MEDICARE: CURES FOR BILLING CODE COMPLEXITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

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MEDICARE: CURES FOR BILLING CODE COMPLEXITY

THURSDAY, APRIL 9, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Kansas City, KS.

The subcommittee met, pursuant to notice, at 11:09 a.m., in the Battenfeld Auditorium, University of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, KS, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Snowbarger, and Barrett.

Staff present: Lawrence J. Halloran, staff director and counsel; Marcia Sayer, professional staff member; Jesse S. Bushman, clerk; and Cherri Branson, minority professional staff member.

Mr. SHAYS. I would like to call this hearing to order and to welcome our witnesses from our two panels. Let me welcome our witnesses, our guests, to this very important hearing and I would like to begin by thanking Kansas University Medical Center, and Roger Latson, vice chancellor for administration. I would like to thank our court reporter, William Warren; our clerk, our subcommittee staff and Mr. Snowbarger's staff as well for this hearing.

This hearing is at the request of the vice chairman of the subcommittee, Mr. Snowbarger.

The subcommittee convenes this hearing in Kansas today at the request of our vice chairman, Congressman Vince Snowbarger, who has been an articulate, constructive voice in our oversight work, pressing Federal health officials to focus on quality and efficiency over complexity and bureaucracy. We all appreciate the opportunity to be here, and to hear from our witnesses with a unique perspective on the often conflicting demands of medical practice and Medicare paperwork.

As the April 15 tax deadline nears, we are reminded of the price exacted by the accumulation of regulatory technicalities. The Medicare billing system is beginning to resemble the Internal Revenue Code—some think even surpass it.

The first Medicare guide for physicians was less than 200 pages. I am holding that guide right now, less than 200 pages. Today, providers' reimbursement is governed by thousands of pages of regulations, guidelines, and directives. What you see before us right now are those regulations, guidelines, and directives. Practitioners must master the intricacies of more than 7,000 procedural codes and accompanying documentation requirements, or face the prospect of audits, civil fines and/or criminal sanctions. So elaborate a system

wastes time and resources for those who must comply, as well as those who must enforce it. Such Byzantine complexity spawns even more sophisticated evasive schemes, while the regulatory thicket ensnares more of the innocent along with the guilty in its expanded web.

So today, we ask three questions.

First, how does the complexity of the current Medicare coding and billing system affect the practice of medicine and the cost and quality of care?

Second, how do the Department of Justice and the Department of Health and Human Services make sure inadvertent errors, borne of complexity alone, do not trigger enforcement actions?

And third, how might the current system be improved to ensure quality care while assuring accountability for public funds?

Because the subtleties of the healing arts must be translated to the blunt exactitude of the balance sheet, some tension between practitioners and payers is truly inevitable. Some is avoidable. Today, we ask our witnesses to help us take the measure of each.

We appreciate again the participation and dedication of our witnesses in today's effort, and we welcome them.

At this time, I'd like to recognize Mr. Barrett from Wisconsin.

Mr. BARRETT. Thank you, Mr. Chairman. I would like to say it is a pleasure to be back in Kansas City, but I have never been here before. [Laughter.]

So it is a pleasure to be here for the first time and I am glad that we are having the hearing here today.

In 1998, Medicare is expected to implement a new way of calculating fees. The implementation of a new fee schedule is driven by efforts to contain costs in the Medicare billing system and propelled by the desire to balance the Federal budget. Under the Balanced Budget Act of 1997, several significant changes were made to Medicare, including the changes in calculations affecting physician payments. The act also required the General Accounting Office to review the effects of the changes proposed by the Health Care Financing Administration in response to the overall Federal deficit reduction plans.

GAO published its review in February 1998. It found statistical analysis errors in HCFA's adjustment methods which would affect the practice expense factor in that HCFA's placement of upper limits on labor estimates were not supported by any data. GAO also found that HCFA's method of assigning indirect expenses, such as office overhead is acceptable. GAO was unable to reach any conclusions about whether the new fee schedule will actually result in diminution of income for any particular physicians' group or whether the revisions will adversely affect access to care.

In addition to the proposed new payment structure, new documentation requirements relating to physicians' services have been proposed. While accurate medical record documentation assists in efforts to detect fraud, waste and abuse, appropriate documentation also assists in determining whether a patient has received good care. Concerns, however, have been raised over over-vigilance in enforcement and penalties for innocent errors.

Mr. Chairman, we all want a Medicare system that provides appropriate care to patients and fair compensation to providers. I be-

lieve that by hearing the views that will be expressed by today's witnesses, we will gain valuable insight into the actions we in Congress need to take to assure that outcome.

Thank you.

Mr. SHAYS. Thank you. At this time, I recognize the vice chairman of the subcommittee, Mr. Snowbarger.

Mr. SNOWBARGER. Thank you. I might first point out to the crowd that you are lucky there are only three of us. This process normally takes about an hour when you go through the full committee, with all of us telling you why we are here.

And thank you, Mr. Chairman, I appreciate your coming to Kansas to hold this hearing. I am pleased that the Government Reform and Oversight Subcommittee on Human Resources can join me today in the Third Congressional District of Kansas to discuss the complexity of the Medicare billing process. It is an honor to have you and Congressman Barrett here today, and welcome.

Mr. Chairman, a little more than 30 years ago, Congress amended its Social Security Act to include health care coverage for individuals 65 and over. As with all Federal initiatives, a bureaucracy was created to ensure that the program carried out the congressional intent. The goal was to ensure that quality health care was available and properly administered and that health care providers were fairly compensated for the care they provided.

When Medicare began in 1967, 19 million people were enrolled in Medicare at a cost of slightly more than $3 billion. There were some in Congress at that point in time that predicted that by 1990, the cost of that would be $9 billion. Well, the reality is that the actual cost is more than 10 times the original estimate. Today, Medicare will serve over 40 million beneficiaries, it will process almost 1 billion claims and it is projected to cost $211 billion.

At its inception, Medicare was governed by 150 pages of regulations outlining everything from provider participation to covered services. And at that time, health care providers had seven general categories under which they billed Medicare. By contrast, the regulations for today's Medicare Program take up more than 22,000 pages in the Code of Federal Regulations and instead of 7 general categories for provider reimbursement, today's physician must choose 1 of over 7,500 services that they can bill for.

We cannot say that this entanglement of bureaucracy and regulations is intentional. The 7,500 codes and the 22,000 pages of regulations were written with the assistance of health care providers to ward off problems, not to create them. But one must pause when he hears that there are seven different codes for inserting a catheter into a vein and another seven codes for inserting a catheter into an artery. It leads us all to question the impact this has on the health care community to provide quality and cost-effective care.

