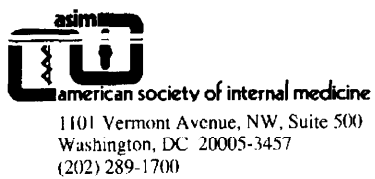


The Hassle Factor

America's Health Care System Strangling in Red Tape





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The Hassle Factor:

America's Health Care System Strangling In Red Tape

Why The Hassle Factor Needs To Be Addressed

1. Reduced benefits to patients
2. Decline in numbers of primary care physicians
3. Erosion of the physician-patient relationship
4. Higher costs

A SIM's Recommendations To Address the Hassle Factor

I. Federal Reforms

1. Enact HR 4475 and S 2051, the Physician Regulatory Relief and Improvement Act, which would:
 - Allow attending physicians to continue to bill Medicare for services provided to a patient by a professional colleague who is simply covering for the absent attending physician;
 - Prohibit carriers from charging physicians for information or documents they need in order to comply with Medicare statutory or regulatory requirements;
 - Require the mandatory release of medical review screens;
 - Allow medical societies to file class reconsiderations and appeals;
 - Establish a Physicians' Advisory Council to review Medicare administrative requirements.
2. Require carrier policy changes to be made in as open a manner as possible. Such changes would include:
 - Establishment of formal advisory bodies;
 - Review by these advisory bodies, and other physicians and consumer representatives of all proposed policy changes;
 - Response in writing by the carrier to all comments;
 - Use of educational forums prior to implementation.
3. Require the Health Care Financing Administration (HCFA) to implement uniform standards and procedures designed to improve carrier service, responsiveness and accuracy, including:
 - Adequate training requirements for carrier staff;
 - Toll-free telephone lines for physicians and their staff;
 - Educational forums to assist physicians and their staff;
 - Specific requirements for services to physicians in carrier performance standards;
 - Improvements in carrier claims processing;
 - Provisions to hold physicians harmless for actions based on inaccurate carrier information.

4. Require HCFA's task force on internal operations to include outside physician and consumer representatives and to review current Medicare administrative operations including:
 - Carrier and peer review organization (PRO) utilization and medical necessity review procedures and policies;
 - The methods in which carrier fair hearings and reconsiderations can be used as precedents.
5. Require Congress and HCFA to examine all new administrative and legislative requirements imposed on physicians in light of intended benefits versus anticipated administrative and paperwork "hassles" — the "hassle-benefit ratio."
6. Use practice guidelines to improve carrier and PRO review processes.
7. Reform the PRO system to emphasize quality of care.
8. Require HCFA to develop guidelines to prevent arbitrary downcoding and unreasonable document requests by carriers.
9. Reform the post-payment utilization review process including:
 - Prohibitions on retroactive application of new policy;
 - Improvements in due process protections for physicians;
 - Repayments to physicians for services found during an audit to be underreimbursed.
10. Reform the manner in which concurrent care and consultant care is recognized by carriers.
11. Revise government policy on nursing home visits.

II. Private Sector Reforms

1. Enact state and federal legislation providing greater uniformity in medical review procedures of private health insurance companies including:
 - Adequate staff training requirements for insurer staffs;
 - Establishment of an ombudsman's office in the office of each state insurance commissioner;
 - Establishment of uniform pre-authorization and pre-certification procedures for insurers operating in a state.
2. Improve regulation of private utilization review firms through:
 - Enactment of state licensure and standards laws;
 - Extension of insurance commission jurisdiction to cover these firms.
3. Application of Medicare review reforms to private insurers including:
 - Establishment of an open policy development process;
 - Release of medical review screens;
 - Adoption of a fair peer review process;
 - Emphasis on changes in physician behavior through education, not penalties.

III. The Hassle Factor and Access to Care

1. Design proposals to improve access to care in a manner that does not increase the hassle factor for physicians and patients.

“The majority of general internists in my area are extremely demoralized by continuing government intervention, and most of them want to quit, too. At the current rate, general internists in rural practice are either going to have to move to the city or change jobs.” — *Texas internist*

“The Denver internists with whom I spoke all said that they vastly preferred caring for patients with any disease to struggles with insurance companies. In their opinion, caring for patients is always preferable to paperwork.”¹ — *Frederick W. Platt, MD*

“Those physicians currently practicing medicine in the private sector are experiencing morale problems of a serious nature. Some are looking to other careers; some are looking at early retirement. Most have just lost their enthusiasm.” — *New York cardiologist*

“Our problem is that the small claims that exceed the Medicare deductible and are submitted on our behalf by our physicians remain unpaid. The doctors have put no pressure on us for payment. However, it is embarrassing to call upon doctors for services when we know that bills which they have submitted previously to Medicare remain unpaid.” — *Constituent letter to Congress*

“I think, and the public is beginning to understand, that payment and the payer do—and will to a greater extent in the future—dictate the kind and quality of health care a person receives. They feel powerless because they cannot afford medical care without employer-sponsored health insurance. Slowly they realize, however, that their doctors are as much toys of the system as they are.”² — *Ruth Sorelle, medical writer*

“Our frustration with Medicare and our local carrier continues to mount...when we asked how soon we could expect our list of maximum allowable actual charges (MAACs), we were told, ‘You’re not the only doctor’s office in Illinois.’ This continual frustration with Medicare and our local carrier causes an undue amount of stress in the workplace.” — *Illinois internist*

“I am disturbed by the inappropriate denial and also by the degrading impression imparted to my patient when he receives a copy of the (carrier’s) reduction letter.” — *Oregon internist*

“I enjoy medicine as a science and an art, but thanks to the federal government, I get a daily dose of drudgery to remind me that, in other peoples’ lives, medicine is neither science nor art but rather business as usual.” — *Illinois internist*

“We received three EOBs — explanations of Medicare benefits — from Medicare. Two had four pages each, and one had two pages, *but* each page came in a separate envelope—10 pages in all and 10 envelopes.” — *Constituent letter to Congress*

“Physicians in the U. S. are now the most litigated against, second-guessed and paperwork-laden physicians in Western industrialized democracies.”³ — *Philip Lee, MD, and Lynn Etheredge*

“I am worried about the growing disenchantment of the average doctor...It’s not as if all the doctors in America are going to move to Australia...but neither should we treat them as if we can abuse them and think we have lost nothing by it.”⁴ — *William Roper, MD, former Deputy Director, Domestic Policy, Bush Administration*

The Hassle Factor Defined

The expressions of frustration printed on the facing page exemplify what has become known as “the hassle factor” in modern medical practice and in the provision of health care in America. The hassle factor has been defined by the American Society of Internal Medicine (ASIM) as:

The increasingly intrusive and often irrational administrative, regulatory review and paperwork burdens being placed on patients and physicians by the Medicare program and other insurers.

Such hassles can have direct consequences on patients as medical students are discouraged from certain fields of medicine, as patients find physicians less accessible or willing to add to their patient caseloads, as administrative costs increase—leading to higher premiums and physicians’ fees, as patients are denied insurance benefits for necessary and appropriate services, and as physicians find their roles changing from patient advocate to cost-containment watchdog for the insurance company.

ASIM, representing physicians nationwide who are specialists in adult medical care, believes the reduction of the hassle factor should be a top public policy issue. Judging from the letters, phone calls and resolutions from ASIM members, the administrative burdens—or hassles—associated with the Medicare program and other payers are now the biggest concern of internists. Physicians are tired of review programs that require them to justify every decision they make on behalf of their patients but seem incapable of disciplining those physicians who are truly abusing the program. The federal government spends more than \$300 million a year to oversee the quality of care given to Medicare patients, yet it found “confirmed quality problems” in only a little more than 2 percent of the cases it reviewed during 1988-89. Of these cases, most problems involved lack of documentation rather than actual harm to patients.⁵ Physicians are tired of going through multiple appeals in order to get paid for their services. One visit by a patient to a physician’s office has been estimated to generate on average 10 pieces of paper.⁶ Physicians are concerned with Medicare’s seeming indifference or hostility to professional input. And they are angry about a never-ending deluge of new requirements—some well-intentioned, many not—that have no relationship to the way medicine is really practiced,

or are extremely costly or difficult to comply with. As a pediatrician in San Diego said to *The New York Times*, “I enjoy seeing patients and I think I would go into medicine again, but I’ve had to be very strong to endure the headaches and the hassles.”⁷

This paper outlines many of the regulations and paperwork burdens introduced recently into modern medical practice and some of the major reasons for these circumstances. It also will illustrate some of the effects on the physician’s ability to care for his or her patients according to his or her best medical judgment. Finally, it presents a series of ASIM recommendations for improving the environment of medical practice while assuring that high quality health care and appropriate medical services are delivered to patients. A glossary of terms used throughout this paper is contained in Appendix A.

The 1980s: The Regulation of Health Care

7

Although one of the basic tenets of the “Reagan Revolution” was the deregulation of almost all major industries in the United States, the treatment of health care during the last decade was exactly the opposite of that philosophy. Over the course of the decade, physicians and other health care providers were faced with a growing list of administrative responsibilities, regulatory requirements and other management duties that forced them to cut back on the amount of time they devote to patient care, to hire additional office staff to contend with the paperwork and telephone calls, and to respond increasingly to third-party inquiries about the necessity and appropriateness of the care they provide.

In 1983, the federal government instituted the Prospective Payment System (PPS) for Medicare whereby payments for hospital services were limited to certain amounts. Hospitals able to treat patients for less than the Medicare payment kept the surplus. When treatment costs exceeded the Medicare payment, the facility would absorb the loss. On the one hand, hospital administrators pressured physicians to release patients from the hospital earlier. On the other hand, peer review organizations pressured physicians to keep patients out of the hospital entirely and to treat them on an outpatient basis.

