American College of Physicians–American Society of Internal Medicine

Statement for the Record to the

Health Task Force
Committee on the Budget
United States House of Representatives

Medicare Regulatory Burden Imposed on Physicians

May 25, 2000

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), representing over 115,000 physicians and medical students, appreciates the opportunity to submit a statement for the record to the Health Task Force of the Committee on the Budget on the regulatory burden the Medicare program imposes on physicians. ACP–ASIM commends the Task Force for its interest in this issue as it is imperative that the regulatory environment protect the integrity of the Medicare program without imposing an undue burden on physicians.

Medicare regulations are vast as physicians must navigate over 100,000 page of regulations pertaining to Medicare alone. A number of these regulations, such as those issued by Medicare carriers, are updated frequently. Physicians are concerned that the government’s focus on fraud and abuse has increased at a time when Medicare regulations are becoming more and more complex. The government needs to ensure that billing errors are not treated as fraud and abuse. Internists frequently tell us that they will go to jail for the simplest of mistakes. Although we explain that the standard for demonstrating fraud and abuse is much higher, the government should be troubled that this perception is so widespread.

ACP–ASIM has worked with the Department of Health and Human Services Office of Inspector General (OIG) over the past year to ensure an appropriate anti fraud and abuse message. We have also attempt to allay internists’ concerns about overzealous prosecution by presenting statistics showing that the government prosecutes very few physicians for fraud and abuse. We believe that we have made significant progress toward raising awareness among Medicare beneficiaries and the public regarding fraud and abuse while conveying that the vast majority of physicians are honest. We expect to continue our on-going dialogue with the OIG.

However, physicians will remain concerned that they are at risk to be investigated for fraud and abuse if the complex regulatory environment, which practically prohibits full compliance, remains unchanged. The OIG has an obligation to enforce the regulations that are in effect. We believe that the complexity of the regulatory environment is the root of the problem and that the government should commit to simplifying it.

The government can demonstrate its commitment to simplifying the current regulatory environment by: (1) streamlining Medicare regulations; (2) improving how regulations and regulatory updates are communicated to physicians; and (3) improve physician education regarding Medicare regulations.
Further, we want to bring a several specific issues that are within the jurisdiction of the Health Care Financing Administration (HCFA) to the Health Task Force’s attention. These issues are: (1) documentation guidelines for evaluation and management (E/M) services; (2) assessing Medicare carrier performance; (3) the Medicare medical review process; and (4) proprietary, black box coding edits. We believe these issues deserve Congressional intention as they are especially problematic for practicing physicians. We urge HCFA to adopt our recommendations and ask Congress to provide oversight.

**Need to Streamline Regulations**

The overall volume of Medicare regulations is tremendous. A document prepared by the majority staff of the House Committee on Budget puts the number of regulations at over 110,000 pages. This figure includes HCFA manuals, carrier Part B manuals and newsletters, fraud and abuse regulations, etc.

A significant portion of Medicare regulations are updated regularly. The experience of a physician who practices in Kansas illustrates the magnitude of the regulatory workload faced by physicians. The Kansas Medicare carrier regularly communicates policies to its physicians through: a Part B Physicians’ Manual; Local Medical Review Policies (LMRPs); and Medicare communiqués. These communications are not user friendly and that the sheer volume of regulatory instructions is overwhelming. The annual volume of regulations can most easily be measured by their height when stacked together. The Kansas carrier’s Part B Physician’s manual is approximately two and a half inches thick. The compilation of LMRPs totals about four inches. A binder containing the communiqués, which are sent out once or twice a month, is about three-quarters of an inch thick.

Congress should establish a task force comprised of representatives from all agencies with Medicare jurisdiction as well as representatives from the physician community and charge it with compiling all Medicare directives into one accessible source. Overly burdensome regulations identified during this comprehensive review could be eliminated. All Medicare regulations should be contained in a single source (or as few sources as possible). A single entry could contain references to multiple laws as appropriate. However, a concentrated source of information is necessary to ensure consistency of information and to reduce the burden on physicians—reducing their costs and providing them more time to treat patients.

Streamlining regulations and compiling them into one accessible source will make it easier for physicians to adhere to Medicare directives. We believe that framework could be modeled after the HCFA Physician Regulatory Issues Team (PRIT). The PRIT is comprised of individuals from various departments within HCFA. It was formed to assess the totality of Medicare regulations and issue recommendations for improvement. However, it is our understanding that the PRIT has yet to make significant progress.