A recent OIG report suggests that the Medicare problem is inherently vulnerable to incorrect provider billing practices and an audit of HCFA's fiscal year 1996 financial statements conclude that Medicare lost $23.2 billion to waste, fraud, and abuse. This report is startling and many in Washington are proposing legislation to remedy this. Unfortunately, there has been very little work done to uncover why we are losing money.

Before Congress proposes a cure, we should better understand what problems are afflicting the program. If we fail to do this, I am afraid that Congress will be tempted to add another layer of regulations to the thousands that already exist.

While it is naive to say that there is no fraud or abuse, I believe it is also wrong to assume that the health care providers are out to defraud or abuse the system. Our hospitals and physicians have a long history of providing quality care to individuals in need, regardless of their ability to pay. However, there is deep concern by those in the provider industry that inadvertent errors will be viewed by administrators as fraudulent. With the passage of the Kennedy-Kassebaum health care bill, the monetary penalties for coding errors increased to $10,000 plus treble damages. Now that is not to say that those who willfully defraud the system should not be punished—clearly they should and the punishment should be harsh. But there is an increased uneasiness among health providers that their ability to care for patients is being compromised by complex regulations and onerous penalties.

There is no doubt that administering and complying with Medicare is an arduous task and if we do not begin to address some of the problems facing it, it may lead to further erosion of the entire system. And we must not let that happen. There is a sense of urgency for dealing with these problems because financial integrity of Medicare will be severely strained by the influx of the baby boomer generation. It is crucial that we bring simplification to the billing process because today's errors will only be exacerbated by the additional millions of people coming into the system.

The question we must ask is why these problems exist. Is it that health care providers are committing fraud? Is it that a complex system is inherently susceptible to waste? Are providers not receiving the information they need to file accurate claims with HCFA?

We will not answer these questions overnight; however, this hearing is a great opportunity to begin a dialog about the issues and our ability to find answers will require the coordinated effort of an informed Congress, an open administrative agency, and all health care providers. We must be committed to seeing this task through to ensure benefits to future Medicare beneficiaries.

Mr. Chairman, I look forward to hearing the testimony. I appreciate the witnesses appearing today. I thank you for holding the hearing here. And one last thing is I would like to thank KU Medical Center for providing the facilities for us today. They have done an excellent job in setting this up for us and I do appreciate that.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you, Mr. Snowbarger.

Let me say something before I recognize the witnesses. First, any reference to the IRS or to HCFA, I want you to know is said with the recognition that Congress is as much a part of the problem as anyone in the executive branch or the bureaucracy. It would simply be wrong for us to place the blame with one particular group. We are all part of this problem and we are all going to be part of the solution. And to let you know this is not a hearing just to have a hearing, this subcommittee was the subcommittee that recommended to the full Congress that we make health care fraud a Federal offense, both for the public and private sector, because we

thought it was rather absurd to deal with health care fraud on the Federal level from wire or mail fraud and only be able to approach it that way. This is a very active subcommittee. We follow through with what we do. This is the first of many hearings. We are literally here in the center of the United States because Mr. Snowbarger, who has been focused on this issue for a long time, requested the hearing be here. It is important that we are here and we are delighted that Kansas City is the first place that we have had a hearing. We want it to lead to tangible results, we want to be part of the solution and we place blame nowhere. And I just want to say that for all our witnesses, both for this panel and the second.

And before introducing our panel, I also want to just point out to you that when we walked into this room, there was a picture of J.R. Battenfeld, a doctor, who gave his life—this is the J.R. Battenfeld Memorial Auditorium. He was in the USNR Medical Corps, and he was killed in the line of duty on February 15, 1945, serving his country, enabling all of us to have this day to debate and to argue as Americans in a free society. And I just want to acknowledge his service and to recognize why all of us have the privileges we have today.

And with that, I would just like to point out who is in our hearing and to swear in our witnesses. We swear in all our witnesses, we are an investigative committee and we swear in everyone, as they all know.

William Robertson, the senior executive officer, Shawnee Mission Medical Center, will be addressing us first. Then Dr. David Leitch, family practitioner, Kansas City; then Dr. Steven Buie, immediate past president, Kansas City Medical Society; then Dr. David Cooley, a rheumatologist, Kansas City; Dr. Arthur Rosenberg, section chief, Department of Oncology and Hematology, Greenwich Hospital in Greenwich, CT, my constituent; and then Kathryn Vance, presently group practice manager for internal medical practice, Greater Kansas City Medical Managers Association.

At this time, I would invite our witnesses to stand and I will administer the oath.

[Witnesses sworn.]

Mr. SHAYS. For the record, all our witnesses have responded in the affirmative.

I will also point out that we are going to be a bit stricter on the 5-minute rule. I realize that many of you have come from different places and 5 minutes is not a long time; but we are going to try to stay pretty strict to this 5-minute rule. We will let you go over a minute, but we cannot let it go on too much longer because what we want to do is allow for the audience, at the request of Mr. Snowbarger, to also contribute to this hearing. We are going to go through panel 1, we are going to ask questions; we are going to go through panel 2 and ask questions; and then we are going to allow for anyone in the audience who has heard what panel 1 and 2 have said, to comment on what they have said, to comment on any question that we have asked. We will ask you to sign a card, we will then see how many people we have. We are going to get out of here by 4. So depending on how much time it has taken for the first and second panel, we will know how much time we have for the audi-

ence. But those in the audience who would like to make comment, we think we will have the opportunity for you to do that. So you can take some good notes.

Mr. Robertson.

STATEMENTS OF WILLIAM G. ROBERTSON, SENIOR EXECUTIVE OFFICER, SHAWNEE MISSION MEDICAL CENTER, MEMBER OF KANSAS HOSPITAL ASSOCIATION; DAVID LEITCH, M.D., FAMILY PRACTITIONER, KANSAS CITY, KS; STEVEN BUIE, M.D., FAMILY PRACTITIONER, IMMEDIATE PAST PRESIDENT OF GREATER KANSAS CITY MEDICAL SOCIETY; DAVID COOLEY, M.D., RHEUMATOLOGIST, KANSAS CITY, KS; ARTHUR ROSENBERG, M.D., SECTION CHIEF, DEPARTMENT OF ONCOLOGY AND HEMATOLOGY, GREENWICH HOSPITAL, GREENWICH, CT; AND KATHRYN VANCE, GROUP PRACTICE MANAGER FOR INTERNAL MEDICINE PRACTICE AND PRESIDENT-ELECT, GREATER KANSAS CITY MEDICAL MANAGERS ASSOCIATION

Mr. ROBERTSON. Congressman Shays——

Mr. SHAYS. I am sorry. I am being reminded by the staff that we have to do one other thing and that is to ask for unanimous consent—I ask unanimous consent that all members of the subcommittee be permitted to place an opening statement in the record and that the record remain open for 3 days for that purpose. And without objection, so ordered.