In 1985, Medicare began to “flag” certain claims for services for further review and to require additional documentation from physicians before paying those claims. In 1987 and 1988, physicians were required to refund to patients any amounts collected on services deemed by the Medicare insurance carrier and peer review organization to be “unnecessary.” To avoid this, physicians had to inform the patient in writing prior to provision of the service that Medicare might not pay for that particular procedure. Also in 1987, a fee freeze from the previous year was replaced by the maximum allowable actual charge (MAAC) system for non-participating physicians—i.e., those physicians who do not agree to accept Medicare fees as payment-in-full for all services. These MAACs (see Glossary for definition) involve a complicated formula to determine the limits placed on total charges a physician can bill a Medicare beneficiary. Diagnosis codes, procedure codes (which number more than 7,000) and physician identification numbers on all claims have been required in the last five years—without them payment will not be made by Medicare. The list of diagnosis categories from which physicians must choose contains more than 11,000 three- to five-digit codes. Providing many of these codes imposes an enormous burden on physicians’ staffs while producing information that is of questionable benefit to the Medicare program.

Clerical staff accounts for 47 percent of non-physician employees in doctors’ offices. Most of their time is spent on billing and other administrative tasks.⁸ Physicians must fill out and sign lengthy questionnaires in order for their patients to receive home care services and medical equipment and to admit patients into nursing homes. For example, Health Care Financing Administration (HCFA) Form 484 must be filled out by the physician to certify a Medicare patient’s need for home oxygen therapy. On the form itself, there is a notation that the form takes approximately 25 minutes to complete. If the physician has the information called for on the form readily available, it may not take as long to fill out—perhaps no more than 5 to 10 minutes. However, if the physician must contact the laboratory or hospital for data, such as blood gas measurements for the patient, this process can take longer. One internist received 15 such forms in a two-week period. Depending on the availability of data, the physician will spend two to six hours preparing paperwork—time that could have been devoted to additional study on treatment of complex illnesses or to seeing patients.

Beginning in September 1990, physicians will be required to submit all Medicare Part B claims on behalf of their patients. A 1986 study found that internists already spend almost one-fifth (18 percent) of their time on administrative tasks.⁹ Considering that approximately 400 million Medicare claims are filed each year, this time spent on paperwork will undoubt-

edly increase.¹⁰ (A list of some of these administrative responsibilities imposed on physicians in the last 10 years is included in Appendix B.)

Medicare is not alone in the extent and complexity of rules required of those who participate in the system. A procedure manual of instructions for filling out a one-page billing form for the New York Medicaid program was 135 pages long and was followed by 260 pages of procedural codes.¹¹

These governmental requirements do not include the proliferation of rules promulgated by private firms engaged by employers around the country to manage utilization of health benefits by their employees. Today, between 200 and 300 utilization review (UR) firms operate in the U.S., each with its own distinct medical necessity rules and preauthorization requirements that obligate physicians to confer with a “reviewer” before undertaking dozens of treatments or procedures. A story in *The Washingtonian* magazine told of an Arlington, Va., internist dealing with a utilization review firm hired by the employer of his patient to manage hospitalizations of employees. Twice within the first week of what was expected to be a lengthy hospital stay for this seriously ill patient, the physician was called by the UR firm. When he complained to the reviewer, he was told, “If you don’t deal with me, you don’t get paid.” Said the physician, “They implied that my major concern was that I wouldn’t get paid. My concern was that the guy would die if he left the hospital. He’ll be dead whether I get paid or not.”¹²

Why More Regulations?

Why have health care regulations increased? To put it simply—money. In 1988, the nation spent \$540 billion on health care. More than one third of that money, \$158 billion, is spent by the federal government in Medicare and Medicaid outlays. Health care spending increased by approximately 10 percent a year during the 1980s.¹³ This has been driven not only by increases in physician and hospital bills but also by a growing senior population that needs more care, the development and use of sophisticated medical technology, increases in drug costs, higher wages to attract health support personnel and cost-shifting by hospitals and other health facilities to pay for indigent care. As the government has watched its health costs mount, it has attempted to stem the dollar outflow through budget reductions, changes in reimbursement policy and increasingly intrusive review requirements. In the private sector, businesses and health insurers have turned to managed health care systems and utilization review as means to control their own expenditures on health care.

ASIM recognizes the need on the part of government and the private sector to restrain health care costs. However, mounting evidence suggests that many of the cost-control methods employed are ineffective and have, in some instances, added to expenditures. Adding more administrative burdens will not be a solution until an honest effort has been made to determine those existing controls and regulations that have had a positive impact on costs without sacrificing quality of care and those rules that have proven counterproductive. To the extent that some containment measures deny needed health care and services, cost control is being bought at a very high price.

Who Cares If Physicians Are Unhappy?

There are many who believe, and often say, that physicians make enough money to put up with a few rules. For most physicians, however, the primary concern is that the rules imposed on them are affecting their ability to provide the best possible care to their patients. As an internist in South Dakota said in a letter to ASIM, "I have tried to put up with the increasing administrative burdens, keeping in mind that the reason I went into medicine was to take care of patients." There is growing unease among physicians that if current trends continue, it is the patients who will lose the most.

Few would disagree that when factory workers, teachers, government officials, nurses, office workers or business people become frustrated, angry and disillusioned with their jobs, their productivity and commitment declines. The same is true, of course, for physicians. Although most physicians' commitment to their patients and to providing high quality care remains strong, there is growing evidence that the cumulative effect of paperwork duties, third-party rules and uncooperative administering agencies is sapping the enthusiasm of many physicians for the practice of medicine. Earlier this year, in a survey of physicians conducted by the American Medical Association (AMA) and the Gallup Organization, almost 40 percent said they would definitely or probably not go into medicine if they had it to do all over again.¹⁴

Will this frustration and disillusionment among physicians have a direct impact on patient care? ASIM believes the negative effects of the hassle factor can already be seen in a variety of developments that are affecting adversely the quality and availability of care.

■ Reduced Benefits to Patients

One of the major reasons for the hassle factor is the increasing amount of cost-containment rules imposed by insurance companies to reduce their own financial outlays. These frequently impede the delivery of

necessary medical care. Gerald Grumet, MD, writing in *The New England Journal of Medicine*, has characterized this trend as "rationing by inconvenience." In that article, he notes, "In managed care's arsenal of cost-control weaponry, probably none is more potent—except for restricting hospital admissions—than superseding the physician's autonomy by a managerial-review process in which armies of claims clerks, administrators, auditors, form processors, peer reviewers, functionaries and technocrats of every description insinuate themselves into a complex system that authorizes, delivers and pays for medical care."¹⁵

"Paradoxically, the savings that ordinarily accrue to an efficiently managed business are reversed in the case of insurance carriers, whose bungling, confusion and delay impede the outflow of funds. For carriers, inefficiency is profitable. The result is a mounting number of dysfunctional bureaucracies with eye-catching logos and slick marketing techniques that contrast sharply with the difficulties encountered each time medical services are used."¹⁶

For example, one manner in which patients are denied insurance benefits for appropriate medical care is through the use of medical necessity screens by Medicare and other third-party insurers. Medicare carriers and private insurers use numerical screens to flag certain claims to determine if the services rendered are medically necessary. For example, a Medicare carrier will establish a numerical screen for lengthy, or "intermediate," hospital visits. If a physician submits a claim for an intermediate hospital visit which exceeds the number of such visits determined "medically necessary" by the carrier, then that claim will be pulled for further review by a carrier employee to see if, in fact, a longer visit with the patient was required. Ostensibly, the purpose of medical review screens is to modify physician behavior so that unnecessary services are not provided to patients—a very legitimate public purpose. However, carriers often reject outright any "screened" claims that are in fact for services that should be covered by Medicare. In many cases, when the physician appeals the denial and the denial is reversed, the carrier soon thereafter denies a similar claim for a similar service for the same patient. In effect, the Medicare carrier will have denied beneficiaries the insurance benefits to which they are legally entitled.

Even so, a recent HCFA-funded study conducted by several University of Minnesota researchers and published by the Blue Cross and Blue Shield Association questioned the success of carrier screens in changing physician behavior. The authors found that "screens are only marginally effective (at best) in reducing the rate at which medically unnecessary claims are submitted." The authors attributed the ineffectiveness of such screens, at least in part, to the fact "that physicians generally view the carriers and

their medical staffs as antagonists. Physicians often complained that most of the decisions about medical necessity were made by lay employees who lacked the professional expertise to make informed, much less, authoritative decisions on medical necessity. Knowing physicians held this attitude...we were not surprised to find little evidence of behavioral change."¹⁷

Private insurers use similar methods to deny patients reimbursement for medically appropriate services that, under the terms of the insurance policy, should be covered. Privately insured patients frequently experience their own version of "sticker shock" when they discover how little of the care provided by the physician is actually covered by insurance. Insurers spend billions of dollars marketing their benefits of "comprehensive coverage"—and billions more making sure that, when claims for services come in, the true level of coverage is anything but comprehensive.

In the worst cases, insurance company cost-containment policies designed to impede the use of medical services could result in the delivery of poor quality care or no care at all. However, physicians' continued commitment to their role as patient's advocate—even if it means taking on the patient's insurer—has protected most patients from direct harm as a result of these cost-control practices.

Two recent examples illustrate the potentially adverse impact third-party payer policies can have on patients. In the first case, an Oklahoma oncologist was treating a patient who was undergoing chemotherapy for cancer. This patient came to his office one day with a slightly elevated temperature. Such a patient, as a result of the chemotherapy, does not have sufficient white blood cells to fight off an infection that a higher temperature indicates. The physician admitted the patient to the hospital knowing that the insurance company would refuse to pay for the admission because the patient's temperature wasn't high enough to meet the insurer's screens. After battling with the insurer, the physician was able to get the payer's decision reversed. Reflecting on that episode, the physician said, "I could have sent the patient home and waited for her temperature to rise some more. But that would not be proper, high-quality medical care. As long as we keep fighting, we can get good medical care for these people, but why do we have to continually go through these hassles?"