One of the few finding announced by the PRIT is that physicians view all Medicare regulations as “government” regulations; they do not associate specific regulations with the agency that
promulgates them. This supports our contention that a review of Medicare regulations should be coordinated among all agencies with jurisdiction.

The Congressionally-established inter-agency task force we are proposing should be more open than the PRIT. It should seek broader physician input. We believe that the best way to assess the impact of regulations is to ask those who must adhere to those regulations. The inter-agency task force should provide frequent updates to Congress and the public regarding its progress.

**Need to Improve How Information is Disseminated to Physicians**

Requirements are communicated to physicians in a disjointed and ineffective way. Dissemination of LMRPs, which are policies that are specific to a particular Medicare carrier’s area, are especially problematic. When LMRPs are updated, typically, only the changes are listed in the materials sent to physicians. The original policy is rarely updated and published in its entirety. The result is that individual practices have to update the original policies in their files to maintain accurate information, which makes it virtually impossible for physicians to learn LMRPs. Even the most well-informed physicians have difficulty keeping apprised of changing Medicare regulations.

Physicians find it extremely difficult to keep track of ever-changing Medicare regulations while treating patients. The problem is compounded for physicians in small group and solo practices, which make up the majority of rural practices. They do not have the staff to keep up with constantly changing rules. Although physician involvement in comprehending and applying regulations is likely to vary according to practice size, all physicians must be mindful of the universe of Medicare regulations. The magnitude and complexity of regulations is compounded for physicians that are covered by more than one carrier jurisdiction. Keeping track of the morass of Medicare regulations detracts from the time physicians have available to treat patients.

A single source for Medicare regulations that would result from an inter-agency effort will greatly enhance physicians’ ability to adhere to regulations.

**Need to Improve Physician Education**

*Medicare Carrier Provider Education and Training*

**Congress should allocate additional funding for Provider Education and Training to help physicians adhere to Medicare regulations.** We are concerned that funding for carrier educational activities has failed to increase as regulations have become more voluminous and complex. The Administration’s proposed fiscal year 2001 budget allocates $15.8 million for Provider Education and Training. The proposed Provider Education and Training 2001 funding level equals the $15.8 million that was allocated for fiscal year 2000 and represents approximately 1% of the 2001 $1.3 billion contractor budget request.

*Medicare Integrity Program Physician Education Contact*
ACP–ASIM is pleased that HCFA is addressing physician education early in its implementation of the Medicare Integrity Program (MIP), recently selecting a contractor to implement the physician education task order.

HCFA must use the physician education task order to find mechanisms to get information to physicians and other providers in a useful and manageable way. Our understanding is that the contractor plans to assess current educational efforts and then develop and implement educational tools. HCFA must maintain its commitment to this process as it evolves. HCFA must also be committed to adequately funding the physician education initiative.

Further, it is essential that HCFA coordinate its education efforts agency-wide. It would be counterproductive for a segment of the agency’s program integrity group to take actions that would undermine contractor physician education. For example, it would be inappropriate for the program integrity group to instruct carriers to issue overpayment requests based on extrapolating the results of a post-payment medical review if the contractor developed an educational approach to conducting review on those who have been audited for the first time. Similarly, other departments within HCFA must avoid contradicting physician education initiatives.

**Specific Regulatory Issues Worthy of Congressional Oversight**

*Documentation Requirements for Evaluation and Management Services*

Although ACP–ASIM is encouraged that HCFA is attempting to work with medical societies to improve the documentation guidelines for evaluation and management (E/M) services, the guidelines that were released in 1997 and currently in place dramatically increase the administrative burden.

- The guidelines require physicians to spend a significant amount of time selecting which code to bill and documenting extensively to satisfy the comprehensive guidelines.

An internist who carefully reviewed the 1997 guidelines calculated the number of decisions that a physician must make before selecting a level of E/M service and billing Medicare. There are 11 decision points in categories to consider before selecting an E/M code. Each decision point requires several choices. There are 42 choices a physician must consider before selecting the proper level of E/M service. There are 6,144 possible combinations representing the number of ways an office visit for a new patient can evolve and be classified.

A physician must spend time documenting in the patient’s record in addition to spending time deciding what is the appropriate level of service to bill. The guidelines put an undue excessive documentation burden on physicians for the sole purpose of billing, not for quality medical care. The guidelines force physicians to spend less time with their patients and more time with the patients’ charts.