I further ask unanimous consent that all witnesses be permitted to include their written statements in the record, and without objection, so ordered.

And I would also ask that the record be open for 5 days for anyone in the audience who would like to submit information to this committee that it be part of the record. In fact, all the unanimous consents, without objection, will be for 5 days.

I am sorry, Mr. Robertson.

Mr. ROBERTSON. Chairman Shays, Vice Chairman Snowbarger and Congressman Barrett, thank you for your interest in addressing the complexity of the Medicare Program and for the invitation to speak here today.

Mr. SHAYS. I am going to start your clock over and I just need to know if you are hearing in the back. You are hearing all right? Just a little louder and that will be great. Start the clock over again, please.

Mr. ROBERTSON. It is good to be here today, I appreciate your invitation to speak here. Welcome to the great State of Kansas.

I am Bill Robertson. I am the senior executive officer of Shawnee Mission Medical Center, one of the largest hospitals here in Kansas City and also one of the largest hospitals in the State of Kansas. Last year, we had the privilege of serving Medicare beneficiaries to about 94,000 encounters. Serving Medicare beneficiaries is a part of our mission as a faith-based, not-for-profit hospital and we consider it to be a privilege to do so.

I like to think of our health care system as an ecosystem; it is one in which there are multiple players and we all interact together, we coexist, we also coevolve together to create what we have today. It is a complex system and yet with all its flaws, it is

one of the best systems in the world. And Medicare plays a very significant part in that system.

Medicare recipients receive their care from a wide variety of providers. They receive care in physician offices, in urgent care centers, in emergency departments, inpatient hospitals, in skilled nursing units and through home health agencies. Shawnee Mission Medical Center provides services across this full continuum in order to best meet our patients' needs.

Each of these delivery settings has a different set of regulations and rules around the billing processes that are required. And they are all complex, they are frequently vague and many times in flux. And there is no single governmental organization or agency to turn to, to get clarification as to how they should be applied.

I would like to illustrate the complexity today by describing a patient. Now this patient is hypothetical, but she is a composite of the typical Medicare patient. I have sitting here the medical record, the coding documents, the bill and the cost report that would be related to this patient. Her name is Grace, she is 70 years old, she has diabetes and hypertension. She recently came to the hospital's outpatient department for a mammogram as routine prior to her doctor's visit that year. She went to her doctor's office the next day where they drew blood work and also sent that to the hospital's reference lab. During her visit to her physician, she complained of some chest pain that had happened earlier that day and he was concerned, so he sent her back to the hospital where a cardiologist did a cardiac catheterization procedure, and the diagnosis was coronary artery disease. Cardiac surgery was scheduled, she was admitted and the surgery was complete and it was successful. She went home after 5 days with orders for outpatient cardiac rehab services.

Now the outpatient mammogram and the blood work that was done in the physician's office were unrelated to her admission; yet we must, because they were within 72 hours of her admission, be rolled into her inpatient bill, bundled with that bill. In addition, outpatient cardiac catheterization procedures are fairly standard and yet that has to also be bundled into that bill. And we submit one bill with that. And we also have to bill the cardiac rehab as a separate encounter.

While the claims will be paid in 1 to 2 months, the cost report will not be settled by the fiscal intermediary for 2, 3, 4 years. We expect to settle our 1995 cost report sometime this summer and we still have an open cost report related back to 1992.

Now the hospital does a lot of things to make sure we are billing correctly, because we are committed to doing so. We have an overt philosophy that we are going to comply with the rules and regulations and laws of the Medicare Program. We have an active corporate integrity plan through which we educate all of our employees; all 2,517 employees get education every year about compliance issues and how to comply. Every patient, on their inpatient stay, is monitored by nurses to make sure their level of care is correctly documented.

In our medical records department, we have a staff that goes through every chart and verifies that all the medical records are complete. In addition, we have a staff of coders, all college-edu-

cated, who go through the chart and put the codes on; very complex process and we do it twice. We have two different people code every inpatient record, in order to make sure they are correct. On the outpatient volumes, we sample that because it is so much larger.

Following the coding, a bill goes through the charge audit department where RN's again go through and audit the bill and finally the billing department performs an audit before sending the claim to the intermediary.

Does our system work? Yes, it works. Is it effective? It is very effective. Is it perfect? No, it is not.

The biggest issue with the complexity of Medicare billing is not necessarily the complexity itself. It is complex and a hospital can deal with that complexity much easier than a physician's practice. The biggest issue is that simple, honest mistakes are treated as criminal and fraud under the False Claims Act.

Mr. Chairman, we are committed to not having a fraudulent environment in health care. We are committed to making the changes necessary to making the complexity less. And I think today is an opportunity to start down that road.

What we would recommend—what I would recommend is first the passage of the Health Care Claims Guidance Act of 1998. This act will clarify those activities and levels of activity that should be addressed by the Department of Justice, as distinguished from those that are simple, honest mistakes in our increasingly complex system. And second, we need to go back to the environment, rebuild the environment where health care and Government are partners together meeting the health care needs of our communities and our citizens.

Thank you.

Mr. SHAYS. Thank you very much, and I appreciate you being so conscious of the time as well.

Dr. Leitch.

[The prepared statement of Mr. Robertson follows:]

Written Testimony
of
William G. Robertson, Senior Executive Officer
Shawnee Mission Medical Center
Merriam, Kansas
before the
Committee on Government Reform and Oversight
Subcommittee on Human Resources
of the
United States House of Representatives
on
"Medicare: Cures for Billing Code Complexity"
April 9, 1998

Chairman Shays, Vice Chairman Snowbarger and members of the Committee, I am Bill Robertson, Senior Executive Officer of Shawnee Mission Medical Center in Merriam, Kansas. Our Medical Center is a 386-bed acute care hospital in suburban Kansas City. I appreciate this opportunity to express my opinion and the opinions of my associates on the complexity of the Medicare billing process; the education and training resources we utilize to better understand and adhere to the current coding and billing requirements; to alert you to problems we and others in the health care community face daily; and to suggest recommendations for rectifying some of these problems while ensuring quality and compliance.

When considering Medicare, most Americans will visualize a senior citizen in an inpatient hospital setting. Acute inpatient care is just one part, in fact a relatively small part, of an array of Medicare services provided to the Medicare eligible population. Others include outpatient services, outpatient surgeries, emergency department visits, reference lab tests, and home

health visits. Across the country, hospitals and health systems submit an average of nearly 200,000 Medicare claims each day. In 1997, our Medical Center had 94,838 Medicare patient episodes, an average of 260 per day.