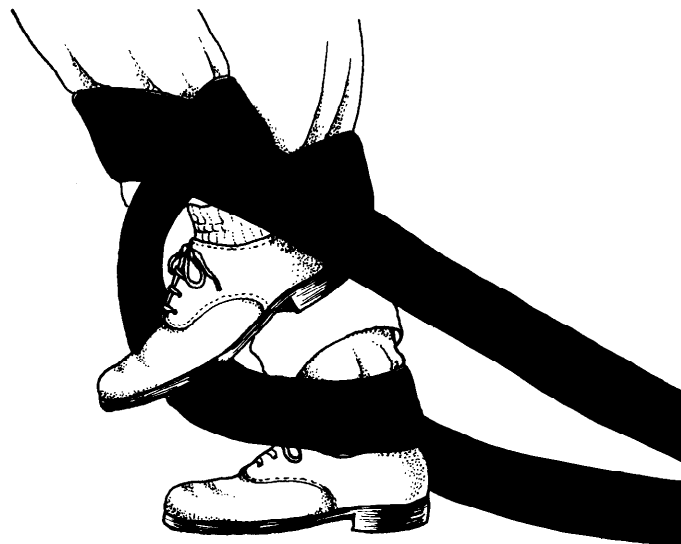
In the second instance, an Arizona internist had a patient in a skilled nursing facility learning how to use a prosthesis (artificial limb). Ordinarily, the patient, whose condition was stable at time of admission, would not require anything more than one visit during the month. However, this diabetic patient developed heart irregularities, depression and anorexia and needed changes in his insulin, all of which required the physician to monitor the patient on a more frequent basis.

The carrier nevertheless denied the physician's claim for service on the grounds that Medicare usually pays for only one nursing home visit per month.

Prior authorization of services is another way in which Medicare, private insurers and managed care systems screen for medical necessity. Although such precertification requirements can be a useful method for determining if a procedure is medically warranted, they can, if used too broadly or improperly, have life-threatening consequences. Warning patients to obtain approval before they use an emergency room or ambulance unless their condition is critical, as has been done by some health maintenance organizations (HMOs), puts people "in the predicament of having to decide whether or not they are dying."¹⁸

Another approach recently employed by the utilization management program of the "Big Three" automakers places the physician and hospital at financial risk if pre-admission authorization is not obtained from the insurer.¹⁹ Failure to comply with these requirements, even for emergency admissions for which authorization must be obtained within 24 hours, will result in fines or 20 percent cuts in payments from the insurer or both. As a result, physicians will have to make sure each patient they admit to the hospital has obtained this authorization, or get the approval themselves.

Legal rules are another way in which certain approaches to care are mandated that can have an adverse impact on the physician's ability to offer the care he or she believes is best for the patient. Illustrative of this is the experience of a San Diego internist whose elderly patient needed a short nursing home stay to recuperate from a fall. The physician wanted to bypass admitting the patient into a hospital because of the hospital-based infections that might hurt the patient's chronic lung condition. Unfortunately, Medicare law required a hospital stay of three days prior to a nursing home admission in order for the admission to be reimbursed.



After the patient was admitted to the hospital, she died from a hospital-acquired lung infection. The physician said, "How do we protect ourselves so that we don't grieve when we recognize a needless death, which is against all that we stand for? I suppose we could build a wall around our emotions and render our medical care as coldly as the bureaucracy administers its laws."²⁰

The cases cited above are examples of third-party payer policies in which the physician must argue with the insurer to ensure the delivery of appropriate medical care to his or her patient. Sometimes the physician is successful in contesting the insurer and other times the "rules and regulations" win. Had the physician been unwilling to take on the insurer, the patient might have been denied insurance benefits for necessary care. At worst, the patient might have received no care or poor care. Sometimes, despite the best efforts of the physician, the "system" not only impedes delivery of care that is best for the patient but also causes that patient irreparable harm.

Fortunately, for most patients, physicians do prevail in countering unreasonable or arbitrary decisions on the part of insurers and Medicare carriers. However, it makes no sense for public policy to set up a system in which physicians must fight constantly to provide appropriate care and for patients and physicians to be reimbursed for that care. A better way would be to assure that third-party review and payment criteria are valid in the first place.

■ Too Few Primary Care Physicians

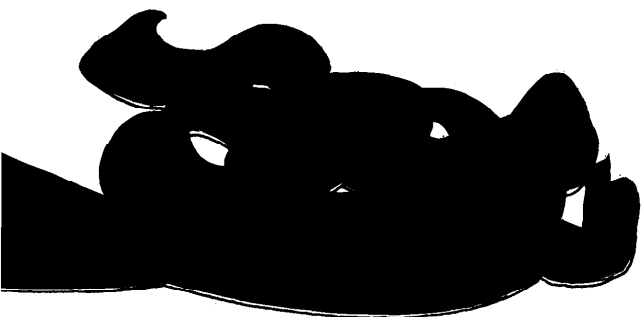
Medical schools have witnessed a decline in applicants from a high in 1974 of three persons for each slot to a low in 1988 of 1.6 applicants for every medical school opening.²¹ In addition, the number and percentage of those graduating from U. S. medical schools choosing internal medicine resident programs—in other words choosing to go into one of the major fields of primary

care—decreased by 6 percent from 1985 to 1987.²² Between 1981 and 1988, medical school graduates choosing any of the primary care specialties (internal medicine, family practice, pediatrics) declined, whereas those selecting other subspecialties increased during that time period.²³ Among the factors contributing to this decrease are the extensive mental and emotional involvement with patients required of internists; the low fees relative to other specialties; the office overhead, which can consume 60 percent or more of fees received; and the debts in excess of \$50,000 that many students have when they graduate from medical school.²⁴ As the elderly population grows, this trend in fewer medical students choosing primary care as a concentration will have a serious impact on patients' access to physicians in the future. This is already apparent in the inability of many rural areas to attract and keep family physicians and internists. Nationally, there is an average 1,300 people per physician in urban areas compared with 2,275 people per physician in rural communities.²⁵

Primary care increasingly is viewed by practicing physicians, as well, as a less desirable field of medicine than other specialties. For example, a 1989 survey of internists in New York state found that paperwork, regulations and financial reimbursement were among the most frequently cited sources of dissatisfaction among the respondents. Over one-third of those surveyed indicated they would consider leaving practice. As the authors of an article about this survey said, "If withdrawal from practice combines with the inability to attract medical students into the field, it is not difficult to construct a scenario in which physicians in practice will become difficult to find."²⁶

■ Erosion of the Physician-Patient Relationship

As the frustration grows, changes are taking place in the way Medicare beneficiaries view physicians—and how physicians view patients. Instead of thinking about the individual who comes through the office door, physicians are beginning to think: "Will I be able to justify this visit to the carrier? How many times will I or the patient be denied payment? Will I be cited by the peer review organization (PRO) for something I do?" When patients begin to be viewed perjoratively as "Medicare patients," the reaction among physicians may come to be as extreme as that expressed by a New York internist who wrote, "My answer to the hassle factor is to stay out of Medicare. I do not see nursing home patients nor do I see any new patients over age 64." This deep-seated dissatisfaction with the program is evident in other parts of the country as well. At a recent congressional hearing investigating problems with the administration of Medicare in Georgia, the HCFA regional administrator observed that 150 physicians in the state have stopped seeing Medicare patients out of irritation with the program.²⁷



For most physicians, however, the effects of the hassle factor on the doctor-patient relationship are far more subtle. A loss of patient confidence—and satisfaction—is a consequence of insurers constantly questioning physicians' medical judgments, and of policies designed to coerce physicians into saving money in direct conflict with what patients want and expect.

On one hand, an informed public has increasingly demanded that physicians make patient satisfaction the primary goal and that this same patient satisfaction be included in reimbursement criteria. On the other hand, what may satisfy patients also may increase costs and is, therefore, in direct conflict with the expectations of third-party payers. No one is suggesting that third-party payers reimburse every type of service patients want or expect. However, it must be recognized that, as physicians are increasingly called on to control costs, some loss of patient satisfaction is bound to occur.

Commenting on this dichotomy, C. Burns Roehrig, MD, editor of *The Internist: Health Policy in Practice*, observed, "If patient satisfaction is to be a primary goal and a basis for financial reward, there can be no push for the physician to discharge a patient from the hospital when it may be safe but not comfortable and convenient. Nor can the doctor be expected to prescribe a generic drug when a patient asks for a brand-name product, to become more 'efficient' by spending less time with patients or using physician extenders, or to decline a dermatology consultation requested by a

patient for the treatment of rather ordinary acne. But health economists generally consider all these to be essential to control costs."²⁸

However, it is not only physicians who are beginning to see damage to the doctor-patient relationship. Eva Skinner, a Board member of the American Association of Retired Persons, has written that patients' confusion about Medicare is "compounded when physicians, traditionally viewed as protectors, as well as healers, give up in frustration and cite 'Medicare rules and regulations' as the reasons for changes contrary to patients' expectations."²⁹

Writing in his column, "The Patient's Advocate," *Washington Post* staff writer Victor Cohn noted, "Some authorities consider concerns like Roehrig's overstated; some do not. But if he is right—and I believe he is right to no small extent—doctors should be more concerned than ever about satisfying their patients, if only to gain allies in the struggle to maintain a healthy degree of free choice and independence for both patients and physicians."³⁰

ASIM believes that the medical profession has a responsibility to do everything it can to continue to provide high-quality, affordable care for all patients, regardless of the rules set up by insurers. It would be a tragedy for the medical profession and the public if physicians determine that they have no choice but to turn away from certain patients. Physicians may decide that they can no longer in good conscience go along



with such restrictions if they conclude that Medicare and other insurers are: demanding more and more paperwork as a prerequisite to getting appropriate services reimbursed; arbitrarily denying more and more medically necessary services; and financially penalizing physicians and their patients for providing the care that patients need and expect. Rather than being accomplices to policies that they find to be wrong, primary care physicians may instead decide that going into another specialty, type of practice, or career is the least objectionable course of action. Alternatively, those who remain increasingly will find that the rules imposed by insurers place them on a collision course with what their ethics and sense of commitment tell them is best for their patients.

