The American College of Physicians—American Society of Internal Medicine (ACP--ASIM), representing the nation’s largest medical specialty, is pleased to provide the following testimony to the Practicing Physicians Advisory Council (PPAC) on Advanced Beneficiary Notices and Regulatory Workload for Physicians.

ADVANCED BENEFICIARY NOTICES

ABN Content

ACP--ASIM recognizes that a physician must include specific information on his or her Advanced Beneficiary Notice (ABN) form to ensure that the beneficiary has been adequately informed that a service may not be covered, even though the Health Care Financing Administration (HCFA) has never developed a standardized form. Because confusion exists regarding what must be included in an ABN, we have published the current criteria required for a valid ABN to educate internists on how to avoid assuming liability for a service that although medically appropriate, may not be covered by Medicare.

It is the ACP--ASIM’s understanding that HCFA is in the process of developing more detailed guidance regarding ABN content to address the existing confusion including development of “model” ABN language. We support the concept of making model ABN language available to physicians. Physicians could either incorporate the exact model language into their ABNs or use it to measure the suitability of their own ABN language. We believe it is necessary for HCFA to involve national medical specialty societies in the development of ABN guidance. HCFA’s failure to solicit comments from ACP--ASIM on its draft Medicare Carriers Manual (MCM) section on ABNs that was circulated in early December 1997 prompts us to make this request. Our organization should have been consulted considering that internists see a significant portion of Medicare beneficiaries. HCFA should include ACP--ASIM and other medical specialty societies in its on-going efforts to provide guidance regarding ABN content. Accordingly, we urge PPAC to recommend that HCFA seek input from all appropriate national medical specialty societies.

While we are encouraged that HCFA is addressing ABN content, ABN use continues to be a confusing and contentious issue. Overuse of ABNs can discourage beneficiaries from receiving medically appropriate care and can be detrimental to the physician-patient relationship. Physicians must be careful to avoid approaching their Medicare patients with ABNs too frequently. The difficulty of this situation is often compounded when physicians order services, such as clinical laboratory tests, that are performed by another entity. The entity performing and
billing the services to Medicare may pressure physicians to increase their use of ABNs so that they are able to collect their fee for the services from the patient in the event that Medicare denies payment. The likely result of informing elderly patients, who often have fixed incomes, that they may have to pay for a service is that they will refuse to receive it. Overuse of ABNs is an impediment to patient access to quality medical care that must be avoided.

**ABNs and Clinical Laboratory Tests**

Pressure on physicians to increase the frequency in which they approach patients with ABNs when ordering lab tests is a direct result of the proliferation in the number of carrier specific local medical review policies (LMRPs) for lab tests. An LMRP for a lab test limits coverage of the test to specific diagnosis codes. Despite containing lists of acceptable diagnosis codes, LMRPs often leave the physician uncertain as to whether or not the carrier will pay for the tests. Carriers publish LMRPs in Medicare bulletins. The policies are subject to change after implementation, however. Also, there is no compilation of up-to-date LMRPs that can easily be accessed.

Even though they are open to physician comment through the Carrier Advisory Committee (CAC) process, lists of diagnosis codes decided upon by carrier Medical Directors and included in LMRPs fail to cover every appropriate medical condition. Carrier frequency screens, which effectively deny payment for tests when a claim hits or exceeds a certain frequency parameter during a specific period of time, also contribute to physicians' uncertainty regarding coverage since these parameters are rarely disclosed.

LMRPs put physicians in a precarious situation. It is difficult for physicians to know when an ABN is warranted as they are unlikely to know exactly which conditions meet the carrier's medically necessary criteria for a test. Compounding this problem is the fact that there is no easy way to locate the information. Additionally, physicians are unable to ascertain when it is necessary to submit documentation beyond a diagnosis code to justify a test that is ordered beyond the normally accepted ordering frequency because they are unaware of "black box" claim denial frequency screens.