When Medicare was created, rules and regulations to ensure the accuracy of Medicare claims were contained in a 30-page document. Today, we must comply with 1,756 pages of law, 1,257 pages of regulations interpreting the law and thousands of additional pages of instructions. In addition, hospitals nationally are required to work with one or more of 43 fiscal intermediaries, each of which has its own distinct procedures hospitals must follow as part of the Medicare billing process. The laws, rules, and regulations governing Medicare and the idiosyncrasies of individual fiscal intermediaries present a formidable and constant challenge to the most experienced billing associate.

Medicare patients have accounted for approximately 36 percent of our health care delivery business for the past three years. In 1997, this represented $49,479,611 in gross revenues. The number of Medicare patients served by Shawnee Mission Medical Center increases every year.

In addition to Medicare, reimbursement rules and regulations must be followed for over 70 insurance companies, managed care plans and HMO's whose customers are served by Shawnee Mission Medical Center. Each of these health plans has individual characteristics – limitations on coverage, determinations of which procedures qualify for reimbursement and

which do not — with which the billing associate must be familiar. Typically, any differences in understanding are negotiated between the parties involved in an effective and timely manner. Such is not the case with the Medicare program. In some cases, adjudication of specific Medicare claims can be in limbo for up to 4-5 years before resolution.

To date, our coding and billing associates have been successful in complying with the intricacies and vagaries of the Medicare requirements. We have 17 associates who are assigned to Medicare coding and billing. Our coding staff of eleven individuals, with coding experience ranging from 10-23 years each, have either a two or four year college degree. All posses the appropriate credentials in their field. The billing staff consists of six individuals representing 30 years of Medicare billing experience. The size of our staff dedicated to this purpose has increased by 40 percent in the past 5 years.

Every effort is being made at Shawnee Mission Medical Center to recruit, educate and train our staff to avoid Medicare claim errors. We are proud of our heritage as a health ministry of the Seventh Day Adventist Church and of our dedication to Christian values in the delivery of quality health care. We seek associates who share those values, and we have confidence that they are solid citizens of high moral and ethical character.

Orientation to our Medicare billing procedures is exhaustive, rigorous and never fully completed. The staff is required to attend workshops and seminars when new regulations are issued or when new interpretations of old regulations are directed. They constantly monitor

federal and professional literature for the most recent updates on changes in how the regulations are being administered. They share information and instruction in regular staff meetings in an effort to be as fully informed as possible.

Procedurally, two individuals separately code each Medicare claim. If there is consensus that the claim is coded properly, it moves forward to the next stage for ultimate payment. If there is disagreement on proper coding, the department supervisor attempts to resolve the question of accuracy. If no clear decision can be made, the supervisor seeks advice from a higher authority. Herein, however, lies a significant problem.

There is no "final authority" to which health care workers can go to find "correct answers" for which an authority will accept responsibility. There is a parallel to the Internal Revenue Service toll-free assistance line. Callers can seek advice and use that advice in their tax preparation. However, if the advice is wrong, the taxpayer is still liable.

Because we are both a hospital and a home health provider, Shawnee Mission Medical Center must deal with two fiscal intermediaries – one for Kansas and one for Missouri. The two fiscal intermediaries do not always agree on the interpretation of Medicare rules. Similarly, the Health Care Financing Administration (HCFA) will provide guidance and advice, which may or may not coincide with that provided by fiscal intermediaries. And none of these organizations is responsible for having provided the advice if, in fact, a hospital finds itself in court over the matter. Thus, courts of law become the final judges of what is legal or illegal,

proper or improper, fraud or unintended error in Medicare claims billing. And if found to be wrong, the hospital will have a significant penalty to pay despite its best efforts to comply with Medicare's rules and regulations.

THE PROBLEM EXACERBATED

Until 1994, government agencies and hospitals were in partnership to make sure both sides were treated fairly in Medicare billing disputes. Sometimes hospitals were underpaid or overpaid, but either way, hospitals and agencies would review all claims and "settle up". It appears now the government has abandoned its partnership with hospitals which, by at least some observers, appears to be a campaign to extract money from hospitals.

The Department of Health and Human Services (HHS) has allocated more than $1 billion through the year 2002 to target every type of provider in the largest-ever investigation of Medicare and Medicaid billing practices. A spokesperson for HHS is on record has having said the government expects to recover between $7 and $11 for every dollar it spends in its investigation.

The Department of Justice (DOJ) is employing the False Claims Act in a series of high-profile investigations of 4,700 hospitals. The subjects of these federal probes include:

The Medicare "DRG three-day window". DOJ is seeking penalties from hospitals for allegedly submitting improper billing for outpatient services that were included in their inpatient payment under the DRG prospective payment system.

Outpatient clinical laboratory "unbundling." DOJ alleges hospitals are inappropriately billing Medicare individually for tests that legally must be grouped together at a lower reimbursement rate.

The physicians at teaching hospitals (PATH) audit. Teaching hospitals and medical schools are being investigated to determine whether physician instructors billed Medicare for work performed by medical residents they supervise.

Fortunately, Shawnee Mission Medical Center has not yet received a "demand" letter from the DOJ notifying us that we are under investigation. The method for determining which hospitals will be investigated is a mystery. The demand letter informs the hospital it has two weeks to respond to the government or face immediate prosecution, including fines up to $10,000 plus triple damages for each disputed claim.

Reports indicate that millions of hospital and health system dollars are being spent on lawyers' and accountants' fees instead of patient care. Yet, few cases of fraud have been uncovered. In the majority of cases, hospital error rates are proving to be minuscule, despite its complexity.

Several examples of investigative results are illustrative:

- DOJ investigated two hospitals in Alaska and found no Medicare billing errors. Yet, they were assessed two small penalties. No reasons have been given for the penalties.

- Thirty-four hospitals in Connecticut were investigated regarding the 72-hour window rule during the years 1990-1995. During that time, the hospitals handled more than 10 million Medicare claims. Fewer than 3,000 claims were found by DOJ to be in error, an accuracy rate of 99.97%. Twenty-four hospitals in Maine, investigated by DOJ over a 5-year period, resulted in finding claim errors of $139,000. The Maine hospitals had filed $2.6 billion in total Medicare claims during that time frame. This represents an accuracy rate of 99.5%.
- Mary Hitchcock Memorial Hospital in Lebanon, NH, spent more than $1 million in staff time and fees for attorneys, consultants and accounting assistance to perform a self audit on Medicare billing. They did this because the government demanded the audit as part of its PATH investigation. They found an error rate of zero.

