The American Society of Internal Medicine (ASIM) represents the nation’s largest medical specialty. ASIM is pleased to provide the following testimony to the Practicing Physicians Advisory Council (PPAC) on the Medicare Transaction System and on Utilization and Quality Control/Peer Review Organization Quality Improvement Projects.

THE MEDICARE TRANSACTION SYSTEM

ASIM is encouraged by the Health Care Financing Administration’s (HCFA) efforts to develop and implement the Medicare Transaction System (MTS). The current Medicare claims processing system is fractured and disconnected. ASIM supports the goal to create a national, multifaceted system designed to simplify claims processing, and improve the electronic data environment—resulting in more accurate and current claims data. We hope that the new system will improve service to beneficiaries, physicians, and other providers; facilitate management of Medicare program expenditures; increase the administrative efficiency of Medicare; more effectively combat fraud and abuse; and accommodate alternative payment methodologies.

Standard Electronic Format

ASIM policy states that physicians should maintain the option of submitting paper claims and that HCFA should eliminate the punitive reimbursement delay for nonelectronic claims submission. However, ASIM supports the HCFA requirement that physicians who submit claims electronically use one of two standard formats. The acceptance of these standard formats for claims submission is a dramatic reduction from the more 400 formats that were accepted by Medicare carriers and intermediaries. ASIM recognizes that submitting claims electronically has the potential to save the Medicare program money by reducing administrative overhead. ASIM views the standardization of electronic formats as consistent with the MTS project, however ASIM urges HCFA to continue to provide physicians with the tools to incorporate these formats into their billing practices for free, or at cost. Also, a significant part of the transition to the standard formats should also focus on assisting physicians with the technical aspects of the MTS. Assurance that physicians will have access to these services is especially important since the number of physicians who submit claims electronically continues to increase.

Software packages provided for claims processing should require little programming ability, hardware adjustments or computer expertise above the most basic of skills (such as data-entry and information transfer between disks). In addition, carriers should provide timely updates for each type of operating system to physicians when changes are made in electronic claims submission requirements so that these packages can be easily used by physicians without interruption.

HCFA should provide software packages that will accommodate the major disk operating systems on the market and not limit hardware options for physicians who wish to submit claims electronically. It is unreasonable for physicians who have already purchased computers with alternative operating systems to be required to reinvest in new hardware in order to process their Medicare claims electronically. Similarly, physicians who are considering purchasing computer equipment should not have their choices limited unreasonably by the MTS. ASIM is concerned that maintenance of the necessary hardware and software could place a financial burden on physicians.
Details regarding the policies and procedures involved in electronic billing should be made available to physicians. As the MTS is implemented, physicians will specifically need to be educated on how the submission of claims will change, how payment will be made, who should be called with inquiries, how the appeals process will function, and how coordination of benefits will work. Physicians will also need to know how payment safeguard activities such as focused medical review, fraud and abuse, Medicare secondary payer and provider cost report audits (e.g., Comparative Performance Review, Limiting Charge Exception Reports), will be conducted. An explanation of how MTS will work in the managed care environment should be provided. HCFA also needs to make physicians aware of the type of data that will be available to them through the MTS.

National Provider and Payer Identifiers

ASIM supports the National Provider Identifier (NPI) project’s goal to establish and maintain a comprehensive and unique number for health provider identification. Many of ASIM’s concerns with HCFA’s proposals for the development and implementation of NPI have already been addressed by HCFA. ASIM commends HCFA’s decision to streamline the Medicare Provider/Supplier Enrollment application. Shortening the length of the form—and making some of the more problematic sections optional—results in an application that is less burdensome for physicians to complete. ASIM is also pleased with HCFA’s decision to eliminate the requirement that physicians have their applications notarized. ASIM remains concerned, however, that HCFA will utilize this application as a means of collecting redundant credentialing information. This new professional verification method is unnecessary since this physician information is currently available from other sources. The American Medical Association’s (AMA) Masterfile provides the physician credentialing information sought in the proposed form. It should be noted that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently announced the acceptance of the AMA Masterfile as a primary source of verified physician information for its credentialing process.

ASIM advises HCFA to work with the AMA to develop a system through which physician credentialing information from its Masterfile would be accessible to HCFA, when appropriate. ASIM recommends that HCFA remain committed to allowing adequate time for provider education and training to ensure a smooth transition to the NPI system. ASIM agrees with HCFA that it is prudent to establish a link from old enumeration systems, such as the Unique Physician Identification Number (UPIN), to NPIs. Even though it is likely that providers will be afforded time to make the transition to NPIs, it is appropriate to equip payers with the means to link old UPINs to new NPIs for a specified period of time after the use of NPIs is mandated. ASIM asks that HCFA remain firm in its plans to establish “crosswalks” as a way to minimize disruptions associated with the processing of claims.

ASIM supports the National Payer Identification (PAYERID) project’s goal to assign a unique identifier to every payer of health care claims. Under PAYERID, physicians will be required to list the unique identification number of the entity to which he or she is billing the claim. Since physicians will no longer be able to simply list the payer’s name, it is imperative that physicians be equipped with the information that is needed to properly fill out their claim forms. HCFA must ensure that PAYERID directories are distributed free to physicians in a timely manner.