HCFA must assume its share of the responsibility in informing beneficiaries that they are more likely to be approached with an ABN for lab tests because of the increased prevalence of lab LMRPs. HCFA must not sit idly by as ABN issues dissuade beneficiaries from receiving appropriate care and harm the physician-patient relationship. The practical solution to this problem is for HCFA to provide all parties involved—patients, physicians, and labs—with the maximum amount of information possible to facilitate informed decisions regarding use of ABNs, including instructing its carriers to publish their frequency screens. We reiterate our call for HCFA to release frequency screens to physicians.

The Department of Health and Human Services has convened a negotiated rulemaking committee that is charged with assisting in the development of national, uniform policies for clinical lab tests. ACP—ASIM and HCFA are both members of the negotiated rulemaking committee. The committee is scheduled to discuss and make recommendations regarding "implementation/education" of national lab coverage policies. HCFA's role in the educating
beneficiaries, physicians, and labs must also be addressed by the negotiated rulemaking committee.

We urge PPAC to recommend that HCFA recognize and fulfill its obligation of informing beneficiaries of the effects of lab LMRPs on the ABN process under the current system. We also urge the Council to recommend that HCFA do what is necessary to educate all parties—especially beneficiaries—on ABN implications resulting from implementation of national coverage policies for lab tests following the completion of the negotiated rulemaking process, which is scheduled to conclude in December 1998.

ABNs and Unwarranted Fraud and Abuse Implications

An equally important issue is the disconnect between typical ABN wording and the subsequent information that beneficiaries receive regarding denied claims. ABNs generally include language that informs the beneficiary that a specific service may not be paid because Medicare typically does not cover the service “for this condition” or “at this frequency.” This wording accurately informs the beneficiary that the service in question may not meet Medicare’s criteria for payment. If the physician is correct and Medicare denies payment for the service, the message the patient receives on his or her Explanation of Medicare Benefits (EOMB) has a drastically different tone.

EOMBs sent to beneficiaries explaining that a physician provided (or ordered) a service that failed to meet Medicare’s coverage criteria can expand the definition of what is perceived to be fraud and abuse. Carrier EOMBs often read that the service(s) provided by the beneficiary’s physician “was not medically necessary.” Heightening beneficiary awareness of fraudulent and abusive activity is an important step toward weeding out fraud and abuse, but inflammatory language resulting in unsubstantiated inquiries or allegations is totally inappropriate.

We urge HCFA to change the inaccurate EOMB terminology to avoid enticing beneficiaries into reporting appropriate behavior as fraud. We recommend the phrases “not payable under Section 1862(a)(1)(A) of the Social Security Act” and “does not meet Medicare’s reasonable and necessary criteria” as examples of more suitable EOMB language. The standard phrase of “not reasonable and necessary” also frequently appears in the notification that a carrier upheld a denial on a beneficiary’s appeal. The wording should be avoided in all correspondence to beneficiaries. The introduction of Medicare’s “Beneficiary Incentive Program,” which provides patients with a financial incentive to report their physician(s) for suspected fraud, compounds this problem and makes the shift from inflammatory language imperative. We urge PPAC to recommend that HCFA change its wording on EOMBs and other beneficiary correspondence to accurately reflect the reason for the denial and to avoid condemning the provision of a service as poor medical practice or fraud.

REGULATORY WORKLOAD FOR PHYSICIANS

Volume of Regulations
A presentation from a physician who practices in Kansas to the negotiated rulemaking committee for clinical lab policies helps illustrate the magnitude of the regulatory workload faced by physicians. The physician stated that his Medicare carrier communicates Medicare policies to its physicians through: (1) a Part B Physician’s Manual; (2) LMRPs; and (3) Medicare communiqués. The presenter remarked that the communications are not user friendly and that the sheer volume of regulatory instructions is overwhelming. The annual volume of regulations can most easily be measured by their height when stacked together. The Kansas carrier’s Part B Physician’s manual is approximately two and a half inches thick. The compilation of LMRPs totals about four inches. A binder containing the communiqués, which are sent out once or twice a month, is about three-quarters of an inch thick.