Adding to the concern of health care providers is the confusion of how rules are to be interpreted and by whom.. The DOJ investigations are at times contrary to HCFA interpretations of its own rules. For example:

- In March 1997, HCFA announced that hospitals had their choice of whether or not to "bundle" (i.e., combine two or more procedures for billing purposes) chemistry tests. HCFA later announced that, effective April 1998, hospitals were not to bundle these tests. As these changes were occurring, U.S. Attorneys were sending out letters accusing hospitals of fraudulently failing to bundle lab tests. One can conclude that there is a lack of consistent, centralized management over these investigations.

The threat posed by the persistent fear of a federal investigation and potential prosecution has unwelcome outcomes on the entire medical community. Our dedicated billing staff now labors under a cloud of anxiety that an unintended Medicare billing error could result in significant cost to themselves or the institution. It has added a new level of stress to an already stressful workload riddled with complexity and confusion.

In an effort to ensure corporate compliance, we have endorsed the statement recently issued by the Board of Trustees of the American Hospital Association to voluntarily adopt regulatory compliance programs " . . .as a way to minimize errors in conforming to highly technical and complicated rules." We are doing everything possible to strengthen our formal compliance program to ensure that regulations are accurately followed. We have adopted the Health Care Compliance Service made available by the American Hospital Association to achieve the best possible compliance with the government's complex billing requirements and regulations. Further, the HHS Office of the Inspector General (OIG) has developed a Model Compliance Program Guidance for Hospitals in conjunction with the American Hospital Association which will help us to maintain internal safeguards to assure compliance.

RECOMMENDATIONS

1. We urge lawmakers and regulators to be especially sensitive to the need for clarity in all their pronouncements. The rules as they exist today have an infinite number of ambiguities which are open to multiple interpretations.
2. We urge the Secretary of HHS to clearly identify "reliable sources" to interpret coding

and billing regulations when questions arise. These authorities must be accountable for the reliability of their determinations so that if an error is made, it is they who face retribution rather than a hospital employee making a judgment based on what was assumed to be accurate information from a higher authority.

3. We urge Congress to amend the False Claims Act by clarifying what is and what is not intentional fraud.
4. We urge that the Department of Justice be instructed to conduct its investigations on the assumption of a hospital's innocence of fraud until proven guilty.
5. Finally, we seek a return to the level of partnership between hospitals and government which existed in years past. The federal government seeks efficient and effective ways to make quality health care available to a targeted population of Americans, a desire shared by health care providers throughout the nation. That lofty goal can only be achieved as allies rather than adversaries.

At least some of our concerns can be addressed by using the False Claims Act less frequently and distinguishing Medicare billing fraud from honest billing mistakes. The Health Care Claims Guidance Act, introduced by Reps. Bill McCollum (R-Fl) and Bill Delahunt (D-MA), appears worthy of your sponsorship and support.

This bill would impose a "de minimus" standard. The standard, defined by the American Institute of Certified Public Accountants, would exact penalties of no more than the amount of the claim plus interest for Medicare error rates of less than a specified percentage.

It would establish a "safe harbor" for hospitals that submit an erroneous claim based on advice given by fiscal intermediaries and carriers. Such hospitals would be subject to fines limited to actual damages and interest, not triple damages plus $5,000 to $10,000 in fines.

The bill would establish a "safe harbor" for hospitals that have adopted effective compliance plans in which they are, after internal discovery of errors, subject only to actual damages and interest, rather than triple damages plus $5,000 to $10,000 in fines.

CONCLUSION

Thank you for giving me this opportunity to share with you the concerns of our staff and thousands of health care providers throughout the country on the very important issue of Medicare fraud and abuse. We understand and support the government's resolve to investigate and punish those who abuse the system. I am confident that the overwhelming majority of providers support those efforts. As taxpayers, we in the health care industry are as disturbed by reports of fraud and abuse in the Medicare system as are all other Americans.

Regrettably, the current dragnet investigative approach dishonors those who daily struggle to make accurate judgments in a health care environment which becomes ever more confusing and complex. When thousands of billing decisions are required on a daily basis, there is potential for the inevitable error. Human error, however, is vastly different from deliberate fraud.

The image being created by this high profile investigation is that health care providers are little more than thieves feasting on the government largess. This image could ultimately erode the confidence our patients have in us and in their physicians. But we are reminded that despite imperfections, problems, and concerns, we are all still beneficiaries of the finest health care system in the world. With the government as a friendly partner, we intend to keep it that way.

Dr. LEITCH. I would like to thank Congressman Snowbarger, Chairman Shays——

Mr. SHAYS. I am going to have you put that mic a little closer—I am sorry.

Dr. LEITCH [continuing]. And Congressman Barrett for allowing me to talk today. My name is David Leitch, I am an old country doc.

I have been invited here by Johnson County Medical Society to speak about my experience with the E&M guidelines that are currently about to take effect. My purpose is to speak against these guidelines because they are going to work against access to medical services by Medicare beneficiaries. In addition, their effects are unpredictable in terms of quality of care and outcomes measurement, and the potential for accusation for fraud and abuse is tremendous, particularly if the record review is not done by professional reviewers, that means either M.D.'s or D.O.'s. The coding after documentation is impossible.

Starting in October 1997, with preparation that I could get from the Kansas Medical Society, my medical journals and Family Practice magazine, I devised a process for recordkeeping to try to comply with all the requirements of this. As you will see in my exhibits in the back—and I am sorry I cannot put them on the screen—my recordkeeping has gone from two lines in 1975 to four lines in 1985 with the SOAP program, to a one page per patient encounter documentation in 1995. Starting in October 1997, it took 10 pages of written documentation for me to see one Medicare beneficiary and feel like that I was in compliance with all the records requirements contained in the pink document you have on that big pile of stuff over there that finally arrived in the mail in March 1998. You have copies of all those and I do not expect you to read those or look at the details at all, but you need to understand what cost this has incurred.

In amount of time to be able to prepare these documents and be ready for a patient encounter tomorrow, my office staff, which is primarily me and my nurse, because I think only professional people could prepare the documents that I think are required to be in that record, we are spending 2 hours in the evening before we saw the patients the next day. In about December, my nurse told me she was going to quit—and my nurse is my wife. [Laughter.]

We have now run this for 6 months and I would like to be able to sit here and tell you that this amount of preparation and time has caused me to see fewer patients, and it really has, it takes me 2 hours in the evening or the nurse, to prepare the documents. It takes me about an hour after I get through in the day to properly code and finish the documentation and satisfy my wife that I have filled all the bullets and all the shaded area.

The problem is that I am in a rural medically underserved area and I cannot see five fewer patients a day, which is what it costs me in time. These are my friends and my neighbors and they do not have any place else to go. So that I sacrifice my time and I sit there and do it because I have to take care of these people. I have been doing it, I have been in the same town for 31-plus years and I aim to retire there sometime, and you all are going to force me

to retire pretty damn quick if I have to keep doing all this paperwork.