■ Higher Costs

In 1986, a study of health care administrative costs using 1983 data revealed that the costs of program administration, private insurance, and hospital, nursing home and physician office administration totalled more than \$77 billion—or 22 percent of all health care spending at that time. Of that amount, \$18.5 billion represented the net costs of Medicare, Medicaid, and private insurance administration and overhead.³¹ More recent studies show these administrative expenses as growing more. For example, an analysis of 1988 national health care spending trends revealed that, of the \$540 billion spent on all health care in the U. S. that year, \$26 billion was used by the federal and state governments and private insurers for claims processing and program administration.³² Finally, AMA figures show that program administration and the net cost of private health insurance grew by 182 percent from 1980 to 1987, providing further evidence of the rapid escalation of health administration costs.³³ These more

recent studies do not address the additional administrative costs incurred by physicians, hospitals and nursing homes. However, it is likely that the overall cost of health care bureaucracy—public and private program administration coupled with the costs incurred by physicians and other providers—is even greater than it was in 1983. As these costs of program administration and claims processing grow, they result directly in higher premium costs to the insured and greater tax expenditures to fund the public programs.

As administrative requirements increase, physicians must hire additional staff to handle the paperwork. The same study that illustrated such dramatic health administration increases also revealed that approximately 45 percent of physicians' gross income nationally was devoted to their office overhead costs.³⁴ Of insurance company overhead, hospital administrative costs, nursing home administration and physicians' overhead, the latter (\$31 billion) represented the largest category of expenditure for health care administration. Clerical staff, most of whose time is spent on billing and claims submission tasks, now constitute almost 50 percent of the non-physicians employed in physicians' offices.³⁵ According to an AMA study, this office staff spends approximately 47 hours per month dealing with Medicare claims and more than 33 hours per month processing private insurance claims.³⁶ Physicians themselves estimated they spend almost 10 hours a month on administrative tasks related to Medicare and private insurance.³⁷ As patients pay their doctor bills, they should realize that a significant portion goes to physicians' overhead costs.

Federal Reforms

The findings just presented suggest several important directions that should guide public policy at the national and state levels to reduce the hassle factor and enable physicians to devote more time to their patients and to improving their practice of medical care.

1 *Congress should enact legislation such as HR 4475, the Physician Regulatory Relief and Improvement Act, to correct some of the most obvious faults in Medicare administration.*

Already, some attention is being given by Congress to the hassle factor and the need to reform the administration of Medicare. On April 4, 1990, Congressman J. Roy Rowland (D-Ga.) introduced the Physician Regulatory Relief and Improvement Act with 17 co-sponsors. Companion legislation has been introduced in the Senate by Sen. Max Baucus (D-Mont.). That measure (S. 2051) is pending before the Senate Finance Committee.

In introducing his measure, Rep. Rowland said, "Red tape is destroying the close personal relationship doctors have traditionally had with their patients. It's interfering with good medicine by denying procedures to patients which physicians feel they may need. It's inundating doctors with paperwork and driving increasing numbers out of medical practice. It's causing many others to withdraw from Medicare participation, making health care less accessible to many people."³⁸

HR 4475, which now has more than 230 co-sponsors and is pending before the health subcommittees of the House Ways and Means and Energy and Commerce Committees would:

- A. Allow attending physicians to continue to bill Medicare for services provided to a patient by a professional colleague who is simply covering for the absent attending physician.

Traditionally, physicians have extended to one another the professional courtesy of looking after each other's patients when their colleagues cannot be on duty. To simplify billing matters, the attending physician would include any visits made to a hospitalized patient by a covering colleague in his or her own bill and would expect to reciprocate this favor at some future time for the covering physician. HCFA recently issued instruc-

tions to several carriers forbidding the attending physician from billing for services provided by the covering physician and requiring the covering physician to submit the bill instead. Although the directive has been temporarily suspended by HCFA, if reinstated, it would not only disrupt longstanding professional relationships among physicians, but it would also require the covering physician to create new files and billing records for patients he or she may see only once. In addition, it could confuse patients who receive bills from unfamiliar doctors and could increase administrative expenses to both physicians and Medicare carriers.

- B. Prohibit Medicare carriers from charging physicians for information or documents that are needed to comply with Medicare statutory and regulatory requirements.

Across the country, there have been reported instances of Medicare carriers charging physicians for data they need in order to comply with the profusion of federal legal and regulatory requirements. Taxpayers are not expected to pay the Internal Revenue Service for information needed to comply with the tax code. Neither should physicians have to pay for information needed to comply with Medicare mandates.

- C. Require the mandatory release of medical review screens.

HCFA contracts with insurance companies to administer the Medicare Part B program. These Part B carriers have the authority to screen physicians' bills for "medical necessity." The carriers do this by using screens that trigger a medical necessity review. For example, Medicare allows payment for only one visit per month by a physician to a patient in a nursing home. Carriers, therefore, set up screens that flag any claims for physician nursing home visits that exceed one per month. There are other numerical screens, however, that are known only to the carrier. The purpose of medical review screens is to modify physician behavior so that unnecessary services are not provided. Screens should not be used to deny medically appropriate services that are legitimately covered under Medicare. Frequently, carriers automatically deny claims that trigger a numerical screen, but they will not reveal to the physician what the screen is so that the physician has no way of knowing how to change practice methods to avoid hitting that screen.

There are other reasons for making public these medical review screens. If physicians know in advance what the screens are for a given service, they will know that, in order to be paid, they had better have sound medical reasons and good documentation to go beyond the screen. Furthermore, release of the screens can result in improved patient care. If the screens are made public, physicians can evaluate them and, if they do not reflect sound medical practice, work with the carrier and HCFA to improve them. The University of Minnesota study cited earlier supports the view that greater professional involvement in developing the screens would make them more effective in modifying physician behavior by providing some degree of assurance that the screens themselves reflect accepted standards of medical necessity. The authors of the study state, "We know from the literature that physicians are more likely to adopt desirable behaviors if it is clear that those behaviors are endorsed either by a majority of their peers or by some senior medical authority with whom they work. In the existing process, the standards are associated with neither."³⁹ Moreover, in the end, poorly drawn screens result in the denial of claims for medically necessary services.

- D. Amend Medicare reconsideration and appeal requirements to allow medical societies to file such actions on behalf of an entire class of physicians.

Under HCFA's present authority, Part B carriers enjoy enormous authority to deny payments for services rendered in good faith by physicians to Medicare beneficiaries. As noted earlier, carriers use numerical screens to make payment denials. In some instances, these screens vary from state to state, creating a "patchwork quilt" of provided benefits. Competition is also a driving force as carriers compete to restrict payment for physicians' services in order to ensure retention of their contract with HCFA. Unfortunately, this competition can lead to overly aggressive and arbitrary medical review decisions. Individual physicians rarely have the time, staff and resources to appeal individual payment denials.

- E. Establish a Physicians' Advisory Council to review Medicare administrative requirements and their implementation prior to initiation of new policies

HCFA currently has an Office of Carrier Operations to oversee performance of Part B insurers and to serve as an ombudsman and liaison for Medicare Part B carriers in policy development. Although there is a Division of Professional and Business Affairs within HCFA, it serves a variety of functions, mostly informational, and has not been able to counter the influence of carriers on HCFA policy in recent years. It would be useful to have physician input into regulations and government

policies to ensure that government requirements reflect sound medical judgment and enhance, not deny, provision of quality care. Furthermore, physicians are more likely to accept rules that have been approved by their peers. In that way, HCFA will have greater success in modifying physician behavior.

However, as comprehensive as these bills are in addressing many of the most serious problems in Medicare administration, ASIM believes that there are other actions that should be taken by Congress to reform the administrative and regulatory process in that program.

2 *Changes in policies made by carriers should be done in as open a manner as possible.*

- A. Carriers should be required to establish a formal advisory body composed of representatives from state medical organizations, medical specialty societies and consumers with whom they would meet at least quarterly to discuss changes in policy and resolve problems brought to that body's attention.

Currently, HCFA only requires carriers to notify state medical societies and state specialty societies of any changes in their review and reimbursement policies and to give those medical societies a brief period to comment on the proposed changes. This does not truly afford the medical and patient communities a real voice in carrier policy development or in alleviating problems caused by carrier operations.

- B. Carriers should be required to solicit the views of the advisory body on all proposed policy changes (including screens and medical review criteria), publish their proposed policy changes and solicit comments from physicians, consumers, state medical associations and specialty societies and offer at least a 60-day time frame for comments before the policy is made final.

The comment period provided by carriers is now limited to 30 days. Thirty days frequently are too short for medical societies to make informed judgments and comments on policy changes. This is particularly true of rural states where the medical society staff may be limited. In addition, a wide distribution of the proposed policy change will increase the likelihood that the policy ultimately adopted will be feasible in the broadest possible practice settings.

- C. Once the comment period is over, the carrier should be required to state, in writing, its reasons for accepting or rejecting the comments made in making the final policy. This justification would be available to the public on request.

Just as HCFA is required to respond to comments made on its proposed rules, so too should carriers have to provide an explanation of why they have adopted a particular policy. In this manner, the medical and patient community can know why a particular course of action is being pursued by that carrier.

- D.** Once a policy is made final, the carrier should release it to the medical community before it takes effect and, whenever possible, conduct educational forums to ensure proper implementation of the new policy.

