

Department of Health and Human Services  
**OFFICE OF  
INSPECTOR GENERAL**

**MONITORING SERVICES PROVIDED  
IN PHYSICIANS' OFFICES**



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OEI-02-90-00410

# EXECUTIVE SUMMARY

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## **PURPOSE**

To identify and describe the current private sector and Medicare initiatives to improve the monitoring of services provided by physicians in their offices.

## **BACKGROUND**

In the past few decades, much of the emphasis given to controlling the utilization and cost of health care has been in the public sector, primarily with the Medicare and Medicaid programs. These programs have made extensive use of pre-payment and post-payment utilization review (UR) and medical review (MR) techniques in the processing of hospital and medical claims by contractors or State agencies.

The soaring cost of U.S. health care in the last 10 years (up from \$230 billion to \$606 billion in 1989) has spurred similar efforts in the private sector where large employers are seeking to control their rapidly escalating expenditures for health care. The private sector has looked to managed care (MC) programs to help solve this problem. These programs attempt to control costs by assessing the appropriateness of proposed care through the use of prior review techniques, and by channeling patients to specific providers. Examples of major health delivery plans utilizing MC are health maintenance organizations (HMO) and preferred provider organizations (PPO). Together, these plans cover about 75 million subscribers and family members nationwide.

In the public sector, the Medicare program made Part B medical payments of \$37 billion to about 33 million beneficiaries in 1989. Physicians are monitored by Medicare carriers through sophisticated computer programs. The Health Care Financing Administration (HCFA) has continued to build upon 25 years of experience with Part B MR by sponsoring Medicare carrier studies to improve this process. In addition, HCFA is sponsoring PPO demonstrations involving an alternative service delivery model for beneficiaries.

In this report, MC/UR refers to all firms which provide UR and/or MR services, either independent of, or as part of, a MC program.

## **METHODOLOGY**

In-person interviews were conducted with a purposive sample of 12 MC/UR firms (including 5 of the nation's 10 largest general service UR firms) and 5 employers. The respondents selected provided or used MC plans with the most extensive monitoring of physician services provided in ambulatory settings. In addition, visits were made to two Medicare carriers and two PPOs involved in HCFA initiatives to develop utilization and alternative service delivery models.

## FINDINGS

### *Private Sector Monitoring Of Physicians' Services Provided In Their Offices Is Limited But Emerging*

- Few MC/UR programs focus on services provided in physicians' offices.
- A few MC/UR firms are using sophisticated computerized software systems in an effort to contain costs of physicians' services and to develop appropriate patterns of ambulatory care based on diagnoses.
- Trade groups are also developing strategies to address ambulatory care.
- Most MC/UR firms employ some specific quality assurance techniques.

### *HCFA's Initiatives Explore New Ways To Monitor Services Provided In Physicians' Offices*

- The Blue Cross Blue Shield of Arizona and Capp Care PPO demonstrations will allow HCFA to evaluate a private sector MC model's potential for providing quality care to Medicare beneficiaries while containing costs.
- The Blue Cross Blue Shield of North Dakota (BCBS/ND) study has developed data on diagnosis-based patterns of care MR/UR screens.
- Blue Cross Blue Shield of Indiana and Blue Cross Blue Shield of Arkansas are "Flexibility Control Carriers" HCFA is evaluating as part of a controlled study. These carriers have been given greater MR/UR flexibility to find innovative ways to improve Medicare operations.

## CONCLUSION

The HCFA appears to be on the cutting edge of efforts to improve the monitoring of services provided to Medicare beneficiaries by physicians in their offices, and to explore alternative service delivery systems for beneficiaries.

# TABLE OF CONTENTS

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## **EXECUTIVE SUMMARY**

<b>INTRODUCTION</b> .....	1
Purpose.....	1
Background.....	1
Methodology .....	2
<b>FINDINGS</b> .....	4
<b>CONCLUSIONS</b> .....	10

# INTRODUCTION

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## PURPOSE

To identify and describe the current private sector and Medicare initiatives to improve the monitoring of services provided by physicians in their offices.

