dollars.

The principal thrusts of these recommendations, which are reviewed in some detail subsequently in this report, are:

- Promulgation of a scheme to identify and register on an annual basis, medical facilities receiving substantial amounts of Medicaid monies.
- Periodic inspection of such facilities for proper procedures and cleanliness.
- Outlawing percentage arrangements between facility owner-operators and practitioners.
- Establishment of a liaison between the Division of Medical Assistance and Health Services and an insurance clearing house to obtain accurate information on payments made by insurance companies to physicians on behalf of Medicaid recipients.

- Enforcement of state statutes prohibiting lay personnel from participating in the practice of medicine.

- Addition to the staff of the Bureau of Medical Care Surveillance of undercover agents who would pose as recipients seeking medical cases to ferret out:

"ping-ponging" - practice of requiring a patient to see several specialists in the same facility without medical need

"family-ganging" - practice under which covered family members are seen by facility personnel without initially requesting care.

"churning" - practice of unnecessarily requiring patients to come to a facility for billable visits.

"steering" - practice of directing patients to specific specialists or pharmacies.

use of para-professionals; requirements to sign claim forms in blank.

- Notification to recipients of services billed by physicians.
- Require that physicians and radiologists justify the need for radiology procedures and holding both the requesting physician and radiologist separately and equally responsible for assuring that all requested procedures are consistent with the patient's diagnosis.
- Outlaw direct telephonic links and common entranceways between medical facilities and pharmacies.
- Reduction in Medicaid reimbursement rates to pharmacies sharing space in medical facilities.

MEDICAID GROUP PRACTICE- CHARACTERISTICS OF NEW JERSEY MILLS

In connection with its evaluation of New Jersey's Medicaid Program, the Commission determined to examine the professional group-pharmacy aspect component for possible abuse. Scrutiny was centered upon the practices and procedures of relatively large dental and physician groups, their relationships with other providers of medical care and services -- especially pharmacies -- and the adequacy of existing regulations and integrity monitoring methods utilized by the Division of Medical Assistance and Health Services (D.M.A.H.S.).

The Commission focused upon recognized professional groups, "professional centers" housing various unassociated tenant practitioners and offices of single practitioners in which other physicians would regularly share space in either an employee or independent contractor capacity. More than twelve facilities across the State -- each having at least a 75% volume of welfare patients and bringing in substantial Medicaid monies yearly -- were examined. Books and records were reviewed, offices were visited by investigators posing as patients, and sworn testimony was taken from practitioners, facility employees, Medicaid recipients and program administrators.

The facilities reviewed were located in poverty areas -- Camden, Hoboken, Irvington, Jersey City, Newark, Passaic and Paterson -- and housed in places such as welfare project high-rise buildings, converted stores, warehouses and tenements. Typically,

the facilities were divided into a reception area for patients -- some of which were equipped with rows of theater-type seats consistent with mass production technique -- and several smaller compartments used for patient examination, X-ray services and laboratory services. Several locations also contained in-house pharmacies.

Each facility had an owner or the equivalent of a business manager to supervise the day-to-day running of the operation, hire and fire physician, nursing and clerical staff, and arrange liaison with out-of-house specialists and suppliers of goods and services. In many cases, the owner or business manager was a layman.

Arrangements are made between owner or administrator and physicians who desire to practice at the facility. In the main, staff practitioners were comprised of foreign physicians and recent graduates anxious to put together enough capital to open their own practice elsewhere. As one doctor told us of plans to stay at a medical center:

I don't think I'd want to be involved with something so fly-by-night. My main attention is for my private practice, and when it's built up enough, this is where I want to be, in my private practice.

Q. In the Passaic area you mean?

A. No, in Englewood.

In earlier years (1971-1973) many facilities paid staff physicians a straight salary averaging only \$15.00 per hour regardless

of the number of patients seen or amount of services billed to Medicaid. A pharmacist who owned part of two facilities described early salary arrangements:

Q. With reference to the salary arrangements at *** Medical Center and when it was existing at the ***Medical Center, were doctors permitted to bill, if you know? Were doctors permitted to bill Medicaid, for instance, for services they performed, or would those monies accrue to the medical center?

A. Well, I'm -- I'm sure that doctors filled out their forms and submitted it, but I'm quite sure the monies or the checks coming in from Medicaid or Medicare, whatever, were made out to *** Medical Center. If that's what you're asking.

Q. Yes. Okay. In other words, what I'm really wondering is, did the doctors get anything more than \$15 an hour?

A. No.

Salary arrangements between facility operators and staff practitioners declined because of a fear that such arrangements might subject facilities to the licensing and cost review requirements of the Health Care Facilities Planning Act, N.J.S.A.26:2H-1, et seq. A center owner described the strategy:

Q. Do you know how the Doctors and other personnel at the center were hired?

A. When we first took over there was a salary basis. But then there seemed to creep up this certificate of need and we went to two meetings and it seemed as though if you were going to be an organization that hired physicians or opened a medical installation, you had to attain this certificate of need.

Q. From the Health Department?

A. Right. Well, being a nonprofessional. And at this meeting it became evident that they didn't like the idea of nonprofessionals in the medical business, so you had to either go -- that idea was canned as far as salary, if you wanted to continue it, and at this point being involved financially I thought we would have to find another way. Then we decided to rent the premises to physicians and that's what we did. We rented the area to physicians.

Arrangements shifted to "rental" or "partnership" agreements based upon a percentage of the fees earned by the practitioner. The Commission identified specific relationships under which the amount kept by the practitioner varied from as little as 30% to as much as 70% less \$100. On the average, practitioners involved in such arrangements turned over 40 to 50% of their earnings

to facility operators or landlords. Typical negotiations with a lay landlord owner were described by a physician:

Q. Do you recall the substance of that interview; the offer, if any, that he would have made to you?

A. Well, he asked, you know -- I told him that at the time I was looking for a job and I was going, you know -- I would be interested in working in the clinic and he said he was looking for a general practitioner for his clinic and if I was interested, you know, I could -- you could -- you know, I could start working at his clinic on the exact day of opening. It was set at the time.

Q. And did you indicate to him that you were interested?

A. Well, I was interested very much to stay in that area because I had a lot of my own patients from *** that I knew would follow me, and I didn't really want to move out of the area which was acceptable to all of my patients buswise and area-wise and at the time I didn't feel very secure to -- by myself, to open an office in the Newark area at that area where it was. So I felt it was a very good deal for me. I would still be seeing my patients; I would be in the same location and at the same time I had the security that I wasn't alone *** practicing in, you know, in an area of Newark that is not really very safe.

Q. Did Mr. *** suggest some type of financial arrangement or salary to you at your meeting with him?

A. Yes, we discussed that too.

Q Can you give us the terms of the financial arrangements.

A Yes. We discussed, and in his terms, I was to bring my knowledge and my stethoscope and he would provide me with space and telephone service and, you know, all medication, nurses, secretarial work, everything, and so for that he would charge me a definite amount of fee.

Q What was the definite amount of fee? Was it a percentage?

A Well, the fee was -- yes, it was 50 percent.

Q How would the 50 percent reach Mr. ***? Would you have to write a check or would he write a check to you after certain deductions would have been made?

A I was to write him a check.

Q Would you bill Medicaid under your own name?

A Yes, sir, I billed Medicaid in my own name

Q Then after you received a check from Medicaid.

A Yes.

Q -- would you then just take half that?

A Yes. I would write him a check for half of the amount that was paid to me.

Q Did Mr.*** require any type of proof from you as to the amount of money that Medicaid had paid you?

A All the billing that came came to -- through *** and there was a secretary --

Q I see.

A --who kept track of it.

The presence of the operator-owner's secretary to keep a watchfull eye on billings was not at all uncommon.

Facility administrators contend that the high percentage return to the center is justified by the space utilized by staff practitioners -- including all common areas -- and expenses including salary of nursing and secretarial personnel as well as other operating costs. The Commission recognizes that certain expenses are indeed borne by the facility, but suggests that economies of scale accruing to large facilities should lessen the necessity of high percentage arrangements. We believe that these percentage arrangements lead to unreasonable profit for facility owner/operators and foster abuses which will be detailed later in this report.

More recently, arrangements between facilities and staff have involved fixed payments which increase with growth of practice. At one facility, a lay owner-operator charged a specialist \$500 per month. On its face, the fee did not appear high. The physician went on to testify that he was present at the facility only two days a week.

Q Can you tell us who the principals in the *** Medical Center might be?

A Mr. ***.

Q Could you classify him as owner or an operator or --

A He's owner of the building, I think. I don't know. He owns *** Medical Center. That's his.

Q Is he a landlord, correct?

A Right, sir.

Q Is there one physician who might be in residence at the *** Medical Center more than anyone else?

A I can't answer. I'm there two days.

Q Is there a physician who might be a director of the center?

A No.

Q No. Would you know which physician might be at the center more than two days?

A I don't think anybody is.

Q How much rent do you pay to the *** Medical Center?

A *** and I worked out an arrangement that I have to pay the equivalent of \$500 a month.

As the physician indicated, he was not the only physician who practiced at the center on a part-time basis. The Commission questioned the owner-operator about his costs and other arrangements at the center. It came to light that he leased the entire building for only \$225 per month and had "arrangements" returning much more:

Q You're paying 225 a month for the floor to *** ?