Impact on Physicians and Complexity of Regulations

HCFA must recognize that physicians practice in a world of constantly changing rules, regulations, and requirements. Requirements are communicated to physicians in a disjointed and ineffective way. The physician from Kansas told the negotiated rulemaking committee that his carrier updates LMRPs by periodically publishing additions and deletions to the list of acceptable diagnosis codes. Typically, only the changes are listed. The original policy is rarely updated and published in its entirety. The result is that individual practices have to update the original policies in their files to maintain accurate information, which makes it virtually impossible for physicians to learn LMRPs. Even the most well-informed physicians have difficulty keeping apprised of changing Medicare regulations.

Based on our constant communication with internists across the country, we believe that the Kansas experience described above is common. It is extremely difficult for a physician’s office to keep track of a seven inch thick pile of regulations while treating patients. We acknowledge that the burden is muted for physicians who are in large group practices that maintain separate coding and billing departments. However, physicians in small group and solo practices, which make up the majority of rural practices, do not have the staff to keep up with constantly changing rules. Although physician involvement in comprehending and applying regulations is likely to vary according to practice size, all physicians must be mindful of the universe of Medicare regulations. The magnitude and complexity of regulations is compounded for physicians that are covered by more than one carrier jurisdiction. Keeping track of the morass of Medicare regulations detracts from the time physicians and their staff have available to treat patients.

While the totality of Medicare regulations is daunting, individual events periodically arise that impose an extreme, almost absurd, regulatory burden on physicians. The issue of documentation guidelines for evaluation and management (E/M) services is a good example. Although ACP--ASIM is encouraged that HCFA is attempting to work with medical societies to improve the guidelines, the guidelines that were released in 1997 and are currently in place dramatically complicate physician billing decisions. An internist who carefully reviewed the 1997 guidelines calculated the number of decisions that a physician must make before billing Medicare for an E/M service. There are 11 decision points in categories to consider before selecting an E/M code. Each decision point requires several choices. There are 42 choices a physician must consider before selecting the proper level of E/M service, and 6,144 possible combinations representing the number of ways an office visit for a new patient can evolve and be classified. In
addition to imposing a regulatory burden and detracting from the time physicians have to spend taking care of patients, billing errors are likely to occur because of the regulatory complexity involved.

ACP—ASIM believes that Medicare’s billing regulations are too complex. The responsibility of complying with the myriad of requirements, during the course of treating patients, is becoming increasingly difficult to bear. To illustrate, a physician must be knowledgeable of HCFA national directives—what documentation is needed to substantiate a particular level of service under the documentation guidelines for E/M services, inappropriate coding combinations as identified by the Correct Coding Initiative, and when it is appropriate to bill for services that involve a resident under the “teaching physician” regulations, as well as numerous carrier-specific policies. We believe that simply imposing additional requirements on physicians will not strike at the root of the problem; instead HCFA needs to fix the system that makes compliance exceedingly difficult even under ideal conditions.

The broad scope of the regulatory workload issue precludes us from making specific recommendations. However, we hope that our testimony illustrates the need for a comprehensive assessment of the current regulatory environment and its impact on physicians and their patients. ACP—ASIM urges PPAC to recommend that HCFA undertake such an assessment, and we would welcome the opportunity to work with PPAC and HCFA to reform the regulatory environment.

Implications of Government Efforts to Eliminate Fraud and Abuse

ACP—ASIM contends that government efforts to curb fraud and abuse have resulted in an overly complex Medicare regulatory environment that keeps our health care system mired in red tape by imposing burdens on all physicians simply to eliminate the actions of a few. The following section from our 1998 policy paper, “Reducing Waste, Fraud, and Abuse Without Increasing the Hassle Factor for Physicians and Their Patients,” describes the current regulatory environment.

Over the past 17 years, three consecutive administrations (Reagan, Bush and Clinton) have pledged to reduce Medicare red tape. There has been some progress—the elimination of unnecessary certification requirements, the improvement of a few forms, and the establishment of procedures to allow physicians a greater voice at both the local and national levels in developing Medicare requirements. But the limited progress to date is now at risk of reversal. A new tidal wave of audits, prepayment screens, certification, documentation and paperwork hassles has hit physicians—this time, to rid Medicare of waste, fraud and abuse. The original source of most of this is not the bureaucracy itself, but Congress.