The problem with the paperwork also is that if I give a reviewer 10 pages of office notes, there is going to be a mistake someplace. If it is going to cost me $10,000 for that one mistake, for $36.99, I am not going to stay in business very long. The threat of some claims reviewer at point X looking at a record and saying this is wrong and it costs you $10,000 is terrible. And this is going to happen. This is rumor, but I think it is really true and you can prove it. A clinic in North America, in the northern United States was reviewed by pre-audit claims and $40,000 worth of claims were denied. They were not denied because of the documentation, they were not denied because the codes were wrong. They were denied because the claims reviewer could not read the doctor's signature. And because it was not legible, they denied the claims.

Now even in a court of law, you are entitled to put down your X. As long as you hold the pencil, the X is yours, you are entitled to scribble your name even if it is scribbled, but it is yours. But to allow someone to deny your claim for a significant financial outcome because of that, I think you can understand what we are worried about as far as fraud and abuse is concerned.

There are no good studies that all of these added requirements does anything for quality of care, for review by HCFA.

In summary, I would like to say two things—one, there is no pilot project that all of this documentation will do anything, there are no scientific studies that show it will do a thing. My recommendation is that this whole thing be scrapped, that it go back to the drawing board, that the guidelines be looked at after a pilot study that shows what is possible and what is not possible. There is not even any computer gurus that can figure out something to be able to let you plug this in and come out with an answer. How can they expect us to stand the risk of fraud and abuse when nobody else can figure out what is going on?

I thank you very much for allowing me to make comments and I would be happy to entertain any questions or provide written summaries of this if you wish. Thank you.

Mr. SHAYS. Thank you, Dr. Leitch. [Applause.]

Let me just say I get the sense of where the audience is coming from, but I am just concerned—[laughter.] I am just concerned that it not happen after every speaker because I know it would be a bit redundant, and given that Dr. Rosenberg, my own constituent, led the applause, I feel—[laughter.] Dr. Buie.

[The prepared statement of Dr. Leitch follows:]

WRITTEN TESTIMONY TO THE HOUSE

GOVERNMENT REFORM OVERSIGHT SUB-COMMITTEE

ON HUMAN RESOURCES

Presented 9Apr98 at Battenfeld Auditorium, U. of Kansas Medical School, Kansas City, Kansas

I would like to thank Congressman Snowberger, Chairman Shaya, and the rest of the subcommittee on Human Resources for allowing me to speak before them today.

My name is David A. Leitch, M.D. ABFP, a solo, rural family physician, for 31 + years in Garnett, Kansas, (population 3200), and I have been asked to speak by the JOHNSON COUNTY MEDICAL SOCIETY, to speak for THE ANDERSON COUNTY MEDICAL SOCIETY, and the KANSAS ACADEMY OF FAMILY PHYSICIANS. It is an honor to be allowed to do this as I authored a resolution in the Kansas Medical Society in 1992 which passed and was carried to the American Medical Association by Kansas and adopted by the AMA; that to make negotiation between the AMA and the governmental bodies of HFCA, HHS, the Department of Justice, and the Congress be the highest priority of the AMA.

My PURPOSE IS TO SPEAK AGAINST the recently written E/M charting requirements by HFCA scheduled to go into effect 1Jul98 because they are going to work against ACCESS TO MEDICAL SERVICES by Medicare beneficiaries, particularly in rural America. In addition their effects are unpredictable in terms of quality of care and outcomes measurement, and the potential for accusation of FRAUD AND ABUSE is tremendous, particularly if record review is not done by professional reviewers (M.D. or D.O.). The coding after the documentation is impossible!

My background in this area besides taking care of patients who choose to have me attend them includes two years in the USPHS, participant in medical staff records review at my local hospital, peer reviewer for the Kansas Medicare carrier in years past, participant in the pretrial review of medical care as legislated by the state of Kansas, member of the KMS THIRD PARTY PAYOR COMMITTEE for 6 years, member of the KMS PRO OVERSIGHT COMMITTEE for 7 years, member of the Kansas Medical Society Executive Committee for two years while chairman of the Kansas HOSPITAL MEDICAL STAFF SECTION, and representative to the AMA-HMSS SECTION, serving both on reference committees at the AMA-HMSS and as their spokesperson to a reference committee of the AMA.

The training of physicians currently in practice in this area, many of them trained as I was at the University of Kansas School of Medicine, did not include any preparation for charting as it is required at the present time. The practice of medicine in 1975 at the start of Medicare was thought to be QUALITY MEDICINE, and progress notes entered into physician's records looked like EXHIBIT I in 1975. Evolution of office notes looks like EXHIBIT II written in 1985, using the then new SOAP format. EXHIBIT III shows what 1995 office notes looked like after the E/M documentation requirements of 1994. You will note the E/M coding guidelines at the top of that (and every patient encounter) page in my office records.

Starting in October, 1997, I have tried to comply with the letter and the intent of the rulings of HFCA as I understand them; and with the help of the Kansas Medical Society (two hour conference by knowledgeable experts in the field), recommendations by the Academy of Family Physicians in their publication AMERICAN FAMILY PHYSICIAN, and published recommendations by the FAMILY PRACTICE MANAGEMENT journal; ("Exam Documentation Just Got Harder," October 1997, page 75, "More Help With Exam Documentation," November/December 1997, page 63, and "Three Documentation Tools That Work," January 1998, page 29). However, after all this, in the March, 1998 , issue of FPM and after discussing a "simple" example coding evaluation of a nursing home patient with their recommendations; their EDITOR'S NOTE; " WHILE CODING CHALLENGE REPRESENTS OUR BEST EFFORTS TO PROVIDE ACCURATE INFORMATION AND USEFUL ADVICE, WE CANNOT GUARANTEE THAT THIRD-PARTY PAYERS WILL ACCEPT THE CODING RECOMMENDED." (FPM, page 29)

As I understand the above and the publication, DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES published by the American Medical Association and HFCA, Nov. 1997, this is what is required at the present time for a Medicare beneficiary to be seen. EXHIBITS IV thru XIV show the ANNUAL ROS pages and patient's listing of family history, medical illnesses, surgery, medications and health screening tests. If this information is not in my record and HFCA does a prepayment audit, which all physicians have been promised, then HFCA will withhold payment for that visit. You can compare Exhibit I or II or III to today 's requirement in just documentation and see the tremendous time outlay increase.