A Right, sir.

Q How much rental do you get? Or any company that you are a principal in, what do they get in rent a month?

A Several thousand dollars. I can't give you an exact number.

Q So you're taking in several thousand dollars a month as a landlord, correct?

A Right, sir.

At another facility, a building was leased for \$500 per month by a physician. He himself practiced there, and sublet space to dentists for \$200 per month and to a physician specialist for \$550 per week.

At yet another center, physicians paid the lay-owner operator a weekly fee.

Q. How do you determine how much rent a particular doctor in one of your offices should pay?

A. Well, they are -- the full time doctors, they paid \$300, you know.

Q. Is that a month or a week?

A. This is a week. It depends upon also the medicines and supplies that they use.

Q. So it would be like a flat fee plus the cost of whatever materials they use; is that right?

A. Yes.

Pharmacies also have arrangements with medical facilities. At one medical group, a pharmacy paid in excess of \$1050 per month rent for some 225 square feet of space. It is significant to note that the rental increased from \$550 to \$850 to its present amount within two years and without any concomitant increase in space.

Several of these facilities were visited by investigators from the State Commission of Investigation and the United States Senate Special Committee on Aging. In many cases, investigators reported filthy conditions and questionable and fraudulent

practices by employees which will be detailed throughout this report. Our experience with these facilities, as partly set out in this document, demonstrates the need for a new approach by the Division of Medical Assistance and Health Services.

Initially, we recommend that facilities receiving substantial Medicaid monies and having several staff practitioners be identified, registered and periodically inspected for proper procedures and cleanliness. We believe that the Division of Medical Assistance and Health Services presently has power to promulgate an administrative scheme to accomplish this purpose. During the course of the Commission's investigation the Division drafted such a scheme and we add our support to it. We suggest, however, that a more effective solution might be to amend existing State health facility licensing law (N.J.S.A.26:2H-1 et seq.) -- the very law which facility operators now seek to evade -- to provide for Health Department jurisdiction irrespective of the nature of the financial arrangements between owner-operators and staff over these facilities which receive substantial amounts of taxpayer dollars. We note that such a statutory amendment would also place in the Health Department power to review and set reasonable rates of reimbursement for these facilities which, hopefully, would be more in keeping with the goals of a public welfare program rather than private profit motive.

Percentage arrangements in a Medicaid setting should be outlawed. As this report will indicate, they are incompatible with the goal of providing quality care to recipients at reasonable cost to taxpayers. Such arrangements foster and incite over-utilization of services, ping-ponging, family ganging and churning. It is unrealistic to expect practitioners to practice fiscal restraint when salary is dependent upon the amount billed.

We further urge that an identification system be developed to indicate on the claim form which specific practitioner rendered service to the recipient and the precise location where the service was rendered. Such information -- which is not now readily available -- will provide program surveillance personnel with easy access to accurate information on monies flowing through particular locations and facilitate detection of ping ponging, and family ganging.

It will also track Medicaid Doctors who wander from facility to facility. The Commission discovered one physician who visited three facilities in different cities a week. Such a practice raises serious questions about continuity of care and treating physician availability to patients.

The testimony also raises serious questions about possible violations of the Professional Practices Act (N.J.S.A.45:9-1 et seq) by facility lay owner-operators who share in the profits of facility associated physicians. The Commission will forward a copy of its investigative record to the State Board of Medical Examiners for consideration of this and other issues.

AFFILIATED RADIOLOGY SERVICES

Once the treating physician determines radiologic services are necessary, a requisition specifying the X-ray procedure desired is drawn. The service may be rendered in one of several ways: The patient can be referred to a specific radiologist or hospital facility; the X-rays can be taken, developed and "read" by a radiologist member of the group using his own equipment and personnel; films can be taken on the group's equipment by a technician paid by the group and interpreted by the radiologist whose office may be located off the group's premises.

Ideally, in this latter situation, the radiologist will closely supervise the work of the X-ray technician and will himself perform (or be present for) more esoteric procedures. During the course of the investigation, however, the Commission discovered one instance where a radiologist receiving in excess of \$118,000 of Medicaid funds between 1972 and 1975 was employed full time at a New York hospital. Despite the fact that Medicaid claim forms signed in his name represented that the radiologic services, including intravenous pyleography, mammography and tomography, "were personally rendered" by him or by a qualified individual in his actual presence, office employees -- including the X-ray technician -- saw him only once or twice over the years. In the absence of the radiologist, numerous X-rays of questionable medical value were ordered by office physicians and taken by the technician.

The radiologist could only review medical necessity on an after the fact basis and, according to the X-ray technician, would question the number of films taken on individual patients:

Q. All right, But what would he say, for instance?

A. Why was an X-ray taken? Or, why was this taken?

Q. He would ask you?

A. Yes.

Q. Would he ask anyone else?

A. No.

Q. Did he sound sort of complaining when he would ask you?

A. I don't know what you mean, complaining.

Q. Well -- A. That I shouldn't do it?

Q. Yes. A. I don't know. He would ask me why did I take it.

Q. I'm sorry. I missed the last part of that.

A. He would ask me why did I take it.

Q. Okay. And you would say what?

A. Because I was told to take it.

The testimony raises serious questions about the quality of care received by office Medicaid patients in this highly sensitive and potentially dangerous area of health care delivery. The record also raises questions about the conduct of certain physicians which appears to transgress basic standards of medical ethics in practice, issues which are beyond the scope of this report.

At another facility, with the radiologist located in a nearby city, evidence exists that unqualified persons were permitted to take X-rays. Rather than hire a licensed X-ray technician, the lay group administrator allegedly instructed a licensed practical nurse (LPN) to take films. If questioned by authorities concerning X-ray procedures, group personnel were supposedly rehearsed to claim that the LPN only positioned the patient and that a physician actually "pushed the button". Questions concerning these allegations to a physician-partner of the group drew the following responses:

EXAMINATION BY COMMISSIONER LUCAS:

Q. During your stay at * * * Health Group was there an employee of the health group by the name of Sonia?

A. Yes.

Q. And do you know how long Sonia was with the group?

A. I'd say about a year.

Q. All right. Do you know what her duties were; that is, were they administrative as opposed to medical?

A. I plead the Fifth and Fourteenth Amendments.

Q. Did Sonia dress in the garb of a nurse?

A. I plead the Fifth and Fourteenth Amendments.

Q. Do you recall if Sonia dressed in the garb of a lay person in the office of a doctor?

A. I plead the Fifth and Fourteenth.

* * *

Q. All right. Now, in the spring of 1974 was there an X-ray technician -- strike that.

In the spring of 1974 was there a young lady at the * * * Health Group by the name of Sonia, who would take X-rays?

[Whereupon, the witness confers with counsel.]

A. I plead the Fifth and Fourteenth Amendments.

Q. Do you know if -- strike that.

Do you know whether or not Sonia was a certified X-ray technician?

A. I plead the Fifth and Fourteenth.

Q. Did you ever hear * * * instruct physicians to say that they, the physicians, rather than Sonia took X-rays if anyone should ask?

A. I plead the Fifth and Fourteenth Amendments.

After the group obtained the services of a licensed technician, problems again developed when the facility's lay administrator himself allegedly took X-rays. The physician-partner again raised constitutional privileges when asked if it was ever brought to her attention that the administrator may have taken X-rays. The administrator denied taking X-rays but acknowledged that he could position patients and develop X-rays for a physician who would "push the button".

Radiologists associated with Medicaid Mills, like other practitioners, often work on a percentage fee arrangement. The

Commission commonly found group associated radiologists keeping only between 35-40% of Medicaid dollars paid for radiology services with the balance flowing to the facility. Other situations were encountered in which the radiologist would pay the group a lower fixed percentage of his fees plus a monthly rental. (30% of fees plus \$100/month is one example of this type arrangement.)

In any percentage relationship, incentive exists to increase dollars received by increasing volume of work performed. The radiologist can maximize his income by billing for as many procedures as possible on each patient. The group can maximize its earnings by supplying as many patients as possible to the radiologist through the practice of "ping-ponging". These temptations often materialize in pressure exerted upon group physicians to order unnecessary X-rays for their patients and radiologists engaging in "creative billing" -- billing based upon the number of readings rather than the number of anatomic areas filmed -- and false billing for services not performed.

In one mill administered by a layman, a pediatrician preferred to use the services of a radiologist in whom she had "tremendous confidence" rather than the radiologist associated with the facility. The landlord-administrator chided the pediatrician for referring patients to outsiders and suggested that the Mill's radiologist -- who paid the landlord a percentage of his fees plus a fixed amount monthly -- should be utilized.

Q. Did Mr. * * * ever tell you why he wanted you to use Dr. * * * rather than another radiologist who might be outside the group?

A. He felt that the medical center would make more money if we used our own and he installed the machines and went into the expense to put everything, that we should utilize what we have in the clinic.