In each of the past two years, Congress has passed laws to increase penalties for fraud and abuse; to expand the definition of abusive practices to include upcoding and billing for medically unnecessary services; and to increase funding for enforcement activities. It has also called HCFA to task for not doing enough to
rid the Medicare program of fraud and abuse, even holding up confirmation of new HCFA Administrator Nancy-Ann Min DeParle last year until she assured Congress that the agency would devote even more resources to fraud and abuse enforcement. HCFA and the Office of Inspector General (OIG) have responded by increasing their scrutiny of the billing practices of commercial laboratories, home health agencies, hospitals, teaching institutions, and--it appears--physicians.

The reason that fraud and abuse enforcement has become popular with members of Congress is that they think it will bring huge savings at minimal political risk. OIG claims that more than $20 billion is wasted each year on abusive and fraudulent billing practices. However, HCFA’s own analysis of the OIG study that produced these estimates indicates that the estimates could be off by $10 billion or more. Regardless of the amount, opinion polls show that the public overwhelmingly prefers increased government enforcement of Medicare providers to means-testing, benefit cuts, or other proposals to reduce Medicare spending.

But no one knows how much this can save. There is little doubt that a small number of laboratories, hospitals, durable medical equipment (DME) suppliers, home health agencies--and even physicians--are engaged in billing practices that are abusive and/or fraudulent. However, much of what OIG counts as fraud and abuse actually represents innocent mistakes or reasonable disagreements on how to code, bill or document for a service--many of these services do not fall under the statutory definition of fraud and abuse.

OIG so far has invested its resources in going after large providers, from which the potential dollar return is highest. Commercial labs have been at the top of the list, followed by home health agencies, DME suppliers, and some physician teaching institutions. Few physicians in solo or small group practices have fallen directly under OIG’s microscope. But it probably won’t be long before some of the mid-to-large size physician group practices find their coding, billing and documentation practices under investigation.

Even if OIG never visits them, virtually all physicians will feel the impact of the government’s crusade against fraud and abuse. Routine post-payment audits by Medicare carriers will increase. Even though such audits rarely result in a referral to OIG for possible violations of the fraud and abuse laws, carriers can ask physicians to pay back tens of thousands of dollars, plus interest, for “overpayments” if it determines that the documentation in the medical records does not support the codes submitted to Medicare. Even if the much-despised documentation requirements for evaluation and management (E/M) services are eased physicians whose medical records don’t support the level of service that was billed will be at risk.

The use of prepayment screens--which kick out a claim for further review before it will be paid--also will increase. And in egregious situations where a physician
consistently refuses to improve documentation and coding practices—after a
carrier has advised that there is a problem—the carrier can call in OIG to
determine if the physician has engaged in "reckless disregard" or "deliberate
ignorance" of the truth—grounds for civil monetary penalties. These civil
penalties are so severe—$10,000 per service, with a maximum of three times the
amount that was falsely claimed, plus a possible five-year exclusion from the
Medicare and Medicaid programs—that most physicians would likely settle with
OIG rather than risk going to court.

Even when OIG’s target is not physicians but other suppliers and providers,
physicians still will feel the effect. For instance, to protect themselves, some
commercial laboratories already are insisting that physicians document the
medical necessity of each test ordered, even within a lab profile. Home health
agencies are likely to insist that physicians spend more time documenting
treatment plans, since the home health agency is at risk if reviewers find that it
billed for medically unnecessary services. Physicians too can be in violation if
they "falsely" certify the need for home health services.

Conclusion

We realize that we would be remiss to point out problems without suggesting solutions. Our
"Reducing Waste, Fraud, and Abuse Without Increasing the Hassle Factor for Physicians and
Their Patients" policy paper, which we provided to the Council at its June 1998 meeting,
recommends solutions to specific problems in the areas of medical review, false claims, skilled
nursing, home health, hospice, and durable medical equipment that are the byproduct of
misguided policies aimed at fraud and abuse detection and prevention. We ask PPAC to review
this paper and to recommend that HCFA implement the solutions proposed in it. Please contact
the ACP—ASIM Washington, D.C. office if you need additional copies.

ACP—ASIM thanks PPAC for the opportunity to comment on the Advanced Beneficiary
Notices and Regulatory Workload for Physicians.