## BACKGROUND

In the past few decades, much of the emphasis given to controlling the utilization and cost of health care has been in the public sector, primarily with the Medicare and Medicaid programs. These programs have made extensive use of pre-payment and post-payment review techniques in the processing of hospital and medical claims by contractors or State agencies. They have also engaged Professional Review Organizations (formerly Professional Standards Review Organizations) to review the medical necessity of hospital admissions and stays. Also, the Public Health Service (PHS) has a 1989 legislative mandate to develop clinical guidelines over the next several years to enhance the quality, appropriateness and effectiveness of health care. In developing standards of quality, PHS will be stressing outcomes, to help health care practitioners and others who review health care to assure its quality.

The soaring cost of U.S. health care in the last 10 years (up from \$230 billion to \$606 billion in 1989) has spurred similar efforts in the private sector where large employers are seeking to control their rapidly escalating expenditures for health care. The private sector has looked to managed care (MC) programs to help solve this problem. About 300 MC firms nationwide currently provide or arrange for review of services on a packaged or customized basis to employers, unions and insurers; some employers and insurers provide this service themselves.

The MC approach attempts to control costs by assessing the appropriateness of proposed care through the use of prior review techniques and by channeling patients to specific providers. Examples of major health delivery models utilizing MC are health maintenance organizations (HMO) and preferred provider organizations (PPO). While HMOs evolved out of public sector initiatives in the 1970s, PPOs are a private sector development of the early 1980s. They generally do not offer the full range of services found in HMOs, but provide more benefits than enrollees receive in conventional plans.

At present, about 600 HMOs operate nationwide, with reported enrollments of around 35 million. Among these HMOs are approximately 105 plans with Medicare contracts enrolling almost 2 million beneficiaries. The number of operational PPOs in the U.S. has increased dramatically, from 25 in 1981 to around 800 in 1990; they serve an estimated 42 million workers and family members. No current data is available on the actual size of physician membership in either HMOs or PPOs, although about half of all physicians in the U.S. are estimated to be members of one or more MC health plans.

In the public sector, the Health Care Financing Administration (HCFA) is the primary insurer of about 33 million Medicare beneficiaries. In 1989, the Medicare program made Part B medical payments of \$37 billion. For calendar year 1988, the program experienced nearly 124 million visits to physicians' offices, and paid about \$3.2 billion for Part B medical services in that setting.

Physicians are monitored by Medicare carriers through sophisticated computer programs. Often, program dollars are withheld or are recovered from providers when the medical necessity of services is not established. The HCFA has continued to build upon 25 years of experience with Part B service review by sponsoring Medicare carrier studies to improve this process. In addition, HCFA is sponsoring PPO demonstrations involving Medicare beneficiaries.

Other Federal agencies also utilize MC health plans. About 1.8 million Federal employees, retirees and dependents are enrolled in HMOs through the Federal Employees Health Benefits Program - up 16 percent from 20 years ago. The Civilian Health and Medical Program of the Uniformed Services makes MC available to 900,000 beneficiaries through PPO networks in California and Hawaii.

The term "ambulatory" care, as used in this report, includes, but is not limited to, services physicians provide in their offices. Monitoring refers to the application of techniques used to review the actual or proposed utilization of all care for its appropriateness and necessity. Utilization review (UR) is a term generally applied to inpatient hospital care, while medical review (MR) is a term generally applied to ambulatory care. In this report, MC/UR refers to all firms which provide UR and/or MR services, either independent of, or as part of, a MC program.

## **METHODOLOGY**

Mail contact was made with all of the 86 MC/UR firms attending a March 1990 "UR Summit" conference of the American Managed Care and Review Association (AMCRA). Information was requested regarding the specific services offered by each to its clients. In addition, the Washington Business Group on Health (WBGH) furnished, at our request, a list of 15 large employers utilizing MC health plans for their employees. These employers were contacted by phone and mail and asked to provide information about their health care plans. Forty-seven MC/UR firms furnished the requested information. Other firms did not respond, or indicated they were not performing MC/UR for ambulatory care. All the employers were contacted but only 10 offered MC/UR plans to substantial numbers of employees.