At another group where the radiologists received 40% of the Medicaid fees for radiology services, a physician complained the lay administrator would approach him with respect to specific patients and ask, "You're going to order X-rays, aren't you?" On other occasions he was chastised by a physician partner for allowing a patient to have X-ray services performed at a near-by hospital rather than at the group

* * *

A. I remember the incident, Dr. * * * called me aside and said to me, "Why did the patient have the X-rays done at St. Michael's?" I don't remember if it was an upper G.I. series. It possibly was and/or a chest X-ray. But I was taken aback by her and I said, "* * *," I said, "the form that I used for the requisition for the X-ray for the patient was to have it taken at the office of a radiologist, and the hospital has a very similar requisition and the patient

can go any place he wants for that X-ray." She says, "Well, we offer the service here. Why didn't you have it done here?" I said, "* * *, the patient had the X-ray done at St. Michael's. I'm only interested that the patient had the X-ray procedure done, not where she had it done." But she was very, very angry with me and I controlled myself. . .

* * * *

When questioned about pressures exerted by the lay group administrator on physicians to take numerous X-rays, a physician partner responded:

* * * *

Did Mr. * * * ever suggest to you that you yourself should order a certain number of X-rays on your patients?

[Whereupon, the witness confers with counsel.]

A. I respectfully plead the Fifth and Fourteenth Amendments and decline to answer the question on the ground that the answer may tend to incriminate me.

THE CHAIRMAN: Doctor, in the event we have occasion to rely on those privileges again, the record will indicate the complete context of your statement, but you would simply have to say you plead the Fifth and Fourteenth Amendments. All right? Instead of going through the entire process.

THE WITNESS: Fine

Q. Doctor, are you aware of any advice or suggestions that Mr. * * * may have given to other physicians at the * * * Health Group concerning the number of X-rays they should order for their patients?

A. I plead the Fifth and Fourteenth Amendments.

* * * *

The radiologist associated with the group maximized his percentage earnings by billing Medicaid for an additional esophogram whenever the group X-ray technician would perform an upper G.I. series and even though the treating physician would not request such a procedure. The X-ray technician testified that he only took films for an upper G.I. series and forwarded a Medicaid claim form to the radiologist which billed only for the procedures he actually performed:

A. I would do a GI series and that would be all. And then one morning I noticed the forms were on the counter and then underneath it, the GI series, and in another person's handwriting "and esophagus," and it had a certain amount of money written on the side.

Q. So "and esophagus" was added in?

A. Right.

Q. You didn't do anything to the esophagus?

A. No.

Q. Right?

A. No.

Q. Who signed the form, do you know?

A. Dr. * * * [the radiologist]

Q. Are you sure?

A. Yes.

Q. Were the words "and esophagus" written in the same color pen as Doctor * * * (radiologist) signature?

Did you notice that?

A. Right, yes.

Q. It was. All right. How many times did this happen, often?

A. On

practically every G.I. series.

This technician was also instructed by the radiologist to take films other than those requested by the treating physician:

Q. Okay. Did anyone ever tell you or suggest to you that, as the X-ray technician, you should do more X-rays than the X-rays requested by the physician?

A. Right, Doctor * * * [radiologist].

Q. Doctor * * * [radiologist]. What did Dr. * * * say ?

A. Doctor * * * requested that if it was a finger, that I would do a full hand on the frame.

Q. Did he tell you why you should do a full hand?

A. No.

Q. He just said do it?

A. Right.

Q. And this is even though the prescription or the written request that you would get from the doctor requesting the X-ray would say the finger?

A. Right.

Q. What would you do, the finger or the full hand?

A. I would do the full hand.

Q. Any other particulars, such as a foot, ankle?

THE WITNESS: Yeah. He said if it was an ankle I was to do a foot and ankle.

Q. What about a request for an X-ray of one of the hips?

A. I was to do both hips.

Q. In other words, if the request said please X-ray right hip --

A. Right.

Q. -- you would do both hips?

A. Both hips.

Q. Do you know why doctor would make that request - Doctor * * * [radiologist]?

A. Just for a comparison. But most comparison studies are done between children under sixteen.

Q. And you say children under sixteen. Were most of these hip X-rays taken of children?

A. Not really.

When questioned concerning the practice of the affiliated radiologist to engage in "creative billing", the physician partner invoked the Fifth Amendment.

Steps can be taken to safeguard the program from over-utilization of X-ray services and "creative billing". Primary physicians requesting radiologic procedures should be required to document clearly the medical necessity of such procedures in the patient's chart. The requesting physician should then specify the precise X-ray procedure desired on a multi-copy combination Medicaid X-ray requisition claim form. A line should be drawn under the last test required and immediately thereunder the requesting physician should list the diagnosis and "rule-outs" for the benefit of the consulting radiologist and Medicaid surveillance personnel. The requesting physician should then personally sign the form and forward it to the radiology consultant for use as a description of services to be rendered and as his own program billing invoice. Both the requesting physician and the radiologist should be separately and equally responsible for assuring that all requested procedures are consistent with the patient's diagnosis. If a radiologist believes that services requested should be modified, extended, or rejected, he should be required to consult with the requesting physician. Claims not submitted in complete accord with the above procedure, should be rejected by the processing agent.

Steps should be taken to make it clear to providers that radiology billing should be based on the number of anatomic areas filmed rather than on the number of readings. While for example, a pelvic film allows interpretation of multiple anatomic segments, a radiologist should not bill for readings of "right hip," "left hip", "pelvic", "lumbosacral spine", etc. Only the

NOT GETTING OUR MONEY'S WORTH

minimum number of views necessary to delineate anatomic pathology should be taken.

The Commission also suggests that the Division of Medical Assistance and Health Services give serious consideration to the amount and method of reimbursement to program radiological providers. The fact that many providers are willing to accept 35-40% of the present Medicaid fee itself suggests that the fee may be high. 60-65% of that fee, or the portion taken by the group, may contain excess profit in addition to monies sufficient to cover costs related to radiological procedures. The Division may well decide to adopt a method similar to that now utilized by New York City whereby one fee is paid to the radiologist for X-ray interpretation and another to the entity which owns and operates the equipment.

One method of maximizing Medicaid income is to disguise non-reimbursable treatment through the use of codes applicable to reimbursable procedures. Medicaid pays for physical therapy under certain conditions. Payments are not made for "physical medicine procedures administered by a physician, or physical therapy which is purely palliative such as the application of heat, ice, or any form, massage, routine callisthenics, or group exercises, assistance in any activity or use of a simple mechanical device not requiring the special skill of a qualified physical therapist." S.J.A.C. 10.54-1.7.

NOT GETTING OUR MONEY'S WORTH

The Commission's investigation disclosed a number of practices used by physicians to maximize unfairly the amount of Medicaid reimbursement they receive. Many of these practices contravene the requirement (N.J.A.C. 10:54-1.1) that reimbursable services be rendered by the physician or in his actual presence:

"Physician's services" means those services provided within the scope of practice of the profession as defined by the Laws of New Jersey, or if in practice in another state by the laws of that state, by or under the direct personal supervision of an individual licensed by the State of New Jersey to practice medicine or osteopathy. It includes services furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere. Direct personal supervision means that the services must be rendered in the physician's presence.

One method of maximizing Medicaid income is to disguise non-reimbursable treatment through the use of codes applicable to reimbursable procedures. Medicaid pays for physical therapy under certain conditions. Payments are not made for "physical medicine procedures administered by a physician, or physical therapy which is purely palliative such as the application of heat per se in any form, massage, routine calisthenics or group exercises, assistance in any activity or use of a simple mechanical device not requiring the special skill of a qualified physical therapist." N.J.A.C. 10:54-1.7.

At one facility, patients were scheduled to come in for diathermy, hydroculator and electric muscle stimulator (E.M.S.) treatments at a time when the physician was not in the office. A facility clerical employee who operated the equipment testified as follows:

Q I see. Now, would you run this EMS and hot pack machine when Dr. *** was not in the office?

A Sure. That's when we used it. We used it mostly in the morning because when he came in he had patients to see, and, you know, if we had a patient in there taking treatment, it would tie the room up and we needed the room. So we advised most of the patients to come in in the morning for their treatment.

Q I see. What about the EKG. Now, was this another situation where an EKG would be taken in the morning when Dr. *** would be absent?

A Yes.

Q Was that standard procedure?

A Yes, because it took time and it was also done in the same room and that took time to do also.

Q Is all this equipment that we are talking about located in the one room?

A Yes.

Q And is this room also used for the examination of patients?

A Yes.

Q I see. So that any patients who would require treatments from these various electronic devices would be handled in the morning?

A Yes, because if they came when he was seeing patients they would tie up that room for like ten or fifteen minutes and we only have four examination rooms to work with.

The clerical employee often "treated" as many as 30 patients per day out of the physicians presence.

Medicaid claim forms were submitted for these services in the name of the physician. The services rendered were described as "prolonged office visit" and processed for payment by the fiscal intermediary. The facility's registered nurse, who handled much of the Medicaid billing, testified as follows:

Q When would you write prolonged office visit?

A Whenever we give a physical therapy treatment.

Q But, again, the physical therapy treatment might be diathermy?

A Diathermy, EMS, EMS and hot packs, hot packs.

Q So in your own mind were all these words and descriptions synonymous, they all meant the same?

A No, because the diathermy machine is a different machine than the electro -- electro-muscle stimulator machine.

THE WITNESS: Did you get that lisp in there?

Q No. But the prolonged office visit category, okay, would be used sometimes at least when physical therapy services would be rendered?