A visit for help by a Medicare beneficiary at the present time requires filling out a 7 page health assessment and ROS (review of systems) before they are seen. If you are 30 years old and are healthy this is not a big problem, but if you are 80 years old, have multiple illnesses or conditions, don't see too well, or perhaps a little handicapped by Altzheimers this requires up to one hour of time and a lot of frustration. Some patients even are allowed to take these pages home to complete so they can get it right. This requirement is almost impossible for many nursing home patients, yet there is no ruling about whether the nursing home personnel may help complete this, whether the legal guardian has to do this, or who is to decide if in fact the patient can do it, (and I am accused of fraud and abuse by giving my professional opinion that the patient is in my opinion unable to complete this chore). Yet there are no good studies that all of this added

data, (if it is data and not incorrect remembering), is going to improve QUALITY OF CARE, or even improve the accuracy of billing information for HFCA.

The assimilation of all of this information, true or false, for the allegation of improved QUALITY OF CARE OR OUTCOMES DETERMINATION under the threat of withhold of payment reduces the practice of medicine to gathering BULLETS AND SHADED BOXES for claims reviewers. There are no satisfactory guidelines issued to determine what is a satisfactory office note in terms of style or other format; there is no assurrance that provider generated forms will be satisfactory to claims reviewers or physicians (if they are used for review), and there is no assurrance that any deviation from unknown standards generated by HFCA will not be considered FRAUD AND ABUSE and result in refusal to render payment. There is no agreement that present rules will not be changed in the immediate future, thus decreasing the urge to design or buy some computer package to satisfy the present requirements if such a program was available, which I have been told is not.

The seriousness that CONGRESS and HHS have placed upon FRAUD AND ABUSE is well recognized in rural America. We understand that HHS and the Department of Justice took over $100 million in Medicare trust funds in addition to their regular budgeted appropriations to fight FRAUD AND ABUSE, and the FBI received $47 million this year and that will increase to $114 over the next three years to investigate and prosecute FRAUD AND ABUSE as they choose to define it (AMANews 9Mar98). In Kansas the Medicare Medical Director has just released a status report on audits of the first 3,000 claims in the prepayment review process: 4% were up-coded (as determined by Medicare without appeal or further information), 2 % were under-coded, and, "Most surprising to the Medical Director, however, was that the same physicians who were up-coding were under-coding!" (KANSAS PHYSICIAN, FEB98). THIS POINTS OUT JUST HOW HARD IT IS TO PRACTICE E/M CODING UNDER THE PRESENT GUIDELINES, and further scares all of us as to the potential for FRAUD AND ABUSE charges. The guidelines are " too complicated " according to the AMERICAN SOCIETY OF INTERNAL MEDICINE and some of the other groups. (HEALTH BUSINESS DIGEST Vol.3 No.2 Feb98)

The added rules take a considerable amount of time that an already overburdened private rural practice doesn't have. I have two and one-half employees in the front office and one office nurse to help me take care of twenty-five to thirty patients a day in a rural underserved area. The added form requirement takes staff time to generate blank forms, run forms thru a copy machine three times to generate a single patient encounter form with what I think is a satisfactory content of what HFCA MIGHT WANT! In addition the front staff has to make sure the beneficiaries fill out completely the health inventory now (and keep track of the anniversary of the ANNUAL ROS). They have to file all these forms when they are finished in an immmediately accessible location as they will be necessary for documentation with each patient encounter, and this paging thru will have to be individually noted on the page: ("A NOTATION OF "OLD RECORDS REVIEWED" OR "ADDITIONAL HISTORY OBTAINED FROM FAMILY" WITHOUT

ELABORATION IS INSUFFICIENT"...DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES, page 47).

In addition to the staff time there is a considerable PROFESSIONAL TIME component in preparing a CUMULATIVE PATIENT PROFILE either from the patient prepared forms, or more likely studying the previous records for precisely documented diagnoses, dates of procedures, documenting medications, allergies and what reaction occurred, and updates of family illnesses, many which occurred at the turn of the century. This takes about two hours every evening to prepare for the appointments for the following day in a practice which is 60 % Medicare. To follow the letter of the law you have to initial the source material scanned to obtain this information and date it every time. This can only be done by a nurse or a physician in my opinion.

The additional patient time includes the completetion of the seven pages of health information and ANNUAL ROS, the elevation of the patient's blood pressure in doing this bureaucratic gathering process, the amount of time it takes for the patient's BP to go down so I can be sure what the real BP is, and a sometimes short and sometimes long explanation to the patient just what this is all about, as I understand it. THEN, AFTER ALL OF THE ABOVE, the doctor, me, gets to converse with the beneficiary, examine the patient, order the appropriate tests and document the necessity and the results of those tests, evaluate lab and x-rays as there are no consultants or radiologist to read them for me while the patient is there, then diagnosis the condition, reassess any and all co-morbidity conditions, prescribe appropriate medications after reviewing all current medications, and reduce all of this to BULLETS AND SHADED BOXES for some claims reviewer to add up, and arrive at a cpt code and not apppear to be commiting FRAUD AND ABUSE when arriving at an E/M code. There are no E/M evaluation programs available in computer form, and I am told that this has been tried and declared NOT POSSIBLE! I have the Kansas Medical Society and its Medicare interface person, Carolyn Price, to consult with, and a practice consultant who is sometimes available, but how can you use them with coding thirty charts a day in the office plus hospital inpatients, ER patients, and nursing home visits. It makes cents to use them if you are risking a $10,000. fine for every claim to HFCA, but it doesn't make sense, and IT ISN'T THE PRACTICE OF MEDICINE!

THIS PROCESS RESULTS IN A DECREASED ACCESS OF MEDICARE BENEFICIARIES TO MEDICAL CARE IN RURAL AMERICA. It takes two hours of professional time a day to get ready for a typical office day. It takes me about one extra hour a day to complete the records and do the other necessary work to code as accurately as I know how . This makes me either work one hour longer a day for the same reimbursement, or see FIVE fewer patients a day in an already underserved area. In some areas this added documentation requirement will cause some physicians to just not take care of Medicare patients. The added pages of paper creates additional space requirements to store the added pages resulting in the only economic benefit to all this documenting, that of the paper and ink industry and the building trades.

The E/M codes scheduled to go into effect 1July98 were written as a response to many speciality groups' complaints that they were not able to bill for Level 4 or Level 5 visits. "Many carriers were arbitrarily denying payments for specialists billing for Level 4 and 5 visits. For example, the Iowa carrier refused to pay ophthalmologist above a Level 3 because there was no established definition of a comprehensive eye exam." (Am.Med News, Vol 41, num 12, page 3A). There were no pilot projects to see if they would work in the real world, and they just won't work! I would agree with Dr. Neil Brooks, M.D, President of the AAFP in his March 16, 1998, presentation to the Practicing Physicians Advisory Council;

"The American Academy of Family Physicians strongly believes that the E/M documentation guidelines as currently constructed are unacceptable and cannot be fixed by minor alterations. Accordingly, we urge the Health Care Financing Administration to recall guidelines and suspend the July 1 implementation date for their useage. It is time to return to the drawing board and to develop another proposal for documenting the services that physicians furnish to beneficiaries."