We expect that HCFA will soon announce at least its preliminary intent regarding the content of revised guidelines. **Congress should ensure that the documentation standard selected by**
HCFA imposes a minimal regulatory burden. The Medicare Payment Advisory Commission’s (MedPAC) agrees. MedPAC’s 2000 report to Congress on Medicare Payment Policy MedPAC specifically states that “HCFA will need to consider avoiding overly complex and burdensome requirements for physicians, such as counting formulas that assign points for each element of a physician’s service to determine the level at which services can be billed.” It recommends that “HCFA should continue to work with the medical community in developing guidelines for evaluation and management services, minimizing their complexity, and exploring alternative approaches to promote accurate coding for these services.”

HCFA has also committed to pilot testing the guidelines before they are fully implemented. The agency has yet to announce specific pilot testing approaches. ACP–ASIM recommends that any HCFA pilot test of the eventual guidelines should assess the amount of time physicians spend writing or dictating a patient’s chart note to satisfy the guidelines. Guidelines that require physicians to spend too much time documenting information (beyond what is necessary for on-going care of the patient) unnecessarily interfere with patient care.

We also believe that HCFA should pilot test alternatives to the guidelines, such as allowing physicians to use time spent with the patient to determine what code to bill (while meeting a less onerous documentation standard). Academic research on this issue generally shows that time is a valid proxy for the amount of physician work involved in providing an E/M service.

In its 2000 report to Congress, MedPAC recommends that HCFA “should pilot-test documentation guidelines” and “continue to work with the medical community in developing the pilot tests, and should ensure adequate time for physician education.”

Congress should also investigate as to whether more aggressive auditing of E/M services coupled with heightened fraud and abuse concerns have caused physicians to under bill for their E/M services. The MedPAC report demonstrates how past annual OIG financial audits of HCFA have led to intensified review requirements on physicians, possibly leading to undesirable changes in coding. MedPAC notes that beginning in 1998, “decreases began to occur for almost all types of E/M coding. This change occurred simultaneously with several factors, including heightened attention to the fraud and abuse issues in the Medicare program and random audits investigating documentation of E/M claims.” The report notes that “results from the Chief Financial Officer’s (CFO) audit of FY 1996 Medicare spending prompted HCFA to address concerns about the adequacy of documentation for services billed. Random audits grew from this impetus and the results of this and the subsequent two CFO audits further focused attention on fraud and abuse issues.”

MedPAC observes that it is unclear why the change in 1998 occurred, saying that “it may reflect a return to a more appropriate level of coding” or “alternatively, the change may indicate the beginning of downcodeling, that is physicians erring on the side of being overly cautious. This downcodeling may be inappropriate, given that the beneficiary population is older and in poorer health and that Medicare+Choice programs generally draw low-risk individuals from the traditional program. These dynamics would predict a trend toward higher-level E/M codes.”
Physician Input Into Medicare Carrier Performance

HCFA should establish a mechanism to assess valid regulatory hassles imposed by a specific policy or by carrier misinterpretation of HCFA policy identified by state and/or national medical societies. Carrier misinterpretation of national Medicare policy is problematic. Carriers are unlikely to recognize that their interpretation of a national policy is incorrect, leaving physicians no outlet to address their concerns. There are numerous instances in which a carrier(s) implemented a policy that inappropriately denied or reduced payment for services that were billed correctly.

We believe that HCFA can best identify hassles imposed by the current regulatory environment by listening to the concerns of individual physicians through their state and/or national medical society. Frustrated, rank-in-file physicians need a mechanism to address valid concerns. It is imperative that a process be established to listen and respond to these concerns so that physicians do not feel that the government is unresponsive to their legitimate concerns.

We envision that medical societies would only bring well-documented problems and/or carrier misinterpretations of national policy to the attention of the HCFA central office. We do not envision that frivolous or trivial policy matters would be brought to the attention of the HCFA central office. The HCFA central office would only become involved if a problem could not be resolved at the carrier or regional office level.

As noted above, it is our understanding that the HCFA regional offices are vital to addressing physician concerns regarding carrier policy. Individual physicians and their medical society representatives can have difficulty in locating appropriate regional office staff. The HCFA central office should designate a Medicare liaison in the each regional office to serve as a contact for medical societies and individuals. HCFA should make contact information available through its http://www.hcfa.gov Internet site. Providing medical societies access to central and regional office officials encourages dialogue and collaborative efforts to solve legitimate problems.

Maintaining a mechanism to collect and assess concerns about carrier actions will enable HCFA to be more informed regarding the performance of its carriers. The General Accounting Office (GAO) recently issued reports detailing HCFA’s general lack of oversight of its Medicare carriers and other contractors. HCFA cannot fully evaluate its carriers if it lacks a mechanism to collect documented inappropriate carrier actions. Also, the lack of such a mechanism unnecessarily antagonizes physicians by making it difficult for them to get relief for their valid concerns.