A Would be used all the time when physical therapy service is rendered.

Q All the time?

A Yes.

Q And generally what kind of training did you receive? The women who operated the physical therapy equipment and also gave injections, had no medical training. One of them testified concerning her background as follows:

Q Are you a registered nurse?

A No.

Q Are you an L.P.N. or practical nurse?

A No.

Q Do you have any kind of training in the medical field?

A I'm a medical secretary by training.

Q And where were you trained?

A Lyon's Educational Center, 900 Broad Street, Newark, New Jersey.

Q And how long did you attend Lyon's? How long did you study there?

A It was a year.

Q Did you receive some sort of certificate --

A Yes.

Q -- or diploma?

A Yes, a thousand hours.

Q And generally what kind of training did you receive there? What did they teach you?

A Well, medical terminology. I had shorthand already in school, so I had shorthand, medical office procedures. I had typing. I imagine that's about it. English.

Q Did you learn to operate any type of office equipment at Lyon's, any medical equipment?

A No.

Q Like a diathermy machine?

A No.

Q Did you learn how to give injections at Lyon's?

A No.

Q Did you learn how to take blood from a patient at Lyon's?

A No.

She went on to detail the methods she used to give electric muscle stimulation treatments:

Q What's a EMS and hot packs?

A Electrical muscle stimulation. That was part of that machine. It was just like -- I never knew heads or tails what it did. I was just told that's the way I had to do it. You just put the lotion on and you just iron; give him certain amount of watts. You ask him if he feels it. If he feels it, then you just leave him there and iron him for ten minutes. Just rub him back and forth.

Q And did Dr. *** leave you instructions as to what degree of voltage you should use with each patient?

A Well, he showed me a couple of times and he said you would normally leave it on -- like it was just a knob and it has numbers from one through eight, and like I used to put it midway, somewhere between four, five and six, you know, unless the patient said it was too much. Then I would turn it down. That's all.

One must seriously question the quality and value of these services.

Another abuse involved billing Medicaid for injections administered by a nurse or clerical assistant rather than the physician under the guise of an office visit. A registered nurse testified as follows:

Q You mentioned earlier you gave injections, right?

A Yes.

Q Suppose the patient came in for an injection and you actually gave the injection. Would you fill out a Medicaid form --

A Yes.

Q -- if the patient were a Medicaid patient? All right. And would you sign it in Doctor *** name?

A Yes. When a patient comes in for an injection and walks in the door, it's an injection that Doctor *** has said, "Mrs. Jones, you come here each week for an Imferon injection each week and she comes for an injection.

The nurse claimed that in addition to giving the injection, she would check the patient's weight and blood pressure and ask questions about general well-being. Again, the services billed were not rendered by the physician although claims were submitted in his name.

Medicaid was also billed for office visits when patients telephoned the facility for prescription renewals. Often the

decision to renew the medication would not even be made by a physician but by a nurse or clerical assistant. The nurse explained her procedure when a call from a patient was referred to her by the receptionist:

Q Suppose she gave it to you, what would you do?

A I check the patient's chart.

Q Then what would you do?

A See when her last visit was. If it was somebody who I was familiar with and her medications were normally renewed, they would be renewed. If it was somebody I was not familiar with or if she hadn't been there for a long time, I'd have her come in or I would hand it over to Dr. ***.

In addition to the nurse, clerical personnel in the office renewed prescriptions. Instructions from the physician called for a Medicaid claim to be submitted in these situations. The medical secretary testified as follows:

A Yeah. A lot of times I would go ahead and refill it and I would tell the patient, you know, you would have to come in and see Doctor some time this week.

Q Okay, A Nine out of ten they would never show.

Q What would happen as far as someone filling out a Medicaid form based upon my telephone call?

A You see, I never did it. But it has --

Q Would (the nurse) A Yes.

Q Well, what were her procedures?

Would you make a list?

A Doctor would tell -- if Doctor was there and I told him a patient called and wanted meds renewed and I renewed it already, he had said get a form and fill it out. Any one of us could do that. Just fill out the top part, the name and Medicaid number. We would hand it over to him or (the nurse) and they would take it from there.

Q But the Medicaid form that's filled out is based upon the telephone call?

A Right.

Q Right. Not the patient coming in to see the Doctor?

A Right.

Q Right, Okay. Do you know what procedure code -- you know what a procedure code is --

A Yeah.

Q -- in Medicaid? A Um-hum.

Q Do you know what procedure code is placed in or on that Medicaid form?

A Triple o-one.

Q Triple o-one means what to you?

A Just a regular office visit.

A related problem involved instructions given by facility employees to patients who would call in for prescription renewals. The receptionist described her procedures which were geared to getting the patient into the office for a billable visit:

Q Have you ever answered the phone and gotten people on the other end who want to renew their prescriptions?

A Yes.

Q Well, what did you do? What is your procedure when that happens?

A Well, I usually tell them to come down and talk to Dr. *** about it.

Q You ask them to come in in person?

A Yeah.

Q What would you say to them? Suppose I were the patient. What would you say to me?

A Well, say, you know, you better come down to the office and bring your bottles, you know, the empty bottles and talk to him. If he can renew it, then he'll give it to you. If not, you know, whatever he says.

This is one example of techniques which we label as "churning" or unnecessarily requiring patients to come into a facility for a billable visit. A medical secretary at one facility described another technique:

Q Was there any practice or procedure that you were aware of on the part of the doctor or anyone else in the office acting under his instructions to get patients to come back on any type of a regular basis?

A I don't understand what you mean.

Q Well, for instance, did Dr. *** ever instruct you or the receptionist or any other persons working in the office to instruct the patients to return next week or the week after --

A Yes, me.

Q -- to -- all right. How would that work? What would his instructions be like?

A Well, he would see a patient and say the patient had a cold, So he would say tell her I would want to see her Wednesday or Thursday. If they came in on Monday, tell her to come back Wednesday or Thursday to see me.

Q And would the doctor actually examine these patients when they came back the second time?

A He would come in and say, you know, "How do you feel?" you know, "How's the medicine working?" And they would say, "Okay." He would say, "Finish up your medicine and come back and see me again." That's what he would say.

Q So he would want them to come back a third time?

A Yeah. A lot of them came back three times a week.

Q Three times a week?

A (The witness nods her head.)

Q What would happen the third time?

A The same thing. He would come in and say, "How do you feel?" You know, "Cold all gone?" and they would say "Yeah." "Okay. Take it easy." And that was it.

Q Okay. But there wouldn't be any further physical examination?

A No.

Q On his part?

A No.

Another abuse involved billing medicaid and an insurance company for services rendered to recipients in connection with auto accidents or workmen's compensation claims. Medicaid claim forms presently ask the following questions:

8. Was patient's illness or injury connected with his employment? Yes/No
If yes, give name and address of employer here.

10. Did injury result from automobile accident? Yes/No

The fiscal intermediaries depend on accurate and truthful responses to these questions in determining whether treatment for certain conditions is reimbursable under the program. At one facility, these sections purposefully would be left blank. The fiscal intermediary processed the claims in this condition rather than rejecting them, and Medicaid was billed and paid for services which would also be billed and paid by an insurance company. The medical assistant/secretary testified as follows:

Q Do you know of any instances where patients who were involved in accidents received payments from the insurance company or an insurance company and some of these payments from the insurance company went to Dr. *** ?

A Yes.

Q But Medicaid was also billed for services that Dr. *** rendered to these patients?

A Yes.

Q What can you tell us about that type of a situation? How would that work?

A Well, that patient -- we had an invoice card on the patients. So whenever they came in, we would put down the date and at the end of the twenty-five or thirty treatments, you know, the secretary would type the bill up and send it into the lawyer. Meanwhile, if they were on Medicaid, we still had to fill out a form and submit the form to Medicaid. That's all.

Q Do you recall any specific names of patients

where this happened?

A Yes.

Because of this ruse, Medicaid monies could not only be paid to the physician, but also to pharmacies, laboratories and other providers of care.

The Division should take a hard stand with respect to this double billing. Any physician submitting claims to Medicaid who also claims reimbursement for identical services from another third party payer should be immediately and permanently suspended from the program.

We further suggest that appropriate State and Federal agencies consider such conduct in connection with possible actions against professional licenses and criminal sanctions.

Rather than relying upon the accuracy of information provided on the claim sheets or the good faith of hospitals or physicians in notifying Medicaid of any inquiries indicating the existence of an insurance claim, we suggest that the Division consider establishing a liaison with a local insurance clearing house. During the course of the investigation the Commission subpoenaed one such clearing house for information relevant to Medicaid recipients treated by suspect physicians for "trauma." The clearing house was quickly able to provide details of treatment and insurance company payments for which Medicaid was also billed.

Other common abuses include ping-ponging - the practice whereby a Medicaid recipient will be seen by many or all practitioners in a clinic, and family ganging - the practice under which covered

family members of the patient are seen by facility personnel without initially requesting medical care. "Family ganging" often occurs when small children accompany a "Medicaid mom" to a facility.

A medical secretary described the procedure at one office:

Q. All right. Did Dr. *** himself or did Dr. * ** instruct personnel in his office to try to get patients to bring their children in to him?