Giving physicians and other providers adequate notice of the day on which a new policy will become effective allows them to adjust office procedures in an organized manner. Educating physicians and their staffs about the policy change would further the goal of correct policy adoption and relieve carriers of administrative burdens resulting from physicians' misunderstandings of the policy.

3 *HCFA should be required to implement procedures to improve carrier service, responsiveness and accuracy.*

Physicians and their office staffs also encounter problems in submitting claims for services when they are unsure how to code a particular service. Phone lines provided by carriers for such questions are too often busy. Some carriers have instituted rules whereby the physician's office is allowed to ask only one coding question, meaning that the physician's staff must call back repeatedly in order to get their questions answered. Frequently, the carrier staff handling such inquiries from physicians' offices has had only minimal training in the procedure and diagnosis code manuals and has less knowledge about the medical services and diseases under discussion than has the physician's staff.

In a report recently published by the General Accounting Office (GAO), ASIM's 1987 carrier survey is cited in which 76 percent of internists responding said they had difficulty reaching the carrier by telephone, 63 percent reported the carrier failed to answer their letters in six weeks, and 60 percent said there were occasions where the carrier failed to respond at all to written inquiries. The GAO goes on to name incomplete claims and the inability of physicians and other providers to obtain easily information about their claims as major contributors to Medicare's paperwork burdens.⁴⁰

In 1989, 28 million claims were insufficiently completed to the extent that they were returned by the carrier to the beneficiary or physician for more information. In addition, physicians and other providers wrote more than 3 million letters and made over 5 million telephone calls to carriers for information about program coverage, claims status and payments. Frequently, when the physician or his or her staff cannot obtain the

information they need about a claim previously submitted, they will resubmit it in frustration. More than one-third of the 72 million claims denied payment in 1989 were refused as duplicate claims. According to the GAO, the number of denials could be reduced simply "by giving providers ready access to up-to-date information on the status of claims and beneficiary eligibility."⁴¹

The methods recommended by the GAO to reduce the paperwork burden on physicians and providers are: 1) making it easier for physicians to file claims electronically and 2) establishing electronic communications (e.g., computer) hookups between carriers and medical offices so that information can be conveyed in that manner rather than over the telephone or through the mail. To address the problem of improperly filed claims, the GAO notes that money is provided by HCFA to carriers to inform physicians and other health care providers about the data needed to complete claims. The GAO specifically recommends that HCFA should identify effective methods used by carriers to reduce incomplete claims and encourage their use by other carriers. Unfortunately, HCFA does not require carriers to submit information about educational assistance given to physicians. Therefore, HCFA does not know what effective programs, if any, are being conducted by the carriers to educate the medical community about Medicare program requirements.⁴²

ASIM believes there are a number of actions that can be taken to improve carriers' services to physicians. Specifically:

- A.** There should be adequate training requirements established for carrier employees who review claims and answer questions from physicians' offices including, but not limited to, training in diagnostic and procedural coding and general medical technology.
- B.** HCFA should be required to establish a toll-free telephone line or lines for physicians to answer questions about billing and other general reimbursement matters.
- C.** Limiting the number of questions that can be answered in a call to a carrier should be expressly forbidden.
- D.** Carriers should be required to hold educational programs to help physicians and their staffs meet everchanging regulations and requirements and convey this information to HCFA. Information about particularly effective programs should then be shared by HCFA with all carriers.
- E.** HCFA should be required to include in its carrier performance standards specific requirements for services to physicians and other health care providers. These carrier performance standards

should be provided to the state medical societies and other medical organizations within the state. The standards should include the address to which complaints about the carrier can be directed and information about bringing complaints about the carrier to the attention of HCFA.

- F.** Claims processing by carriers must be reformed to maintain the integrity of claims submitted. HCFA should be specifically required to revise its claims processing instructions to carriers to ensure that supporting documentation supplied with claims is not separated from the claims themselves. In addition, electronically submitted claims should either provide room for supporting documentation or identification of supporting documentation.

Under current HCFA instructions to carriers, the treatment of documents submitted with claims is a prescription for disaster. A common complaint by physicians is that they submitted documentation with their claim for payment to support the services they rendered only to be told by the carrier that "additional documentation is needed." Unfortunately, when a claim comes to a carrier with supporting documentation, the claim is separated from the documents and sent to the claims processing department. The documents are sent to the carrier's "development" department, which is supposed to investigate those claims about which questions arise. Ostensibly, both claim and documents were to have been identified with the same "control" number by the carrier. That way, if the claims processing department raises a question about a claim, that department is supposed to go to the development department and match the claim with the properly identified supporting documents. However, if the carrier failed to give the documents the same control number as the claim, no match can be made, the documents are lost, and the carrier goes back to the physician for "additional documentation." The time and money spent on copying documents for carriers could be better spent on services that directly benefit patient care.

- G.** Whenever possible, the option of electronic claims submission should be encouraged and facilitated by HCFA. Furthermore, HCFA should be directed to offer, or at least identify to its carriers, innovative means of electronic communication between physicians and carriers to reduce the need for telephone inquiries and written correspondence. However, Medicare should not coerce physicians into submitting claims electronically or penalize those physicians who choose not to do so.

For every 1 percent increase in the number of claims filed electronically each year, carriers could save \$1.3 million in processing costs. This money could then be

spent on improving other services to beneficiaries and physicians. The 1989 Omnibus Budget Reconciliation Act called on HCFA to develop a system for expedited payment of electronic claims and to provide physicians with the technical assistance necessary to permit them to file claims electronically. HCFA should fulfill this congressional mandate immediately.

One or two carriers already have established systems whereby physicians can determine the status of claims or request other information from the carrier by electronic means. HCFA has, according to the GAO, resisted promotion of increased automation in claims processing and communications between carriers and physicians out of concern that the costs are too much for the carriers to bear. The GAO dismissed this contention, observing the fact that some carriers have begun to offer electronic communications with physicians on their own initiative "indicates electronic links can be cost-effective."⁴³

- H.** Physicians should be held harmless for actions based on inaccurate carrier advice provided to them in written transmittals or other documents.

Each year, physicians rely on information supplied by the carrier to determine whether they will be a Medicare "participating" physician—that is, take Medicare's reimbursement for all services as payment in full. Every day, physicians ask their carriers for advice on how to submit proper claims that won't be denied or flagged as violating medical necessity rules or exceeding the amounts Medicare will allow them to charge. If the information supplied by the carrier is wrong, and the carrier determines that the physician's actions (based on the wrong information) are in violation of a Medicare rule, the physician can be fined or even barred from Medicare and other federal health programs.

- I.** Congress should appropriate more money if necessary to carry out these reforms.

Many of these reforms may cost additional money. However, if they alleviate physicians' and patients' frustrations with the Medicare program and reduce unnecessary paperwork resulting from misunderstandings of policy, they will reduce costs in the long run through improved administrative efficiency.

4 *HCFA should conduct a review of its current Medicare administrative operations through a task force designated by the HCFA administrator. Representatives of physicians and patients should be included on the task force.*

ASIM is pleased that the new administrator of HCFA, Gail Wilensky, PhD, has identified improving physician/provider relations with that agency as a top priority of her administration. ASIM further applauds her efforts to that end in appointment of an ad hoc task force in HCFA to look at ways of streamlining the regulatory process and smoothing physician interaction with HCFA and its contractual entities.

ASIM believes that this internal task force should be expanded to include outside physician and beneficiary representatives. In addition, there are a number of actions that this task force should take to accomplish its goals:

- A. A comprehensive review should be made of HCFA's carrier and PRO utilization and medical necessity review procedures and policies.

Inconsistencies in policy application and incorrect application of policy by carriers and PROs should be the target of proposed solutions. Because these issues involve medical questions requiring a medical background to address them, HCFA should involve in this task force representatives from the medical community to ensure that those most affected by review policies have some input into their reform. Should HR 4475 be enacted, review of existing regulations and proposed rules could become a formal function of the Physicians' Advisory Council that would be established at HCFA.

- B. Following such review, current requirements that cannot be justified on the basis of a hassle-benefit ratio (see Recommendation 5) should be withdrawn or substantially modified to accomplish the desired end in a less burdensome, more cost-effective manner.
- C. The task force should make specific recommendations for using the results of carrier fair hearings and reconsiderations as precedents for future carrier payment decisions.

This would address one of physicians' most frustrating experiences, whereby they are successful in getting reversed a payment denial for a service only to have a subsequent claim for that service on the same patient for the same condition denied again by the carrier.

- D. Carriers should be advised by HCFA to adopt a system of identification for such claims to alleviate the cycle of denials, reconsiderations, fair hearings and reversals on the same claim for payment.

5 *Congress should mandate that all new HCFA administrative requirements be examined in light of their intended benefits compared with anticipated*

administrative costs and burdens placed on physicians and patients. In essence, HCFA should be required to adopt a "hassle-benefit ratio." Congress should hold all proposed new legislative requirements to the same hassle-benefit ratio.

All new proposed regulations and other administrative requirements that impose additional duties on physicians should be subject to a hassle-benefit analysis to determine whether the intended benefit from the rule will outweigh any additional physician hours, office staff resources, increased physician (overhead) costs and increased program administration costs needed to comply with and administer the rule. Included in that review should be recommendations for achieving the goal in a manner least burdensome to physicians and patients. The burden of proof to justify new requirements should be on HCFA. If a convincing case cannot be made that the benefits outweigh the costs, the requirement should be rejected or replaced with a less costly approach. Similarly, Congress should hold all proposed new statutory requirements to the same standard. Too often, unnecessary or overly intrusive Medicare requirements have been mandated by Congress as part of the budget reconciliation process without first undergoing such scrutiny.