From those respondents, a purposive sample of 12 MC/UR firms (including 5 of the nation's 10 largest general service UR firms) and 5 employers was selected for onsite visits. The respondents selected provided or used MC plans with the most extensive monitoring of physician services provided in ambulatory settings. In addition, visits were made to two Medicare carriers and two PPOs involved in HCFA initiatives to develop utilization and alternative service delivery models. Detailed information was collected about each organization's MR/UR activities, quality assurance practices and provider relations. Employers were asked about how health care plans offered to employees were selected and their experience

with MC firms. This information was complemented by statistical and survey data from the Midwest Business Group on Health (MBGH), the American Medical Association (AMA), the Blue Cross Blue Shield Association (BCBSA), the American Managed Care and Review Association (AMCRA), the Group Health Association of America (GHAA), the American Association for Retired Persons (AARP), the Health Insurance Association of America (HIAA) and HCFA.

# FINDINGS

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## **PRIVATE SECTOR MONITORING OF PHYSICIANS' SERVICES PROVIDED IN THEIR OFFICES IS LIMITED BUT EMERGING**

*Few MC/UR programs focus on services provided in physicians' offices.*

The focus of MC/UR has been on inpatient hospital services with special concern for mental health and substance abuse cases (MHSA). All 47 responding MC/UR firms provide comprehensive programs for managing inpatient hospital services and some ambulatory services. Most of these firms (37 of 47) perform UR of inpatient hospital and ambulatory MHSA services. Four specialize in MC/UR for MHSA services.

While twenty-two of the 47 firms report performing some variety of ambulatory care review, the extent is quite limited. Seventeen of these 22 firms limit ambulatory care review to prospective certification of selected procedures or procedures over a certain dollar amount. Some also perform retrospective review of targeted ambulatory services, such as chiropractic care. Only the remaining five firms are using relatively new and highly sophisticated computer software systems to monitor services provided in a physician's office.

The lack of private sector experience with the monitoring of physicians' in-office services was noted in a recent issue of *Medical Utilization Review*, an industry newsletter:

Currently, carriers and other vendors of UR management services are promoting new ambulatory care UR systems. However, employers must keep in mind that ambulatory care UR is immature and has not yet evolved to the same degree as inpatient UR. (Faulkner & Gray's *Healthcare Information Center*, Washington, D.C., October 25, 1990)

*A few MC/UR firms are using sophisticated computerized software systems to contain costs of physicians' services and to develop appropriate patterns of ambulatory care based on diagnoses.*

The computer programs used by four of the five MC/UR firms which review in-office services screen physicians prospectively (where prior utilization data is available) and identify physician member outliers through sophisticated data base management programs. The firms get outliers to conform to acceptable utilization levels or drop them from their HMO and PPO networks. In contrast, Medicare law permits HCFA to exclude a physician from participation because of excessive utilization only as the result of a long and complex sanctions procedure, usually related to a quality of care issue.

Three of these MC/UR firms, including two insurers, utilize an adaptation of a patented software program that measures services billed against established standards of treatment based on diagnoses. A key element in the patented program is the use of local physician control and input. However, the three firms have obtained little or no local medical community input in adapting



the program. All use the system primarily on a prospective basis, to determine appropriateness of services based on the established guidelines.

According to these respondents only about 40 organizations nationwide, including major insurers and HMO networks, use the patented software program for this purpose. The total population covered by all these programs is estimated to be three million, or less than five percent of all those estimated to be covered by MC plans.

Indications are that the popularity of such programs is growing. Similar types of software have been developed or are being developed. The insurers and MC/UR firms using them say they now have a clearer picture of where health care costs are located. More time is needed, however, to adequately assess financial impact and employer and subscriber satisfaction.