Further, HCFA communicates policy instructions to its Medicare carriers through Program Memoranda and other transmittals, which are then implemented by the carriers. HCFA should ensure that these instructions are clear to avoid misinterpretations. The instructions HCFA sends to its Medicare carriers should be reviewed by practicing physicians to promote clarity and to assure that the regulatory burden is minimized.
Medicare Medical Review Process

The Medicare medical review process is a major concern of physicians. ACP–ASIM is encouraged that HCFA has contracted with the consulting firm of PricewaterhouseCoopers (PwC) to make recommendations to improve the effectiveness and the efficiency of medical review. We await the results of the contractor’s report. However, the current medical review process denies physicians their due process. The design also coerces physicians into entering into a settlement with their carrier. Physicians often have a disincentive to prove their billing is appropriate as the legal costs involved in appealing an audit determination can rival the amount in question as the overpayment amount is often determined by extrapolating the results of a small sample.

Carriers should use detailed statistical analyses of severity-adjusted provider billing patterns to identify true outliers. Outliers who fail to exhibit egregious behavior should receive educational coding assistance before being subjected to comprehensive audits. While improved technology makes this possible, it is essential that carriers share the results of statistical analyses with providers and use them in a constructive manner.

HCFA should standardize the process for how carriers conduct medical review. The process then needs to be clearly communicated to physicians. Currently, carriers have wide latitude when conducting physician audits.

Program integrity entails paying claims appropriately in addition to detecting and preventing fraud and abuse. Carrier-initiated medical review should be furnished by a physician licensed in the same specialty as the physician whose claim(s) is under review. Also, appeal of overpayment requests over a certain monetary threshold should be conducted by an independent organization, such as the state Peer Review Organization. These steps would inject fairness and give physicians more confidence in the Medicare medical review process. HCFA should use the stable source of funding provided by Congress for the Medicare Integrity Program to assure fairness in medical review activities.

Physicians should be able to retain their appeal rights without opening themselves up to a more comprehensive audit. Currently, physicians must open themselves up to a review of the patient records pertaining to all claims for the identified service(s) over an open-ended period of time simply to maintain their appeal rights. In addition to opening oneself up to such a practice-disrupting audit, physician can accumulate substantial legal costs.

Physicians should not have to repay carrier-determined overpayment amounts until they exhaust all appeal rights and an accurate overpayment amount has been established. Currently, physicians must repay overpayments within 30 days even if the case is under appeal.

Proprietary, “Black Box” Coding Edits

ACP–ASIM opposes the use of proprietary Commercial Off-the-Shelf Software (COTS), known as “black box” coding edit systems. Congress should instruct HCFA to refrain from entering into contracts with entities that maintain proprietary editing systems. Also, Congress
should instruct HCFA to disclose all existing proprietary coding edits. We believe that such a closed edit system is inappropriate. The Medicare Correct Coding Initiative (CCI) demonstrates the need for a coding edit system that is open to peer review. ACP–ASIM and other medical organizations often identify numerous inappropriate coding edits in each proposed version of the CCI when HCFA distributes it for public review. Ideally, inappropriate edits are deleted or altered before they are implemented. The end result is that the claims payment system is more accurate because it had been appropriately peer reviewed. Many inappropriate edits would remain if the CCI was a closed system, which would deny payment for appropriately provided services.

While we understand that proprietary, black box coding edit systems are used to save money, we point out that the appropriateness of these edits cannot be judged solely on their ability to generate savings by denying payments to providers. The OIG report, “Using Software to Detect Upcoding of Hospital Bills,” released August 12, 1998, questions the ability of commercial software to accurately detect inappropriate over-billing. The report, which analyzed two off the shelf software products currently on the market to identify hospital upcoding, found that only about 20 percent of the Medicare billing cases that commercially available software identified as being upcoded were in fact upcoded.

MedPAC takes a similar position. In its 2000 report, MedPAC recommends that “HCFA should disclose coding edits to physicians and should seek review of the appropriateness of those edits by the medical community.”

There are numerous other issues that impose a regulatory burden on physicians. Examples include: random prepayment review of E/M claims; prescribing durable medical equipment and supplies, including completing certificates of medical necessity forms; and the Medicare provider enrollment process. The Task Force can contact our Washington, DC office for specifics.

Thank you for holding this hearing and for the opportunity to submit a statement for the record. We look forward to working with the Health Task Force and the entire Committee on Budget to reduce the Medicare regulatory burden imposed upon physicians.