Conclusion

HCFA should consider the impact that MTS supporting initiatives, as well as the MTS project itself, will have on physicians. ASIM urges PPAC to advise HCFA to (1) continue to allow physicians to submit paper claims; (2) eliminate the delay in reimbursement for paper claims; (3) continue to provide software and technical assistance to physicians who must convert to the mandatory standard electronic claim formats; (4) guarantee that implementation imposes no extraordinary costs on physicians; (5) ensure that the MTS design does not restrict physician choice of computer hardware; (6) assure that the up-keep of both hardware and software does not impose future, financial hardship on physicians; (7) allow for adequate physician education and training during the implementation of the NPI project; (8) remain firm in its plans to establish a “crosswalk” to link enumeration systems after the use of NPIs is mandatory; (9)
work with the AMA to obtain credentialing information through the AMA’s Masterfile; (10) provide physicians with the PAYERID information that is required to complete claims free and in a timely manner; and (11) provide physicians with additional information pertaining to the MTS project as it becomes available.

UTILIZATION AND QUALITY CONTROL/ PEER REVIEW ORGANIZATION QUALITY IMPROVEMENT PROJECTS

ASIM commends HCFA for changing the focus of the Peer Review Organization (PRO) program. Historically, HCFA’s PRO quality assurance programs were directed toward identifying instances of poor care. Situations where less than adequate care was provided would either be corrected or the health care provider would be excluded from receiving Medicare and/or Medicaid payments. This approach to quality assurance failed to improve the care provided to Medicare and Medicaid beneficiaries because it lacked an educational component.

ASIM supports PROs’ obligations as specified in the Fourth Scope of Work (SOW). Under the Fourth SOW, the PRO program is undergoing a fundamental change as PRO review is being directed away from dealing with individual clinical errors toward assisting physicians and hospitals to improve the "mainstream" of care they provide through variations research and principles inherent in continuous quality improvement. The cornerstone of the Fourth SOW is the Health Care Quality Improvement Program (HCQIP). ASIM supports HCQIP’s goals of improving outcomes and promoting quality measurement. The centerpiece of HCQIP is the development of projects that aim to achieve these goals. PROs are to conduct studies on patterns of care through both national projects and projects they develop locally. The assessment of patterns of care is far more likely to benefit patients than focusing on isolated events.

ASIM supports the National Cooperative projects that are developed by HCFA in conjunction with other groups. It is important that each project has a particular clinical focus. The objective of these projects is to develop quality indicators to accurately measure quality of care that can assist physicians and hospitals in the development of their own quality improvement efforts. Equally as important as the national efforts have been the local improvement projects. Currently, more than 400 individual quality improvement projects are being implemented, affecting genuine improvements in the quality of health care delivered in local communities. ASIM is encouraged by the fact that in some instances it has been the physician community who has identified opportunities for improvement—an indication that the new PRO approach is fostering a cooperation between the provider community and the entities that are designed to monitor it.

ASIM is pleased that the HCQIP will continue under the Fifth SOW that will be in effect by October 1996. ASIM is encouraged with the plans for the Fifth SOW, which envision even greater involvement by the physician community. The focus of improvement projects will be broadened to include more initiatives in outpatient settings. Managed care projects, with a focus on preventive care, will also play a more prominent role. ASIM supports these efforts and encourages increased participation by physicians. The Fifth SOW will also allow outcomes information to be solicited directly from patients, but only when the information cannot be obtained through any other source. ASIM recognizes the benefit that can be derived from “closing this information loop” (i.e. HCFA’s data shows that 60% of beneficiaries received flu shots through Medicare in 1995, while a direct survey of beneficiaries indicated that 80% had actually received the vaccine). However, ASIM asserts that it is inappropriate to seek outcomes information from a beneficiary when the information is available through other sources.

ASIM is pleased with HCFA’s decision to replace the Quality Intervention Plan (QIP), a process where hospitals and physicians were assigned “points” when quality problems were identified in review of their care, with the Quality Review Process (QRP). The objective of QRP is to identify quality “concerns” in care rendered to Medicare patients and to assess the causal relationship between these concerns and adverse outcomes. When a physician is recognized as having an area of “concern” the PRO is expected
to provide educational feedback to the physician in an effort to improve the quality of care provided to the beneficiary. The intent is to change the PRO's role from enforcer to educator and facilitator.

Also, HCFA's decision to act on ASIM's request for physician relief from PRO quality citations that are greater than five years old when no more recent citations have been made against the physician is appropriate. However, rather than only requiring PROs to respond to physicians' written requests to expunge the PRO files of quality citations that are five or more years old when no more recent citations have been made, this process should occur automatically.

In conclusion, ASIM supports the change in the focus of PROs from searching for instances of inadequate care toward assisting physicians in improving the quality of care provided to beneficiaries. ASIM urges PPAC to advise HCFA to (1) continue to allow physicians to participate directly in quality improvement projects; (2) only seek outcomes information directly from beneficiaries when it cannot be obtained through other sources; and (3) instruct PROs to automatically remove quality citations after five years when no more recent citations exist.

ASIM thanks PPAC for the opportunity to comment on the Medicare Transaction System and Utilization and Quality Control/Peer Review Organization Quality Improvement Projects.