***Trade groups are also developing strategies to address ambulatory care.***

The HIAA has proposed a strategy to achieve efficient and high-quality health care in the private sector through a public-private insurance system. Such a system would include efforts to channel patients to efficient, high-quality providers, and to promote and participate in the development, dissemination and use of outcome-based medical guidelines and protocols as a means of improving the quality of patient care.

According to the MBGH, major strategies currently being pursued by employers include developing employer-sponsored purchasing initiatives for specific procedures or comprehensive service, and requiring quality and cost-containment features from insurers and providers as a basis for contracting.

Recently, the AMA, HIAA, BCBSA and AMCRA formed a task force to develop national utilization review guidelines for inpatient hospital services. Down the road, a similar effort is planned for out-of-hospital services.

***Most MC/UR firms employ some specific quality assurance techniques.***

Seven of the sample MC/UR firms select physicians for health care plans, based on rigorous credentialing which screens physicians prospectively, and analysis of utilization data to identify aberrant practices. These are quality assurance (QA) techniques used by all. Credentialing committees are used by these firms to develop, maintain and apply the qualifications standards necessary in the selection of physicians wishing to join the HMO or PPO plans. Data is collected on medical specialty and licensure, board eligibility or certification, medical education, professional liability coverage, hospital affiliation(s), preference as to participation as either a primary care physician or specialist, call coverage and other administrative information. Some of these firms also conduct consumer satisfaction surveys. (In contrast, a physician providing services to Medicare beneficiaries need only be licensed in the State of practice in order to be reimbursed.)

One large insurer among these seven firms has an extensive credentialing process for physicians. All physicians in an area selected for the development of a network are invited to focus group

discussions. Their perceptions and attitudes towards MC, PPOs, utilization review and other topics are collected. Preliminary screening consists of checks for prior sanctions or disciplinary action, board eligibility or certification, malpractice history, and hospital staff privileges. In addition, provider relations staff visit every provider's office to check for modern and sanitary conditions, adequacy of waiting room area, administrative as well as record keeping procedures and additional aspects of the physician's practice. This usually takes up to 3 months to complete. Following selection, provider relations staff visit every primary care physician in the network at least quarterly to discuss any problems, complaints or areas of concern of either party.

For the most part employers do not get involved in the particulars of quality assurance but instead rely on MC firms to perform these duties. The five major employers visited either use internal medical staff or QA coordinators to monitor quality, but most of the emphasis is on inpatient care. These employers all use survey instruments to determine employee satisfaction with their current health plans and as a way to spot poor quality care.

Comprehensive quality review procedures involving proactive approaches are generally not found in MC/UR firms affiliated with PPOs. As PPOs are a recent innovation in the health care market, little evidence is available about their effects on health care costs, quality of care or patient satisfaction.

The firms visited rely mainly on contact with the providers through prior authorization of specific services, e.g., elective surgery, to assure quality and appropriate care. However, HMO plans are generally required to have a formal QA program in place, as was the case with four of the sample MC/UR firms affiliated with HMOs.

About 75 percent of nearly 600 active HMO plans nationally meet Federal standards and most States also regulate them. These HMOs have QA programs which include some review of in-office services. PPOs are exempt from the State and Federal regulations governing HMOs.

Some of the MC/UR firms visited said that a barrier to assuring quality of care was the lack of an acceptable definition of quality. In this regard, the Institute of Medicine's (IOM) Committee to Design a Strategy for Quality Review and Assurance in Medicare, formed at the behest of the Congress as a result of OBRA 1986, defined quality of care in its 1990 report as "the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge." The IOM study noted with regard to ambulatory care:

Both overuse and underuse of services are of concern in the physician-office setting ... We know far less about methods for reviewing the quality of care in the ambulatory setting than those for inpatient care. In the coming years, information from PRO pilot projects, HMO experiences, and research and demonstration studies focusing on outcomes management in ambulatory care should help to close that gap....