A. Well, no. He would ask the patient when they were there - - you know, if the mother had the child with her, he would, you know, ask her if, you know, the child had all his baby shots. That's what he hit them with most, the baby shot bit. And she would say no or something and he would say get a form, fill out a chart and then we would start with the baby.

Q. And the mother would return with the baby to get the shots?

A. Um-hum.

Q. And who would give the shots?

A. Me.

Q. You would. Would the Doctor see the baby?

A. No, not unless the baby was sick.

At one facility, ping-ponging to the Dentist-tenant was common.

Q. And do you know who would, if anyone, make suggestions to the patients that the dentist be seen?

A. Usually Dr. ***.

Q. Did he ever make that suggestion in front of you? A. Yes.

Q. What would he say?

A. Your teeth look bad. I want you to see the dentist.

Q. And would he then escort them to the dentist's office? A. Yes, most of the times he would.

Another employee corroborated ping-ponging to the dentists:

Q. Were there any other medical personnel associated with Dr. ***? How about dentists?

A. Dr. *** and Dr. ***.

Q. All right. And would they come to Dr. *** office?

A. The office was right behind us. All we had to do is walk through a hall.

Q. And were these two dentists in every day?

A. Yes. Well, they would take turns.

Q. I see. One of them would be present every day?

A. Yeah.

Q. And how did Dr. *** refer people to the dentist?

Strike that question.

Did Dr. *** refer his patients to the dentists?

A. Yes.

Q. How would that happen?

A. He would look in their mouths, you know, and like he would just ask them, "When was the last time you saw a dentist?" And he would send them right over to them.

Q. Would this be the same day that Dr. *** saw the patient?

A. Yeah.

Q. He would send them to the dentist?

A. Yeah.

Q. Would the dentist then do something?

A. Take it from there.

At another facility a physician was pressured by the lay owner to refer patients to other in-house specialists, even for procedures which did not require services of a specialist:

Q. All right. Can you give us an idea of the nature of his advice; what did he suggest or advise you to do?

A. To have, for example, breast screening done on more female patients over age thirty.

Q. This would have entailed the services of the radiologist?

A. Yes.

Q. On the premises?

A. Yes.

Q. Possibly it was Dr. ***?

A. Yes.

Q. All right. Any other advice concerning what might be done with the patients or for the patients?

A. Well, that, for example, I shouldn't be -- while there was available a GYN man on the premises that I should utilize his services.

Q. And was this the suggestion to you to utilize the service of the GYN man in connection with some specialized service that only a GYN man could render?

A. No. The pap smears I presume could be done by a general practitioner as well.

This facility was visited by investigators from the New Jersey State Commission of Investigation and the United States Senate Select Committee on Aging who posed as Medicaid recipients. Each of the three "patients" was greeted by a receptionist who extolled the merits of the facility and the various specialists who practiced there. Before each of the investigators was examined or even seen by a physician, the receptionist made appointments for return visits with the dermatologist, radiologist, podiatrist, gynecologist, optometrist and dentist.

At another medical group a physician described pressures to ping-pong exerted by the lay administrator.

Q. It started -- A. When the Group got downstairs which was approximately May of '74 and the new office suites were ready and the dentist had then come in the area and there was an optometrist there part time and then the optometry office was on the other side of the clinic. When we got downstairs. I was told to make referrals to the dentist, to the optometrist, to the obstetrician, to the gynecologist and also with the orthopedic doctor who was coming in eventually. And my answer at that time, I recall, to Mr. *** was that if I think it's medically necessary for this patient to be

seen by the dentist, I will tell him to go to a dentist, but I will not tell him to go to your dentist. I will not tell him to go to this eye doctor or that eye doctor. I will ask him when was the last time your vision was checked and examine eyes, which is a normal part of my routine exam.

X X X
Q. Okay. Now, you have indicated to us that Mr. *** approached you with suggestions that you make referrals to certain of the other physicians in the group?

A. That's right.

Q. Are you aware of Mr. *** or anyone else approaching other physicians and making a similar request for referrals?

A. Yes. I know that he was quite frequently harassing, I'll use the word harassing, Dr. *** to make referrals to the gynecologist and eye, ear, nose and throat specialist or an orthopedic doctor.

X X X

Q. Do you have any idea why he requested the referrals to be made?

A. I assume that he was looking to ping pong his patients. That's an assumption -- a presumption on my part, and that he was going to get a percent of the billing from the particular consultant, which would increase his income, certainly not mine.

The physician claimed that these pressures were one reason which caused him to disassociate himself from the group. The administrator involved allegedly referred to group patients as "warm bodies" and urged physician staffers to "keep the warm bodies flowing" ("ping-pong"). A physician partner was questioned about the activity of the lay administrator:

Q. Doctor, have you ever heard Mr. *** use the term "warm bodies" in connection with the patients at *** Health Group?

A. I plead the Fifth and Fourteenth Amendments.

Q. Doctor, have you ever heard Mr. *** suggest to physicians at the *** Health Group that they should circulate the warm bodies amongst themselves?

A. I plead the Fifth and Fourteenth Amendments.

The lay administrator's actions apparently did not end at advising physicians how to practice medicine. One female Medicaid recipient told of being examined at the facility by a "physician who did not wear a white coat."

Q. What did this man, this person do? Did he examine you?

A. He examined me with that thing around his neck. With it up here.

A. The thing that you put on your ears and hangs on your neck.

X X X

Q. Did he listen to your heart?

A. He put it in a lot of places and in back and in front.

Q. Do you remember what he told you or did he tell you anything?

A. No, he didn't say anything to me.

Q. Did you tell him you felt sick?

A. Yes, I did.

Q. And then he examined you with a stethoscope?

A. Um-hum.

Q. Now, let's go back to when this person examined you, okay?

Did he ask you to open your mouth and say ah?

A. He put something in my mouth and looked into my throat and he just examined my throat and then he gave me the pills.

Q. But he listened to your body with an instrument, didn't he, besides examining your throat?

A. Yeah.

THE INTERPRETER: She doesn't know--

A. I don't know the name of the instrument he used, but

he put it in his ears and examined by back and front and all over.

Q. When he was examining you with this instrument, did he tell you to breathe in and out deeply?

A. Yes, he told me to breathe deeply.

Q. When he was examining you, did he ask you to put on a gown?

A. Yes--he asked me to put another gown on--no.

THE INTERPRETER: She just--

A. He just had me lift my blouse--open my blouse. I had pants on at the time.

The individual -- who also prescribed medication for the recipient -- was positively identified by the recipient as the group's lay administrator.

The Commission also discovered it a prevalent practice for Medicaid recipients to be required to sign claim forms in blank and prior to having any service rendered. This practice allows physicians to bill the program for other than services actually rendered. United States Senate Select Committee on Aging personnel who assisted the New Jersey State Commission of Investigation were required to sign forms in blank virtually at every facility visited. A comparison of claims submitted by the facilities for services

allegedly rendered with detailed investigative notes itemizing services actually rendered showed gross discrepancies in many cases. Physicians billed for injections that were not given, for blood which was not drawn and for urinalysis and tine tests which were not performed.

The Commission is also concerned with the amount of time spent with Medicaid patients by physicians. In several facilities visited, undercover investigators from the United States Senate Special Committee on Aging reported that physicians would spend only minutes with them and give the most cursory examination for which Medicaid was billed \$30.00. Such minimal procedures again do not appear consistent with quality medical care.

Many of the abuses outlined above -- extensive use of paramedical and even lay personnel for duties which are reimbursable only to physicians, double billing, ping-ponging and family ganging -- can be and are being detected by the Division of Medical Assistance and Health Services through the use of sophisticated computer screens and time studies. We commend the Division and specifically the Bureau of Medical Care Surveillance for the effectiveness of current methodology. Existing computer program comparison procedures, however, do not uncover abusive practices in each and every case, but only when certain factors are present. To further protect the integrity of the program, we recommend that the Division obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. The Commission found that the use of such agents provided a quick, reliable and efficient method of uncovering practices inconsistent with the aims of the Medicaid program. Evidence gathered by such investigators, who

we envision would be assigned to the Bureau of Medical Care Surveillance, could and should be aggressively used by the Division in suspension hearings or passed along for the review of appropriate law enforcement agencies.

We additionally recommend that facilities performing substantial amounts of Medicaid work be required to disclose to the Division the names and positions of employees. This information which, of course, should be updated periodically, will prove helpful in detecting use of para-professionals in place of physicians. We would also suggest that the Division consider legitimatizing the use of qualified medical para-professionals in certain instances. Services rendered by such individuals, however, should be paid at a rate lower than that now designated for physicians.

We again recommend that the Division consider the possibility of contracting with an insurance clearing house. Our own experience indicates this to be an effective step in obtaining reliable information on the presence of sources of medical payments other than the Medicaid program.

Lastly, we urge that steps be taken to insure that recipients be made aware of services billed to Medicaid on their behalf and be given an opportunity to challenge the accuracy of physician requests for reimbursement. At very least, a procedure should be instituted and strictly followed requiring recipients to sign only completed, itemized claim forms. We further recommend that recipients be advised of services billed on their behalf, either by a Division listing of billings periodically through the year, or simply by adding a copy claim form to be given to the recipient by the

physician at the time of service as a "receipt". We anticipate that costs incurred as a result of the adoption of either of these proposals would be offset by savings realized from more truthful billings. Either procedure would build a sorely needed "check and balance" into the existing system.