6 *Practice guidelines should be used to improve carrier and PRO review performance.*

Last year, Congress established within the Public Health Service the Agency for Health Care Policy and Research (AHCPR) and charged it with the task of creating at least three practice guidelines by 1991. Practice guidelines are defined by AHCPR as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."⁴⁴ The AMA suggests that guidelines "are recommendations for patient management, which may identify a particular management strategy or a range of management strategies."⁴⁵

In all likelihood, the guidelines developed by AHCPR ultimately will be used by Medicare carriers and PROs in judging the appropriateness and necessity of medical care given to Medicare patients. In fact, the authors of the Blue Cross/Blue Shield study agree that "guidelines for medical necessity (based perhaps on outcomes research) that can be applied by HCFA and its carriers to Medicare Part B claims" would "increase the authority associated with the review process."⁴⁶ Without any clear direction from HCFA and AHCPR as to the use of these guidelines, carriers and PROs may wield them as a weapon to unjustly deny payment for services and penalize physicians for providing medically necessary care. It is essential that any guidelines adopted by Medicare and other insurers include an appropriate range of acceptable behaviors rather than a strict

delineation of what the physician is allowed to do in treating a patient. Guidelines must be applied by insurers in a manner that allows appropriate flexibility.

ASIM has developed a set of principles for use of practice guidelines in medical review and reimbursement criteria that would assure these goals are accomplished. These principles are as follows:

A. Improve coordination between AHCPR and HCFA.

Congress should direct AHCPR, the agency developing guidelines, to coordinate its activities with HCFA, the agency with jurisdiction over the incorporation of guidelines into reimbursement and review policies. HCFA would draft procedures for incorporation into carrier payment and PRO review criteria of practice guidelines. The draft of the HCFA recommendations would then be reviewed by the existing AHCPR Advisory Council and the new Physicians' Advisory Council at HCFA.

B. Incorporate guidelines into carrier policy.

Congress should require HCFA to direct carriers and PROs to review their existing payment and review criteria and, where they conflict with the practice guidelines, revise them accordingly. Carriers and PROs should also be required to notify the medical community in their states of the dates on which they plan to begin using practice guidelines in their decisions. Before that date, however, PROs and carriers should be directed to establish a reasonable period—60 days at least—for physicians to comment on the plan and suggest appropriate screens to conform with the guidelines. The screens ultimately developed from the guidelines should be made available to the public.

C. Properly apply guidelines to payment and coverage determinations.

Once the guidelines are in use, carriers should automatically pay for, and PROs should not question the necessity of, those services and procedures deemed clearly appropriate by the practice guidelines. Furthermore, a service or procedure deemed inappropriate by the guidelines should be considered medically unnecessary by the carrier and PRO, unless the physician has provided an acceptable explanation (with reasonable supporting documentation) to support deviation from the guideline.

When a guideline indicates there may be circumstances in which the appropriateness of a service or procedure has not yet been determined or there is a lack of consensus on appropriateness, carriers and reviewers must be explicitly instructed by HCFA to recognize that lack of consensus. In such instances, carriers and PROs should ensure that any claim questioned under these circum-

stances is given proper professional review. They should be prohibited from denying the claim until the physician is contacted and given the opportunity to provide whatever additional information is necessary to reach a determination of appropriateness.

In applying the guidelines for conditions or diseases, carriers and PROs must be directed to allow for a patient's overall condition, age and other factors such as the physician's background and experience.

When using guidelines for patterns of care review, rather than claim by claim determinations, PROs and carriers should be given specific instructions on how to deal with physicians whose practice patterns are outside the norm. Specifically, physicians should be given an opportunity to respond and explain the difference in practice patterns. If the explanation is unsatisfactory, closer review may be performed on his or her office record to determine whether the aberration is warranted. If the physician constantly abridges the guidelines, he or she should be given an opportunity to correct that practice through education. However, if problems persist, then the carrier or PRO should resort to pursuing denials or other sanctions or both.

7 *The PRO system should be reformed to emphasize quality of care. The Medicare PRO system should be reformed in line with the recommendations of the Institute of Medicine (IOM), particularly with regard to its emphasis on health and quality-of-life outcomes, review of patterns of care, improvements in physician and practitioner decision-making, and rewards for high-quality caregivers.*

Recent evidence collected by the IOM indicates that a small number of physicians in the country accounts for most of the very serious quality problems detected by PROs. In California, only 6 to 8 percent of that state's 50,000 physicians have been cited by the PRO for "serious, recurring problems in quality." In another state, the IOM reports, the PRO medical director reported that "about 5 percent of the practicing physicians in that state accounted for 95 percent of the identified problems in quality."⁴⁷

Every year, the federal government spends \$300 million on its PRO quality and utilization review program to catch a few aberrant physicians. Yet thousands of physicians are cited each year for potential quality problems by PROs and are required to provide dozens of documents to respond to quality questions. They live with the apprehension that they may have points assessed against them by the PRO that can lead to fines or suspension from Medicare and other federal health care programs. One Ohio internist's correspondence with the PRO involved more than 65 pages of letters, patient history, discharge summaries and other documentation. Another internist was cited by his PRO for failure to "indicate discharge

instructions given to patient or family” on the discharge summary the PRO had reviewed. In fact, the discharge summary contained several references to discussions with the patient’s family for his care after discharge that the PRO had apparently overlooked.

In a study recently released by the IOM on the PRO program, the IOM criticizes the current Medicare peer review system for imposing “excessive burdens on providers,” for not using “positive incentives to alter performance” and for being perceived as “adversarial and punitive.” The IOM recommends the gradual replacement of PROs with Medicare Quality Review Organizations (MQROs) to focus more on review of patterns of patient care to detect physicians who fall outside the norm rather than individual case reviews. The IOM further recommends a shift in emphasis to the outcomes of medical care, patient satisfaction and strengthening the ability of health care organizations and physicians to evaluate their own performance. In addition, the report envisions a quality assurance system that would include incentives for physicians and health care providers to provide high-quality care, such as lowering the amount of intrusive review, selective contracting or sharing information with third-party insurers on exemplary health care providers.⁴⁸

8 *Guidelines should be developed to prevent arbitrary downcoding and excessive documentation requests by third-party payers. Specifically, HCFA should be required to issue a directive to all carriers clearly stating the requirements for comprehensive office and hospital visits and the documents that carriers may reasonably request for justifying those services. That directive should also be made available to all state medical societies and specialty societies to ensure that all physicians are aware of the requirements and that the carriers are following these rules.*

In addition to the problems with carrier screens noted earlier in this paper, internists encounter instances where they have spent a great deal of time with a seriously ill patient evaluating a variety of complex conditions and assessing the best means for treatment only to find the carrier downgraded their services, along with their payments, to a “routine” or “limited” office visit. To respond to payment denials, the physicians are asked to supply patient histories and progress notes that can often run into the hundreds of pages for patients with particularly complicated illnesses and chronic conditions. On the other hand, physicians may be kept in the dark about what documents are needed to support their claims for services. Such was the experience of a Virginia internist who recently called ASIM upset because several lengthy visits he made to a hospitalized patient were denied for reimbursement. He submitted to the carrier the patient’s history and physical records, progress notes and patient charts and other records to prove the need for the comprehensive attention given to the very sick patient.

Yet, he was still denied payment for his services. The carrier said he failed to justify the needed services but would not tell him what it would accept as justification.

Still other carriers are coercing physicians into using lower-paying codes through threatened imposition of penalties. Recently, the Medicare carrier for Illinois sent a notice to physicians that said when the carrier downcodes a claim to a less extensive service level with a lower level of payment, the physician must use that code, with its associated lower payment, on future claims for that service or risk being accused by the carrier of overcharging. In essence, the carrier is dictating to the physician what level of service he or she may provide without penalty. This is clearly inappropriate.

Although an ad hoc advisory committee composed of representatives from the AMA and HCFA has been working on recommended reforms to office and hospital visit coding, any changes suggested should be implemented nationwide to ensure consistency in carrier implementation. ASIM believes the following actions should be taken:

- A. Until permanent uniform guidelines are issued, temporary guidelines should be developed on appropriate coding and carrier review. This will prevent inappropriate upcoding while allowing appropriate recognition of visits requiring a higher level of care.
- B. In addition to clarifying coding requirements for office visits, the directive issued by HCFA should explicitly state that claims are not to be routinely denied, that a limited service level is not by definition the appropriate code for a physician’s “usual” visit, that physicians providing proper documentation on a claim are not to be denied payment for higher levels of care, that carriers consider specialty (and case mix) in reviewing the appropriateness of the level of service submitted by a physician for Medicare payment, and that retroactive application of changes in payment policy during post-payment audits will not be condoned.
- C. Finally, HCFA should also advise carriers not to threaten physicians with violations of Medicare maximum charge rules or other penalties to force physicians to use lower service level codes.

9 *The post-payment utilization review process conducted by carriers should be reformed.*

- A. Carriers should be prohibited by law from retroactively applying new policies to old claims in post-payment utilization review (PUR) audits. (See Glossary for definition of PUR audit)

Under current HCFA policy, carriers are authorized to request from physicians a certain number of patient records on which they will conduct a review, or audit, of services provided by the physician and submitted to the carrier for payment. This review is meant to determine if the services provided were medically necessary or were paid at a correct level of reimbursement. If the carrier determines, for example, that 10 percent of the services provided from the sample were not medically necessary, or were coded at an inappropriately high level of reimbursement, the carrier can apply that percentage to several previous years of patient claims and demand repayment from the physician. What sometimes happens, however, is that carriers will change their payment policies and will use the new policies to audit old patient records.

- B. Physicians should be provided better due process in PUR audits and should not be required to pay back any amount until the appeals process is completed.

Once a physician has been notified of a repayment demand resulting from an audit, he or she has 30 days to make that repayment, even if that physician appeals the audit's results. When the amounts to be paid back run into thousands of dollars (some internists have been asked to repay amounts ranging from \$30,000 to over \$100,000), this creates a severe hardship for the physician.

- C. Physicians should be repaid for any services found during an audit to have been insufficiently reimbursed or for which they received no payment at all.