## **HCFA'S INITIATIVES EXPLORE NEW WAYS TO MONITOR SERVICES PROVIDED IN PHYSICIANS' OFFICES**

The HCFA's efforts to monitor physician services more effectively and study alternative service delivery models have resulted in various initiatives. Two of five PPO demonstrations planned by HCFA are under way and a third is being considered. The Blue Cross Blue Shield of Arizona (BCBS/AZ) private business PPO and Capp Care PPO of California are demonstration sites. Each is required by HCFA to maintain a structured QA program. The HCFA also entered into an agreement with Blue Cross Blue Shield of North Dakota (BCBS/ND) for the development of diagnosis-based patterns of care MR/UR screens. Blue Cross Blue Shield of Indiana (BCBS/IN) and Blue Cross Blue Shield of Arkansas (BCBS/AR) have also been funded by HCFA as "Flexibility Control Carriers"; each has been given greater MR/UR flexibility to find innovative ways to improve Medicare operations. Following are brief descriptions of each of these initiatives:

### ***The Blue Cross Blue Shield of Arizona Demonstration***

The HCFA contracted with Blue Cross Blue Shield of Arizona (BCBS/AZ) in 1988 for a Medicare demonstration of the PPO concept which marketed a Medigap policy (Senior Preferred) with lower premiums than usual and added benefits. A panel of 1,100 physicians was established from those who met and maintained PPO participation criteria set by BCBS/AZ for its own PPO. Physician profiling is the key means of exercising utilization control over physicians' services. The plan has not emphasized MR/UR activity but monitors the physicians receiving the largest reimbursement. It relies less on the physician's ability to change behavior and more on having chosen efficient physicians in the first place through effective credentialing. The entire membership is reviewed according to formalized criteria on a bi-annual basis, including review of economic profiles and quality concerns. The contract signed by participating physicians can be terminated at any time by either party.

The BCBS/AZ has a structured QA program which includes the Medical Office Review and Evaluation Program (M.O.R.E). This program, with its onsite visits and evaluations of physicians' office and medical practices, includes reviews of the content of medical records, evaluation of office facilities, safety and hygiene, laboratory and X-ray facilities and procedures. The M.O.R.E. gives BCBS/AZ useful information for individual and peer quality assessments. The visits are conducted confidentially and the findings are shared with the member physician, along with recommendations to correct problems noted. Physicians are expected to implement the recommendations.

Patient grievances serve as quality checks; BCBS/AZ is planning a patient satisfaction survey of Senior Preferred enrollees to assess their reactions to the provider panel and to the service and benefits.

### ***The Capp Care PPO Demonstration.***

The CAPP CARE PPO demonstration started in Orange County, California and is due to expand to nine counties in Southern California. The pilot demonstration, open to all 188,000 Medicare beneficiaries in Orange County, began operating in March 1990. Approximately 900 physicians participate. Providers must be willing to accept assignment and comply with all billing guidelines and UR procedures.

These physicians are part of CAPP CARE's private PPO network and are subjected to a rigorous credentialing process, including licensure, liability claims, professional society complaints and other disciplinary indicators. In addition, a profile of each physician is gathered containing such information as medical school, specialty, board certification and hospital affiliations. If a sufficient number of claims are available, physician-specific profiles are developed and compared to established normative values. Physicians whose practice profile shows a significant variation from established parameters are excluded. Physicians whose various profiles conform to CAPP CARE standards are eligible to join the network.

The CAPP CARE demonstration has a quality assurance program for ambulatory services similar to the one it uses with its private payers. Ambulatory care review is performed using a computerized system that compares physician claims to normative values that are specialty-specific. The review is completely automated and data is run through edits that detect frequency of use of certain higher reimbursable codes and frequency of injections and laboratory tests. The system generates QA reports that detect aberrant billing practices and are reviewed by a QA committee. Ambulatory services are also monitored through a formal patient grievance system specifically designed for the Medicare PPO. It allows beneficiaries to register complaints and sets down guidelines for their effective resolution.