Q. Do the physicians at the Medical Center consider this part of your business?

A. Enough to make us nervous. I don't think we have it due to the fact that we have only done about 10% of the work that the physicians were there at the time. I don't know how you know quite a few.

Q. Give us a better idea.

A. I would say that we have a few.

Q. About a dozen?

A. My prescription book is in the medical center.

UNHOLY ALLIANCES BETWEEN MILLS AND PHARMACIES

During the course of the investigation, the Commission discovered a number of questionable relationships between pharmacies and mills. At one location an owner of the pharmacy and a lay "entrepreneur" also "owned" a substantial interest in a medical center located less than a block away. The pharmacist paid the salaries of physicians at the Center and subsequently played a role in determining the "rent" physicians would pay for use of the facility. According to the pharmacist, Center patients initially numbered more than 50 a day and rose to the point where they comprised about a third of his business. We believe this estimate to be conservative.

Q. Do these prescriptions from the * * * Medical Center constitute any significant part of your business?

A. Enough to make me notice. I didn't want to lose it due to the fact when I took over my store we were only doing about fifty a day, and when the physicians were there at the medical center I had seen, you know quite a few.

Q. Give us a ball park figure.

A. I would say about a third of my business.

Q. About a third?

A. My prescription business is from the medical center.

Q. Was that in May of 1973 or are we talking about today?

A. No. It's the same as it was.

Q. All the way through?

A. Right.

According to the pharmacist, Center patients patronized his store because of convenience. He claimed that the next closest pharmacy was four blocks away. In order to determine whether factors other than convenience were involved, personnel from the State Commission of Investigation and the United States Senate Select Committee on Aging recently visited the subject medical center. Following an examination, a physician at the Center contacted the pharmacy by an automatic-dial phone and ordered several prescriptions for a Committee undercover investigator. The Center receptionist then directed the investigator to the pharmacy to pick up her medication.

In another area, a pharmacy and a medical center located directly across the street were sold as a "package" to a pharmacist and a lay person. Initially, physicians at this Center were paid a salary and subsequently, arrangements changed to a percentage "rental". The County Medical Society recently objected to the pharmacist and his lay partner acting as owners of the Center. Accordingly, arrangements were made to the end that the Center was "sold" to a physician. The physician now pays rent

to a realty company whose principals are the former owners, a fee for the former owners to open and close the facility daily, and a fee to the "former" owner's brother who acts as facility book-keeper. Investigators from the State Commission of Investigation and the United States Senate Select Committee on Aging who visited this facility were directed to the "former" owner's nearby pharmacy for prescriptions.

A comparison of the location of the medical center and that of the pharmacy rendering service to significant numbers of the center's patients may itself suggest impropriety. Surveillance personnel should closely scrutinize situations where pharmacies distant from centers provide service to large numbers of center patients. The Commission was surprised to find one situation where the majority of one medical facility's patients were having their prescriptions filled by a pharmacy located some five to eight miles away, notwithstanding the fact that at least two drugstores were located within blocks of the office. Prescriptions from the one facility alone accounted for 55% of the drugstore's total business and 80% of its Medicaid volume.

Investigation disclosed that the pharmacy was once a tenant of the physician. When the physician relocated to another town, direct telephone lines were established to the subject pharmacy. The physician, as well as his registered nurse and lay office help, would phone in prescriptions to the pharmacy and the pharmacist would then type a script with the relevant information for

his files. Evidence indicates that the pharmacist would be supplied with blank prescriptions pre-signed in the physician's name by his registered nurse. These blanks were apparently used in violation of Federal Law to record transactions involving controlled substances.

The medical facility involved maintained a cardboard box into which was placed drug samples left by pharmaceutical salesmen and medications returned to the physician by patients. According to several present and past employees, the pharmacy's delivery man would regularly pick these up. The facility's registered nurse described the items placed in the box as follows:

Q. All right. Now, did Mr. * * * ever take things away from Doctor * * * office?

A. Yes.

Q. What type of items would he take away?

A. Samples.

Q. What type of samples? You mean pharmaceutical samples that salesmen might drop off?

A. Yes.

Q. Any other type of material?

A. Sometimes he would pick up my laundry for me.

Q. Well, relating to medicine, would patients ever bring in syrups or pills into Dr. * * * office?

A. Yes.

Q. Well, would these ever go to Mr. * * *,
these syrups or pills the patients would bring in?

A. Yes.

Another employee agreed that the box contained mainly sample pills and syrups.

Q. * * *, do you know what an injectable is, something that you inject into a patient rather than give the patient orally?

A. An injectable?

Q. Yes, an injectable is a drug that you might inject into a patient.

A. Yes.

Q. As opposed to something you might take like a pill or some syrup.

A. Yes.

Q. All right. What type of items would go into the box? What type of samples, pills or syrups or injectables?

A. Mainly pills and syrups.

The pharmacy's deliveryman recalled picking up only outdated vaccine and specifically denied ever taking pills and syrups. He recalled picking up samples only between one and three times a year. While the drugstore's employee maintained that he personally placed the medication in a trash receptacle, a real possibility exists that these

items were redispensed. In addition to this possibility, the Commission has received material from the State Division of Consumer Affairs indicating that the pharmacy had been billing the Medicaid program for expensive brand name drugs while actually dispensing cheaper "look-alike" generic drugs.

Another abuse involved the short-circuiting of normal checks and balances between the pharmacy and recipients. The pharmacy's deliveryman would take the prescriptions to the facility's patients. The Medicaid claim forms acknowledging receipt of and requesting payment for the medication were not signed by the recipients. They were pre-signed in the patient's name by another pharmacy employee. With such a procedure, there is no need for the recipient to ever see the claim form and no way for the recipient to compare drugs billed on his behalf with drugs actually received.

All of the facilities and pharmacies mentioned above were involved with others in an ingenious scheme designed to maximize personal profits. A lay entrepreneur who owned substantial interests in several medical centers banded together with a relatively small group of physicians, pharmacists and clinical laboratory operators to form a company which would arrange for laboratory tests to be performed and repackage and resell relatively inexpensive generic drugs under its own brand name. Stockholders included the physicians who would write prescriptions for their corporation's products and lay medical facility owners. With each prescription and sale, stockholder equity in the corporation increased. Questions of product quality aside, such a situation raises grave questions

of conflict of interest and temptation to overutilize scant Medicaid program funds.

The Commission's investigation also surfaced what appears to be a new trend in the medical center-pharmacy alliance. More and more centers are opening with on-site pharmacies whose hours of operation exactly coincide with those of the facility. These pharmacies often "rent" small amounts of floor space at high rates and share waiting room and entrance space with physicians. Because these pharmacies cater almost exclusively to center patients, they are able to concentrate upon maintaining an inventory of only those items which center physicians prescribe. Thus, they may qualify for volume discounts or institutional rates on drugs purchased and at the same time save monies by not stocking drugs facility physicians do not commonly prescribe.

Problems of steering are exacerbated in physician groups having an on-premises pharmacy. At one facility the in-house pharmacy "rented" some 225 sq. ft. of space for in excess of \$1050 per month. Entrance to the pharmacy was via the facility's door and waiting room. A plexiglass partition separated the two areas and prevented the patient from physically entering the pharmacy. Employees of the facility testified that it was the practice of the lay administrator to approach patients following an examination and say in English or in Spanish, "You can obtain the prescription at the pharmacy and you can wait in the waiting room," or "Honey, could you please take your prescription to the pharmacy and then have a

seat outside." Another facility employee told of instructions to direct patients to the pharmacy which were given by the lay administrator.

Q. Would Mr. * * * instruct any of the girls or any of the doctors to send the patients in to the pharmacy?

A. Especially he told me himself.

Q. Mr. * * * told you to send patients to the pharmacy?

A. Right.

Q. What did he tell you?

A. When the pharmacy was open, he go straight to the lab and he told me that they should tell the patient to go to the pharmacy to pick up the prescription.

Q. And along with his instructions, did you tell the patients to go to the pharmacy?

A. It was in front of the patient and most of the patients understands a little bit in English.

Q. So you didn't have to tell them, they heard?

A. Right.

The same employee, who was neither a State licensed registered nurse (RN) or practical nurse (LPN) -- described another ploy used upon patients to insure that prescriptions would be filled at the in-house pharmacy:

Q. Did you ever hear any of the other doctors who worked at the * * * Health Group telling patients to go into the pharmacy with their prescriptions?

A. No, only if the patient had to have penicillin injection I am. So then I have to tell the patient to go to the pharmacy and get it and bring it back to the lab. Then I give it to the patient.

MR. DICKSON: Off the record.

(Whereupon, there is a discussion off the record.)

A. (Continuing) The patient handed the needle, right.

Q. The patient handles the needle, yes.

A. And back again to the lab.

Q. Where you are?

A. I am right in my office. I call my office, anyway. I give the needles to the babies or the patients. Is the patient from Dr. * * * [the internist], sometime I give the needle for them, right, or the babies.

Q. But you have to tell the patient first you have to go to the pharmacy?

A. Yes

Q. To get the penicillin?

A. Yes, they have to go there and sign, and the girl in the pharmacy give it to the patient. The patient come inside again and I give it to the patient.