There may be occasions when, in the course of an audit, the carrier finds that the physician coded services at an inappropriately low level of reimbursement. The IRS will credit taxpayers for findings made in their favor during a tax audit. So, too, should physicians get a similar benefit for undergoing a HCFA audit.

If HCFA continues using this statistical sampling method for the purpose of denying claims for payment, it should be applied in the physician's favor as well. However, as discussed below, ASIM questions the overall validity of the post-payment utilization review process.

- D. Claims should not be denied solely by extrapolating findings from a statistical sampling to all claims submitted by a physician for similar services.

ASIM has serious reservations overall with the entire concept of denying payments for individual claims based on statistical samples. Using statistical samples of office records is not a valid way of determining

appropriateness of care in any individual case, and frequently, the "problems" found by audits are due to inadequate documentation, not improper or unnecessary care. Beneficiaries have a right to review of the services provided to them based on their individual circumstances. Across-the-board denials based on a sampling technique result in the denial of benefits for services rendered to some beneficiaries on the basis that they were unnecessary, when in fact the care that was provided in those particular cases—if reviewed based on their own individual merits—would have been found necessary and appropriate. Sampling may be a legitimate technique for triggering more intensive review of individual claims, but denials based on an extrapolation from statistical samples alone—without such individual review—should be prohibited.

- E. Finally, carriers should be required to inform physicians of the criteria on which PUR audits are based and what documentation is needed in the patient records to justify services questioned in an audit.

10 *Reforms should be made in the way consultant services and concurrent care are recognized by carriers. Specifically, the requirements for consulting and concurrent care should be clarified so that there are fewer disputes over their legal validity and the specialty and subspecialties of the physicians' rendering care are taken into consideration. HCFA should require carriers to adopt a uniform system for identifying physician specialty and subspecialty for the purpose of determining the need for consulting and concurrent care services. HCFA should then be required to issue those requirements to all carriers with specific instructions for reimbursing those services and supply state medical societies and specialty societies with this information.*

Internists with subspecialties in complicated diseases frequently are called in as consultants on complex cases or asked to provide care to a patient concurrently with the patient's attending physician. Subspecialists often see their services downgraded by the carrier to brief or limited visits because the carrier fails to recognize their subspecialty in their claims processing.

Recently, HCFA issued a directive to its carriers that affects physicians providing such concurrent or consultant services. Effective July 1, 1990, if there is more than one physician treating a hospitalized patient, and one of those physicians exceeds the carrier screens for intermediate level hospital visits, all of those physicians will have their claims for the hospital visit downgraded to the lowest-paying visit level. Thus, if a cardiologist and oncologist are called in by the attending physician to assist in the care of a very ill patient, and the attending physician has exceeded the number of intermediate level visits allowed by the

carrier to that patient, not only will the attending physician have his or her visits downgraded to a limited visit but so too will the cardiologist and oncologist be downgraded and paid accordingly. There is no legitimate reason for the subspecialty physicians to be penalized because the attending physician fails a carrier screen.

Another problem results from the fact that under HCFA rules, the first consulting physician to submit a bill gets paid the consultant fee and another specialist called in as a consultant who submits a bill second gets paid only for a lesser hospital visit. If physicians are forced to resubmit claims for services provided on a consultant or concurrent basis, or to pursue hearings with the carrier in order to get paid, they will eventually be reluctant to provide those additional services so often required on elderly patients with complicated illnesses.

11 *Government policy on nursing home visits should be revised. Specifically, payment for nursing home visits should be improved to reflect the extent of service provided by the physician. In addition, physician visits to nursing home patients made at the request of the facility should not be automatically denied, and physicians should not be required to see nursing home patients more often than is medically needed.*

As noted earlier in this paper, Medicare will usually pay for no more than one visit per month by a physician to a patient residing in a nursing home. Not only are these nursing home visits paid for at very low levels but the rate of pay is often reduced by the carrier on the grounds that the physician is simply making a “brief” or “limited” visit—even when that visit involves the evaluation and treatment of a patient with multiple, severe and complicated conditions. If the physician is

asked by the nursing home to check on a sudden illness of a patient whom that physician has already seen during that month, a conflict arises between the physician’s desire to help his or her patient and the knowledge that the carrier will deny payment for the visit without substantial additional documentation. For some physicians, particularly those in rural communities, this has become too great a burden, and they have stopped seeing nursing home patients. Other physicians may choose instead to have the patient sent to the hospital emergency room—thereby increasing Medicare’s costs with the expenses of the ambulance and emergency room services.

There is considerable dissatisfaction among physicians with this same requirement for an entirely opposite reason. While Medicare may allow no more than one visit per month to a patient in a nursing home, the program requires the physician of that patient to see him or her at least once a month. For patients whose conditions are stable and who don’t require the attention of the physician, this becomes an unreasonable expense for Medicare to bear and an additional “hassle” for the physician.

ASIM believes the basic issue of limits on or requirements for nursing home visits should be reassessed. Medical necessity reviews will ascertain those visits which do not meet appropriate levels of care. However, it is questionable whether arbitrary limits should be imposed on physician visits with nursing home patients any more than limits should be imposed on the number of times a physician can see a patient in his or her office or the hospital. Conversely, scarce health care dollars should not be expended on unnecessary, but mandatory, visits to nursing homes.

Private Sector Reforms

I *Congress should enact legislation to provide for greater uniformity in the medical review procedures of private health insurance companies. State legislatures should standardize such procedures for insurers operating within their state.*

Traditionally, regulation of the private health insurance industry has fallen to state governments. However, recent attention to the question of access to health care has focused on the need to eliminate, on a national scale, certain inequities characteristic of the private health insurance market. For example, the U. S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) recommended blanket elimination of certain health insurance industry practices, such as excluding from coverage pre-existing conditions or setting a company's employee health insurance premiums based on the experience of that group rather than on the risk pool of the community at large.

A similar judgment can be made about reforming, on a nationwide basis, the medical review and authorization practices of private health insurers. There are approximately 1,500 private health insurers in the United States, each with its own set of rules governing preauthorization of hospital admissions, second opinions and certification of various medical services and procedures. To enhance the consistency of these rules by which physicians and hospitals must live and to introduce some accountability into the actions of private health insurers, the following basic steps should be taken:

- A. Persons reviewing claims for private health insurers should be certified as having an adequate amount of training in medical review.
- B. Each state should be required to have within its insurance commissioner's office or other appropriate state agency an insurance ombudsman for investigation of complaints against private health insurers.
- C. Uniform standards should be set for all insurers operating in a state, for hospital admission preauthorization and other precertification procedures. Such standards should include the services or procedures subject to review, how much in advance review is to be obtained and a

time limit, such as 24 hours, when an approval decision is to be rendered. These standards should be based on the following principles:

- All preadmission review programs should provide for immediate hospitalization, without prior authorization or subsequent denial of payment based on lack of such authorization, of any patient whose treating physician determines the admission to be of an urgent and emergency nature.
- Blanket preadmission review of all or the majority of hospital admissions in and of itself does not improve the quality of care and should not be mandated by the government, other payers or hospitals.
- Policies for review should be established with input from state or local physician review committees and reflect reasonable standards of medical practice. The actual review should be performed by physicians or under the close supervision of physicians with experience in rendering care under review.
- Adverse decisions concerning hospital admissions should be finalized only by physician reviewers, and only after the reviewing physician has discussed the case with the attending physician. Physicians should be able to appeal adverse decisions.
- There should be direct and continuing communications to physicians and patients by the review organization explaining the prior authorization and preadmission review requirements.
- No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review, or solely on the fact that hospitalization occurred in the face of a denial for such admissions without consideration of extenuating circumstances.

- When appreciable amounts of physician time or effort are involved in complying with preadmission review requirements, the physician may charge the payer or the patient for the reasonable cost incurred.
- Preadmission review programs should train their personnel so they can collect the needed data, communicate any necessary information and make valid medical judgments with minimal disruption of physicians' offices.

2 *Regulation of private utilization review (UR) firms should be improved.*

As noted earlier, there are some 200 to 300 utilization review firms operating in the United States. A story in a health care journal recently reported that it is not unusual for physicians to have to answer 10 to 20 calls from different UR firms every day. Typically, these calls involve nurse-reviewers of the UR company comparing the physician's proposed treatment plan to computerized formulas for acceptable medical practice. If the physician's approach does not meet with these computerized screens, the UR firm calls the physician for justification in order for his or her services to be approved for payment.⁴⁹

The tenacity with which some of these UR firms attempt to control costs has led to serious abuses and legal challenges. For example, a story appeared last year in the *The Wall Street Journal* about legal action taken against a UR firm employed by Aetna Casualty and Surety Company and State Farm Mutual Automobile Insurance. Filings in that law suit indicate that the UR firm set dollar amounts, such as \$17,000 per quarter, that reviewers were to save from claims submitted and, as a result, legitimate claims for services were being denied.⁵⁰ One memo from Aetna indicated a proposed plan to make physicians a party to contested benefit claims to encourage quicker settlements. As stated in the memo, "Since most doctors would not find it worth their time to spend several days away from their offices, we would not have nearly so many of these cases."⁵¹

Because UR firms are for the most part unregulated, the only way to respond to their questionable practices has been through the court system. However, a number of states have passed laws regulating private UR firms operating in their borders. Maryland, the first state to enact such legislation, requires UR firms to be licensed

and meet strict standards for their review and appeal procedures and employee qualifications. Violations can be punishable by fines up to \$1,000 a day.

Given the degree of activity in this field, ASIM proposes a number of approaches that can be used to instill greater accountability and reliability on the part of private UR companies:

- A. Private utilization review firms should be regulated through enactment of state laws, such as those adopted by the state of Maryland, which require UR companies to be licensed and meet strict standards for their review and appeal procedures and employees' qualifications.
- B. UR firms should be brought under the jurisdiction of states' insurance commissioners, if they are not already overseen by these state agencies.