The demonstration is a non-enrollment model which is free of risk to Medicare beneficiaries; participation is automatic any time they choose to see a plan physician. Marketing of the demonstration was limited to a mailing to all Orange County beneficiaries announcing the demonstration and providing a directory with the names, addresses and specialties of all participating physicians.

### ***The Blue Cross Blue Shield of North Dakota Patterns of Care Study.***

In March 1988, HCFA entered into an agreement with Blue Cross Blue Shield of North Dakota (BCBS/ND) for the development of diagnosis-based patterns of care MR/UR screens. These patterns included the full range of services generally provided to patients with a given diagnosis. The carrier started with 8 diagnoses based on volume of claims processed and reimbursed, e.g., cataract surgery. The carrier added additional patterns, establishing 63 altogether. Each of the patterns was developed with the assistance and review of physician consultants and with general provider input. Acceptance by the medical community in North and South Dakota was necessary before implementation of the program began.

Based on an agreement between the AMA and HCFA (Transmittal No. 1290, dated 2/89), the carrier notified the providers in North and South Dakota that the MR/UR system had been

developed. Meetings were held with peer review organizations and medical associations in both States to discuss the project, solicit comments and open a channel of communication with the medical community.

The carrier developed and implemented a computerized system for applying the new screens and began testing the program. Using the beneficiary histories and paid claims information in the system, it found that the screens were successful in identifying claims in need of further review. At present, all the carrier data concerning this process has been turned over to HCFA for review and disposition.

### *The Flexibility Control Carrier Studies*

Blue Cross Blue Shield of Indiana (BCBS/IN) and Blue Cross Blue Shield of Arkansas (BCBS/AR) are "Flexibility Control Carriers" HCFA is evaluating as part of a controlled study. These carriers have been given greater MR/UR flexibility to find innovative ways to improve Medicare operations. For BCBS/IN and BCBS/AR, HCFA has suspended or waived many MR/UR requirements other carriers must meet, such as relevant CPEP standards, mandated screens, the 5 to 1 cost benefit ratio and prescribed postpayment review processes. The HCFA will decide whether greater flexibility can produce a better MR/UR package. The study also involves Health Care Compare (HCC), a private sector MC firm performing MR/UR of Part B claims for Aetna Life of Georgia, the Medicare carrier, under a subcontract. In this case, HCC must perform under the standard requirements governing all carriers.

The BCBS/IN, which was included in the study sample, has developed some innovative policies and practices to improve MR/UR. The development of medical policy is one such area. The carrier has offered the State and local medical community an extensive role in the development of medical policies and MR/UR guidelines. Every effort is being made to thoroughly research current literature on prospective policies, meet or otherwise communicate with medical specialty societies, the AMA and the Current Physician Terminology board for definition clarification.

The carrier's Medical Director decides on the need for a policy, drafts and circulates it to an internal committee to assure conformity with regulations and law and to assess the practical aspects of implementation. Copies go to a Physician's Committee calling for a response within 30 days. All comments are carefully considered and conflicts are resolved by the Medical Director by phone. The policy, published in a Medicare B Bulletin, takes effect 30 days later. Thus far, 110 new medical policies have been developed under the flexibility study. It appears that bringing the State and local medical community into the policy-making process helps maintain better provider relations and makes enforcing policy guidelines more effective.

The BCBS/IN has hired a programmer/researcher who uses the Statistical Analysis System (SAS) program to generate management reports and analyze MR/UR data and trends. Part A utilization data are merged with Part B data in this program, so that review and analysis of all related services is possible. Validation audits are conducted of large Part B expenditures by specialty and provider. Refined reports are available to focus on utilization patterns of any provider and compare them with their peers.

The BCBS/IN is building a prototype SAS program that allows claims data from other carriers and fiscal intermediaries to be run through the SAS system and generate the same kind and number of management analysis reports. This would assure a consistent format among carriers for producing and analyzing utilization data.

## **CONCLUSIONS**

The HCFA appears to be on the cutting edge of activity to improve the monitoring of services provided to Medicare beneficiaries by physicians in their offices, and to explore alternative service delivery systems for beneficiaries.