When the patient presented the prescription for the injectable at the pharmacy window, another employee would request all other prescriptions and promise that these could be ready for pick-up after the injection was given.

The facility also maintained a double standard as to whether a charge would be made for injectable drugs. Private patients would not be charged for injectables while the taxpayers picked up the bill for injectables given to Medicaid recipients. An employee described the practice as follows:

Q. Now, Mrs. * * *, suppose a Medicaid patient comes in and he needs an injection of penicillin. What would happen?

A. Then the doctor give the prescription and the patient go to the pharmacy. We tell the patient, "Get in the pharmacy, get the needle," you know, because for the patient it's very easy to tell that way, and come back to the lab and I give it, the needle, to the patient.

Q. And at the pharmacy would the patient sign a Medicaid form for the penicillin?

A. Yes, they have to sign.

Q. So Medicaid would be billed for the penicillin injection, right?

A. Right.

Q. Now, suppose a private patient came, somebody who didn't have Medicaid or Medicare but was going to pay cash, and suppose the private patient needed an injection

of penicillin. What would happen?

A. Well, we have a salesman supply some samples, right, and we got some sample, you know, for like we have 600 dozen units of penicillin and we keep it for special patient you know, private patient, and we supply, you know. Like a doctor do a little favor, save a little money.

Q. No charge?

A. No charge.

Q. So the Medicaid patients would have to pay for the penicillin and the other injectables, right?

A. If the doctor order, yes, yes.

Q. Yes.

A. Like Detanusdozide, D-e-t-a-n-u-s-d-o-z-i-d-e.

Q. My point is, if it's a Medicaid patient, Medicaid gets billed for the injectable; but if it's a private patient, then the patient doesn't get billed for the injectable, it comes with the visit, right?

A. Right, right, yes.

A physician-partner of the facility was questioned concerning allegations of abuse involving pharmacy and center staff. The testimony was as follows:

EXAMINATION BY MR. DICKSON:

Q. Doctor, we spoke about the pharmacy being located on the premises at one point in our discussions today. Are you aware of any circumstances where anyone in the

* * * Health Group would direct patients of the * * *
Health Group to the pharmacy in order to have prescriptions
filled?

A. I plead the Fifth and Fourteenth Amendments.

Q. Have you ever had occasion to hear Mr. * * *
[lay administrator] speak to * * * Health Group's -- I'm
sorry -- * * * Health Group patients in Spanish
and direct them to the * * * Medical Pharmacy?

A. I plead the Fifth and Fourteenth.

Q. Would you sometimes write prescriptions
for injectables?

A. Yes, I would.

Q. What would you do with prescriptions for
injectables?

A. The same thing that I gave -- that I did with the
prescriptions for oral medication; gave it to my nurse.

Q. Would your nurse indicate to the patient that an
injectable should be obtained from the * * * Medical
Pharmacy and brought back to you so that an injection could
be administered?

A. I plead the Fifth and Fourteenth Amendments.

Q. Doctor, did Mr. * * * or anyone else at the * * *
Medical Group or Medical Pharmacy suggest to you that
Medicaid patients should be regularly given vitamins?

I'm getting a mixed response.

ATTORNEY: You're not getting any response yet.

A. I plead the Fifth and Fourteenth Amendments.

Q. Did Mr. * * * or anyone else at the * * * Medical Group or Medical Pharmacy give you suggestions or advise as to prescribing vaporizers for patients of the * * * Health Group?

A. I plead the Fifth and Fourteenth Amendments.

The Commission has received material from the State Division of Consumer Affairs indicating that the subject pharmacy short-weighted or short-counted medications going to Medicaid recipients. Information from the Division of Medical Assistance and Health Services suggests over-prescribing of vitamins, preparations and vaporizers.

In another pharmacy, which had a direct telephone link to a doctor's office, evidence of the following additional abusive practices came to light: Medicaid recipients were required to sign forms in blank and prior to receiving medication; billing Medicaid for drugs not dispensed; billing Medicaid for drugs covered by the program and dispensing a drug not so covered; tracing recipients' signatures from old claim forms onto blank forms and billing for drugs allegedly supplied to recipients who were deceased.

A major step in reducing program costs was taken during the pendency of the Commission's probe by the Division of Medical Assistance and Health Services. Under present regulations, generic

rather than brand drugs should be prescribed and dispensed whenever possible. Additional steps can be taken to further reduce abuse and unnecessary expenditure of limited program monies. The Division currently has the computer capability to develop a prescriber profile on Medicaid program physicians. This program would analyze prescribing patterns of physicians and display questionable or abusive practices. Unfortunately, the profile is not effectively used because program providers choose not to supply necessary information on claim forms. We recommend that the Division assume a tough stance on this issue and reject for payment any claims not containing relevant information.

To facilitate the gathering of information relevant to program integrity, we suggest that a standard Medicaid multi-copy prescription/claim form be developed. The name of the prescribing physician could be pre-stamped on the form. The physician should list the medication desired and draw a line immediately under the last item prescribed and personally sign the form. Space can also be provided for the physician to list a substantiating diagnosis. A copy can be kept for the physician's record and the balance forwarded to the pharmacy via the patient for use as a description of drugs to be dispensed and the pharmacist's billing invoice.

Existing program regulations prohibiting the referral of patients to a particular pharmacy by physicians should be broadened to encompass all facility employees and stringently enforced. It should be made clear to all that the physician may not require nor

RECOMMENDATIONS

may he recommend that a prescription be filled by a particular pharmacy; nor may his receptionist or any employee do so. Patients who ask must be reminded of their free choice of pharmacy. Any liaison -- including direct telephonic connection and common entranceway -- between physician and pharmacist should create a presumption of impropriety. Landlord-tenant and other relationships between physicians and pharmacists should be subjected to special scrutiny as to pharmaceutical utilization.

Landlord tenant relationships present perhaps the greatest temptation to overutilize pharmacy services. Even without direct steering by facility staff, patients are usually required to pass the pharmacy entrance to pick up coats or children before arriving at the public street. The in-house pharmacy truly has a "captive" audience. For this reason, the common entranceway should be prohibited. Moreover, when a physician or landlord owns a pharmacy or has a pharmacy for a tenant, he is induced to take whatever steps are necessary to see that the pharmacy succeeds. In-house pharmacies also present opportunity for profit based upon the precise nature of inventory kept and the ability to obtain volume discounts on drugs. We recommend that the Division take these savings into consideration along with the fact that in-house pharmacies primarily -- if not exclusively -- service patients of the facility and reimburse these pharmacies at a lower institutional pharmacy Medicaid rate. We further suggest that the professional boards in their licensing schemes take into account the great potential for overreaching present when pharmacies enter into financial relationships with physicians located on the same premises.

RECOMMENDATIONS

The Commission has already recommended substantial changes in program legislation and administrative practices and procedures in previous reports on nursing homes, independent clinical laboratories and hospitals participating in the New Jersey Medicaid Program. Many of these previous recommendations -- such as those calling for criminal sanctions against kick backs, establishment of a scheme of financial penalties for incidents of fraudulent conduct, subpoena power and accountants for the Division of Medical Assistance and Health Services, and increased monitoring of fiscal agent actions -- have effect in several program component areas. We take this opportunity to supplement the record with recommendations pertinent to the administration of the physician groups aspect of the program.

1. Shared Health Care Facilities receiving substantial amounts of Medicaid funds should be identified and annually approved for program participation by the Division of Medical Assistance and Health Services. Practitioners rendering service and the facility at which service is rendered should clearly be identified. We have reviewed proposals drafted by the Division of Medical Assistance and Health Services to achieve these goals and concur with their substance (see appendix for copy). We pause, however, to add our own suggestions.

D. Prohibited Practices, - Administrative Requirements

1. Percentage letting prohibited -- The rental fee for letting of space to providers in a shared health care facility

OR THE REMUNERATION OF PROVIDERS FOR SERVICES IN SUCH FACILITY shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located. A copy of each lease OR DETAILS OF ANY AGREEMENT BETWEEN THE FACILITY AND ANY PROVIDER and any renewal thereof shall be filed with the Division.

5. The Commission understands that the separate entrance requirement imposed by this section is applicable to in-house pharmacies.

6. Claims-- All provider claims submitted for services rendered at a shared health care facility shall (a) contain the registration code of the facility at which the service was performed and (b) be PERSONALLY signed by the practitioner who rendered service (c) CONTAIN THE CODE NUMBER OF THE PHYSICIAN WHO RENDERED THE SERVICE, (d) BE PERSONALLY SIGNED BY THE PATIENT WHO RECEIVED THE GOODS OR SERVICE.

8. Orders for ancillary clinical services -- ALL orders issued by providers for ancillary clinical services, including, but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the

registration code of the facility at which the order was written AND THE CODE NUMBER OF THE PROVIDER REQUESTING THE SERVICE OR GOODS. A LINE SHALL BE DRAWN UNDER THE LAST GOOD OR SERVICE REQUESTED AND THE DIAGNOSIS JUSTIFYING THE REQUEST AND REQUESTING PROVIDERS PERSONAL SIGNATURE SHALL BE PLACED BELOW THAT LINE.