3 *Reforms proposed for Medicare review procedures should be applied as well to private insurers. Where private insurers are unwilling to adopt these principles voluntarily, state regulatory authority should be enhanced to mandate protections of physicians' and patients' due process rights.*

Many of the principles identified to improve Medicare should be adopted by private insurers. These principles include:

- A. A more open and participatory policy development process including establishment of physician-consumer advisory committees, 60-day comment periods for published policy changes, and educational forums for physicians and their staff;
- B. Release of medical review screens used by the insurer to determine medical necessity;
- C. Improved training of insurer staff conducting preliminary reviews and handling public inquiries;
- D. Adoption of a peer review process wherein physicians are guaranteed the right to have denials evaluated by physicians trained in the subject area in question;
- E. An emphasis in the review process on changing physician behavior through education rather than punishment.

Access to Care and the Hassle Factor

Access to care proposals should be designed to ensure they do not increase the administrative burdens placed on physicians and patients. Specifically, proposals for a government-sponsored and administered national health insurance plan should be rejected.

Experience with Medicare and Medicaid has shown that, when government picks up the tab for health care, the pressure to reduce costs would likely lead to an increase—not a reduction—in the administrative hurdles physicians and patients would have to overcome to get claims for services paid. Medicare is always at risk to competing budget priorities in annual budget battles. Placing all health care financing in the hands of the government, at an estimated \$250 billion a year, would mean that all medical care would compete each year with deficit reduction, education, defense and other federal priorities. In order to limit its financial commitment to pay for needed care, the federal

government would have a powerful incentive to place further administrative barriers—or hassles—in the way of obtaining benefits for covered services. As one Vermont internist, in recounting the administrative nightmares of Medicare, wrote in *The Bennington Banner*, “Physicians are justifiably worried about the implications of a national health program for their profession and their patients. I’m talking about the physicians that you encounter here on Main Street or up in the Southwestern Vermont Medical Center hill. In recent years, we have seen Vermont Blue Cross/Blue Shield bungle the billing claims of thousands of our patients. We live with this. We know that Vermont Medicaid pays only a small fraction of our bills. But the program that causes us the most dismay is Medicare. If a national health program were at all similar to Medicare . . . then how could we remain in practice?”⁵²

Restoring Faith in the Health Care System

Some might look at the foregoing discussion and conclude that the “hassle factor” is just too big to be solved. The problems are too many, too complex and too closely associated with the government and private sector’s overwhelming needs to cut costs. ASIM disagrees with this assessment because accepting that conclusion will only lead to increasing numbers of disillusioned physicians, declining numbers of primary care physicians and, ultimately, access to care limitations on patients.

ASIM recognizes that alleviating the “hassle factor” is not something that must be done by government and private industry alone. Physicians have a responsibility to avoid problems as much as possible by submitting claims for payment that honestly reflect the level of services provided, carefully documenting those services and knowing how to use their existing rights and duties under the health care system. The old adage —

“Physician heal thyself” — can easily be applied to physicians who refuse to become familiar with PRO and carrier operations and appeals procedures, who insist on submitting inflated reimbursement requests, who refuse to respond to carrier requests for comments on policy changes and who ignore the need to have properly trained office staff and modern office equipment.

At the same time, ASIM believes that the steps detailed in this paper are essential to restoring the physicians’ and patients’ faith in America’s health care system. Developing a more open, cost-effective and accountable system will stem the growing “hassle factors” that threaten to destroy the quality and availability of medical care in this country. ASIM calls on Congress, HCFA, consumers and the insurance industry to make reducing the hassle factor a national priority—before America’s health care system strangles in red tape.

Glossary of Terms

Carrier — Insurance companies that contract with the Health Care Financing Administration (HCFA) to administer the Medicare program and process Medicare claims in particular states.

Downcoding — What occurs when a physician submits a claim to the carrier for payment using a particular procedure code and the carrier changes the code, and with it the reimbursement, to a lower level of service and a lower level of payment.

MAAC — Maximum allowable actual charge. In 1987, Congress limited the amount non-participating physicians can charge to Medicare patients for their services over and above what Medicare pays. The MAAC represents that limit and is determined by a complex formula.

Participating Physician — A physician who agrees to accept Medicare's payments for services as payment in full.

PRO — Peer review organization. PROs contract with HCFA to review certain Medicare claims to determine if the services provided were medically necessary and performed according to acceptable standards of quality. There are 54 PROs operating in the U.S. and its territories.

PUR Audit — Post-payment utilization review audit. In a PUR audit, the carrier asks for a certain number of records from the physician's office. The carrier reviews those records to ascertain whether they support claims for services submitted by the physician. If the carrier finds that, in its estimation, 10 percent of those records contain inappropriately billed services, the carrier applies that percentage to past claims for the same service and demands repayment from the physician.

Screens, Utilization or Medical Necessity — These are numerical or condition-related flags that trigger a carrier or PRO review of a physician's claim for service. For example, PROs run patient records through six generic quality "screens" such as adequate discharge planning, nosocomial infections or an unscheduled return to surgery so that, if a patient's record hits one of those screens, it will be pulled for further review by the PRO to determine if the care given was of poor quality. When a claim for payment hits a carrier screen, it will be pulled for further review by the carrier to determine if the claim should be paid.

Utilization Review Firm — Private companies often hired by health insurance firms to monitor the use of health insurance benefits by enrollees of the health insurance company's benefits plan.

Examples of New Administrative Responsibilities Imposed on Physicians

1. Effective Nov. 1, 1985, Medicare carriers are required to establish prepayment medical review screens to "flag" certain services for additional review before payment. Because HCFA will not inform physicians what the parameters of service are by releasing the screens, physicians have the same types of claims held for further review. When a physician successfully refutes a carrier denial based on a screen, no precedent is set. Thus, the same claim, on the same service, for the same patient can be denied repeatedly, even when the physician is proved right.
2. Effective Jan. 1, 1987, mandatory assignment is required on in-office lab tests. Physicians are required to submit separate claims for lab tests and other unassigned Medicare Part B services or to write on the single claim for payment that they accept assignment for clinical lab tests. (OBRA '86)
3. Effective Oct. 1, 1987, non-participating physicians who provide, on an unassigned basis, services determined to be medically unnecessary by the carrier are required to refund to the beneficiary any amounts collected. Refund is waived if the physician notifies the beneficiary in writing in advance that Medicare would not pay for that particular service. (OBRA '86)
4. Effective Oct. 1, 1987, non-participating physicians must provide, in writing to the beneficiary, certain fee information for elective surgery more than \$500. (OBRA '86)
5. Effective Jan. 1, 1988, physicians must comply with PRO "Medical Necessity" refund requirements. For PRO denials of assigned claims based on medical necessity or substandard quality, physicians must refund any amounts collected. For PRO denials of unassigned claims based on substandard quality, physicians must refund to the patient any amounts already collected, unless the physician has notified the patient in writing that Medicare may not cover that particular service or procedure. (OBRA '87)
6. Effective April 1, 1988, physicians are required to list the name, address and supplier of purchased diagnostic tests as well as the amount charged on claims for payment. (OBRA '87)
7. Maximum allowable actual charges (MAACs) are revised. Physicians are required to personally calculate their own MAACs to make sure carriers have not made mistakes. Some MAAC calculations require a five-step formula for each service. (OBRA '87)
8. Preadmission screening and annual resident review requirements intended to eliminate warehousing of mentally ill patients in nursing homes require the physician to complete questionnaires on all nursing home patients. (OBRA '87)
9. Certificates of Medical Necessity. Completion of these are required by physicians for a number of home care services and equipment rentals. For example, OBRA '87 required, effective August 1989, a new Certificate of Medical Necessity (HCFA 484) for home oxygen rental. This form takes a physician approximately 15 to 25 minutes to complete. For certain durable medical equipment payments, (e.g., transcutaneous electrical nerve stimulator device [TENS]) physicians are required to certify the need for this every two months.
10. Effective April 1, 1989, complete ICD-9-CM codes are required on all claims. Unassigned claims without such numbers or inaccurate numbers will be sent to the inspector general for sanctions. Assigned claims without such numbers or inaccurate numbers will be denied reimbursement. (OBRA '89)
11. Effective April 1, 1989, all PROs are required to conduct preadmission review on 100 percent of 10 surgical procedures. Physicians must obtain from the PRO a "preauthorization number" which must be followed by a written confirmation of the number from the PRO. (OBRA '86)

12. Effective 1989 under a grace period, unique physician identification numbers will be required on claims to indicate performing and referring physicians. Until they are available, provider numbers are required.
13. PROs are authorized to undertake physician office review. Pilot programs were begun in 1989 and will require copying and transmittal of office records to the PRO and responding to PRO requests for additional information or questions about services. PROs must undertake "educational" activities with the physician for problems found during this pilot. There is the possibility that these problems will be forwarded to the Department of Health and Human Services inspector general. (OBRA '86)
14. Effective May 1990, assigned claims submitted without the Medicare carrier identification number of the performing physician will be rejected.
15. Physicians are required to submit all Part B claims beginning Sept. 1, 1990. (OBRA '89)
16. Effective 1990, physician office laboratories will be regulated and required to meet certain standards. With the implementation of regulations, approximately 300,000 physician office labs will fall under the jurisdiction of HCFA. Depending on the ultimate rules adopted, a large percentage of physician office labs will have to be recertified every two years under extremely stringent personnel and performance criteria, and physicians will have to pay up to \$2,100 for each recertification. It is possible, for example, that solo practitioners doing occasional finger stick blood tests will face the same requirements for compliance under the Clinical Laboratory Improvement Amendments of 1988 as laboratories at Johns Hopkins Medical Center. Many physicians may simply close their office labs and force their patients to go to hospitals and other facilities for relatively simple tests. (CLIA '88)

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