10. DIRECT TELEPHONIC LINKS BETWEEN PROVIDERS IS PROHIBITED.

11. PROVIDERS SHALL NOT ORDER ANCILLARY CLINICAL SERVICES FROM PROVIDERS IN WHICH THEY HOLD A FINANCIAL INTEREST.

12. PROVIDERS SHALL NOT SUBMIT CLAIMS TO MEDICAID WHO ALSO CLAIM REIMBURSEMENT FOR IDENTICAL SERVICES FROM ANOTHER THIRD PARTY PAYOR. ALL INFORMATION REQUESTED CONCERNING POSSIBLE THIRD PARTY LIABILITY SHALL BE LISTED ON CLAIM FORMS.

2. We strongly recommend that the Division obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. Evidence of improprieties gathered by these agents could and should be aggressively used by the DIVISION in suspension hearings or passed along for the review of appropriate law enforcement agencies.

3. Medicaid recipients should be made aware of services billed to the program on their behalf and be given an opportunity to challenge the accuracy of physicians requests for reimbursement.

Lastly, and perhaps most importantly, we recommend that there be constant and close coordination between Division Surveillance personnel and those responsible for the review and promulgation of administrative regulations applicable to program providers. Many of the abuses identified by the S.C.I. were previously found by surveillance personnel, and passed along for further action. Unfortunately, in many instances warnings of potential wide-spread abuse noticed by the Bureau of Surveillance and passed along to others seem to have fallen through the cracks of bureaucracy. The Commission notes that conditions have improved and many aggressive, explicit regulations have been promulgated during the course of our own investigation by new Division leadership. We fully expect that such efforts will continue.

Copies of the investigative record compiled by the Commission in this probe will be forwarded to the State Attorney General, the United States Attorney for the State of New Jersey, the State Board of Medical Examiners, the State Board of Pharmacy, the Division of Medical Assistance and Health Services and the State Legislature for further review and consideration.

APPENDIX

REQUIREMENTS APPLICABLE TO SHARED
HEALTH CARE FACILITIES

A. DEFINITIONS: (When used in this Item)

1. Department shall mean the Department of Institutions and Agencies.
2. Division shall mean the Division of Medical Assistance and Health Services.
3. Program shall mean the New Jersey Health Services Program.
4. Shared Health Care Facility shall mean two or more providers delivering health care, either independently or in association with each other, within a single structure and (a) two or more of whom share any of the following: common waiting areas; examining rooms; treatment rooms; equipment; supporting staff; any shared space; or common records, and (b) one or more of whom receives payment on a fee-for-service basis.
5. Provider shall mean any person, firm, corporation or other entity providing services under the Program.
6. Purveyor shall mean any person, firm, corporation or other entity who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users any medical supplies, equipment and/or services for which reimbursement under the Program is received, including, but not limited to, clinical laboratory services or supplies; x-ray laboratory services or supplies; inhalation therapy services or equipment; ambulance services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eye glasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment.
7. Patient shall mean anyone eligible to receive benefits from the Program.

B. APPLICATION OF ITEM:

1. This Item shall apply to shared health care facilities as defined herein and to the providers located in a specific health care facility.
2. This Item shall apply to purveyors, whether or not located in a building which houses a shared health care facility.
3. Nothing in this Item shall apply to an association of health care practitioners delivering health services on other than a fee-for-service basis.

C. REGISTRATION OF SHARED HEALTH CARE FACILITIES:

1. No shared health care facility shall be operated under the Program unless the owner or, if the structure in which the shared health care facility is located has been leased, the person who leases space in the shared health care facility, has registered such facility with the Division. Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to:

a. The name and residence address of every person, partnership or corporation having any financial interest in the ownership (including leasehold ownership) of the structure and of the shared health care facility.

b. The name and residence address of every person, partnership or corporation holding any mortgage, lien, leasehold or any other security interest in any equipment located in and used in connection with a shared health care facility and a brief description of such lien or security interest.

c. The name, residence address and professional license number of every practitioner working in the shared health care facility. This information shall be maintained on a current basis. Division shall be notified of any change in the status of practitioners within the shared health care facility.

d. The name, residence address and professional qualifications of the individual designated to assume responsibility for the central coordination and management of the shared health care facility's activities.

2. The registrants shall re-register on the June 1 next following the initial registration and annually thereafter on June 1.

3. The Division shall be notified by the shared health care facility of any change in:

a. The persons, partnerships or corporations having any financial interest in the ownership (including leasehold ownership) of the shared health care facility, or

b. The persons, partnerships or corporations holding any mortgage, lien, leasehold or any other security interests in any equipment located in and used in connection with a shared health care facility. A statement of the monetary and repayment provisions of that lien or security interest shall accompany such notification.

4. The Division shall be notified within fifteen days of the termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility's activities. The division shall also be notified within fifteen days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility.

5. The Division shall be notified within fifteen days of any termination of the services of any practitioner in the shared health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

D. PROHIBITED PRACTICES; ADMINISTRATIVE REQUIREMENTS:

1. Percentage letting prohibited -- The rental fee for letting of space to providers in a shared health care facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located. A copy of each lease and any renewal thereof shall be filed with the Division.

2. Referral fees prohibited -- No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for:

a. Recommending or procuring goods, services or equipment of such purveyor or provider for any other person, or

b. Directing patronage or clientele to such purveyor or provider, or

c. Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

3. Patient referrals --

a. No provider in a shared health care facility or person employed in such facility shall refer a patient to another provider located in such facility unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral.

b. Every provider practicing in a shared health care facility who treats a patient referred to him by another provider practicing in the same facility shall communicate in writing to the referring provider the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record.

c. The invoice submitted to the Program by the provider to whom such patient has been referred shall (1) contain the full name and provider number of the referring provider and (2) identify the medical problem which necessitated the referral.

4. Pharmacy notice -- Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the Program may be obtained at any pharmacy of the patient's choice enrolled in the Program in the city.

5. No entrance on the premises by purveyors -- No purveyor who maintains a business in the building in which a shared health care facility is located shall maintain a door or window opening into the offices or waiting room of the shared health care facility, except where the profession of the provider permits the provider to function simultaneously as a purveyor.

6. Claims -- All provider claims submitted for services rendered at a shared health care facility shall (a) contain the registration code of the facility at which the service was performed and (b) be signed by the practitioner who rendered service

7. Billing -- In a shared health care facility, procedure code 9000 (Initial Office Visit) or 9580 (EPSDT), or 9001 (Comprehensive Office Visit) may be billed only once. All referrals within the shared health care facility will be billed as 0001 (Routine Office Visit), 0005 (Brief Office Visit), or 9007 (Prolonged Office Visit). Use of 9029 and 9030 Consultation codes are prohibited. If an ophthalmologist is a member of the shared health care facility and a comprehensive eye examination, including refraction, is performed, then procedure code 5400 may be used.

8. Orders for ancillary clinical services -- All orders issued by providers for ancillary clinical services, including, but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the registration code of the facility at which the order was written.

9. Fee splitting prohibited -- It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred, except where the paying of a fee is compensation for services rendered to the patient.

D. QUALITY OF CARE REQUIREMENTS:

1. To ensure quality, continuity and proper coordination of medical care each shared health care facility shall:

a. Designate an individual, who, on a full-time basis, shall coordinate and manage the facility's activities. The person so designated shall be responsible for compliance with the provisions of this Item.

b. Devise an appropriate means of insuring that (1) patients will be scheduled to return for appropriate follow-up care and (2) will be treated by a practitioner familiar with the patient's medical history.

c. Post conspicuously the names and scheduled office hours of all practitioners practicing in the facility.

d. Maintain proper records. Such records shall contain at least the following information:

(1) The full name, address and Medicaid number of the patient.

(2) The dates of all visits to all providers in the shared health care facility.

(3) The chief complaint for each visit to each provider in the shared health care facility.

(4) Pertinent history and all physical examinations rendered by each provider in the shared health care facility.

(5) Diagnostic impressions for each visit to any provider in the shared health care facility.

(6) All medications prescribed at each visit to any provider in the shared health care facility who is qualified to issue prescriptions.

(7) The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility.

(8) All x-ray, laboratory work and electrocardiograms ordered at each visit by any qualified provider in the shared health care facility.

(9) The results of all x-ray, laboratory work and electrocardiograms ordered as in "8" above.

(10) All referrals by providers in the shared health care facility to other medical practitioners and the reason for such referrals, and date of referral.

(11) A statement as to whether or not the patient is expected to return for further treatment

e. Inspection of records -- The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

f. Names of providers to be filed with Division -- Every shared health care facility shall file with the Division the name of each provider or purveyor currently rendering services in such facility. If any provider vacates a facility or a new provider is added therein, such change shall be reported to the Division by registered mail within fifteen days of such change.

EXHIBIT "B"

It is recommended that a committee of staff and contractor personnel be formed to analyze and prepare a report recommending changes in existing computer capability related to provider identification and service tracking. Specifically, this committee suggests reducing the provider number from a 9 digit code to a 5 digit code, thereby allowing utilization of the remaining 4 digits to identify the provider group and the individual practitioner who rendered the service. It is believed that other applications of the 5-4 digit system could be developed. Although this recommendation is extremely general, it should serve as the starting point for the committee to commence its work.

JJP:vm