IN SUMMARY, THESE ARE THE REASONS I AM AGAINST THE NEW E/M CODES AS STATED BY HFCA TO GO INTO EFFECT 1JUL98.

1. THEY WILL DECREASE ACCESS TO MEDICAL CARE BY TITLE XVIII AND XIX BENEFICIARIES

2. THEY GREATLY INCREASE OUTLAYS OF TIME AND RECORDING ENERGIES

3. THERE IS NO EVIDENCE PREPARATION OF STANDARDIZED FORMS IMPROVES QUALITY OF CARE (and ? effect on outcomes measurement)

4. NO EVIDENCE THAT STANDARDIZING OF FORMS FOR PAYMENT WILL IMPROVE EITHER REPORTING FOR DIAGNOSIS FOR PAYMENT EASE, OR ACCURACY OF CARE RECORDING FOR QUALITY CONCERNS OR FOR ASSESSING FRAUD AND ABUSE

5. NO ASSURANCE FORMS CAN BE AUDITED BY NON-PROFESSIONALS (non- MD or DO)

6. THIS CREATES AN ENLARGING AREA OF INFORMATION FOR BUREAUCRATIC QUESTIONING, PROTESTING, DENYING, OR PROSECUTING UNDER THE ALLEGATION OF FRAUD AND ABUSE

7. I HAVE A STRONG FEELING THAT ACCEPTANCE OF CHECKS OR ABBREVIATIONS OF NORMAL WILL BE REVERSED IN THE IMMEDIATE FUTURE TO THE LARGE INCREASE IN PROFESSIONAL NOTE INPUT ON EACH RECORD WITH RESULTING DECREASE IN TIME AVAILABLE TO OTHER BENEFICIARIES

I, and the many physicians I speak for, thank the sub committee very much for your interest and attention to the subjects discussed above. If I can answer any questions you might have regarding the above, or provide you with any further testimony, written or otherwise, at a later date feel free to ask and I will try to comply with your wishes.

DAVID A. LEITCH, M.D. ABFP
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Dr. BUIE. Thank you. David is going to be tough to follow. That is the bottom line right there.

We are at a critical juncture in the evolution of Medicare. The private practice of medicine——

Mr. SHAYS. Dr. Buie, I am sorry, we will start your time over again. You have got to talk into that mic.

Dr. BUIE. Better?

Mr. SHAYS. Yes, that is better.

Dr. BUIE. We are at a critical juncture in the evolution of Medicare. The private practice of medicine is imperiled like never before and the ability of physicians to advocate for their patients is becoming dramatically limited. Our aging population, demands of all interest groups and the explosion of technology all threaten the viability of Medicare. Cost containment is legitimate, but it must be balanced against the legitimate medical needs of our elderly and infirm.

Over 800 million Medicare claims are filed annually and the expenditures for the 40 million elderly total approximately $210 billion.

Our health care system is simply the most complex in the world. Access to health care coverage in the commercial area is at crisis and if present initiatives are finalized, access to care for Medicare patients will dramatically worsen. Nearly 50 percent of physicians surveyed restrict services to Medicare patients already, three-fourths do so because Medicare generally pays only 50 percent of the physician's actual fee. That same percentage of physicians restrict Medicare services because of regulation. Currently, there are over 47,000 pages of documents related to Medicare, at least three times the size of the IRS Code. In an era when many in Government call for paperwork simplification and reduction, no relief is in sight in the medical arena.

It is critical for us to determine a uniform definition for health care coding to control costs. Presently there are 10,000 different E&M codes that can literally be combined into 99,000 different possibilities. One can easily appreciate how vague and inexact the system is. Compounding the problem is the code determination will be by lay personnel rather than practicing physicians. There is no source that can guarantee a safe harbor for physicians with coding questions, no phone number to call for a guarantee. In the past, regulations defined fraud as intentional deception that resulted in unauthorized benefit. That was consistent in both public and private sector. The courts in the past had to find that a defendant knowingly and willfully committed the act. Abuse has always been much less well-defined. In a time when medical directors and not patients or treating physicians are defining what is medically necessary, a huge conflict of interest exists. Patients and doctors should have coverage understanding at the start of the process and not the end. The past standard of fraud should be maintained. To attach a civil penalty of up to $10,000 per occurrence and criminal prosecution when there are large areas of disagreement in coding is simply not fair or acceptable. Physicians want true fraud prosecuted to the highest degree so that the monetary drain to taxpayers is eliminated.

There is huge concern that the guidelines will diminish already scarce patient and doctor time with charting activity. Pilot physicians pursuing the documentation as proposed will see five fewer Medicare patients per day and increase staff time by at least 2 hours per day. Physician overhead will escalate and reimbursement will continue to shrink. The sickest patients, such as diabetics, run the risk of increased avoidance by a physician due to time and liability demand. Medicare records format requires redundant information at each visit and actually may make the most pertinent clinical assessment harder to find in a chart.

The National Health Care Fraud Association has estimated true fraud, after 27,000 studies, at a conservative 3 percent. The regional director of Blue Cross and Blue Shield in Kansas has reviewed 3,000 claims in our area and finds a net upcoding of 2 percent. Unfortunately, certain areas of the country, such as south Florida show pockets of upcoding of up to 50 percent. This suggests that a pilot project in problem regions may recover the most loss without creating a massive nationwide bureaucracy. Physicians faced with liability and complexity will simply not be able to sustain physician/patient relationships.

There are desirable solutions.

Delay in the implementation of the guidelines as they stand is paramount.

Massive revision and simplification must be undertaken.

Civil monetary penalty and criminal prosecution not be allowed unless a physician intentionally bills a patient for services not given—true fraud.

In cases of repeated upcoding, carriers could reimburse at a lower fee. Physicians then could be allowed to appeal and prove a higher level of care if care is appropriately delivered and reliably documented. That is happening in 70 percent of cases.

A pilot project is necessary.

Copays and medical savings accounts should be enlarged so that patients can self-audit.

Doctors should be allowed to code in their charts significant and positive efforts in the most concise form.

We would also urge that a bipartisan medical commission should examine this issue.

Health care is a business, but it is a business like no other. Care rendered in good faith should be examined without coercion.

We appreciate you re-evaluating this issue.

Mr. SHAYS. Thank you, Dr. Buie. [Applause.]

Dr. Cooley.

[The prepared statement of Dr. Buie follows:]

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Kelly Yousil, M.D.
Alan Z. Kessler, D.O.
V. Paula Meesmore, M.D.

ADMINISTRATION
Donald D. Palmer, Sr.

Medicare Testimony for Field Hearing:

On behalf of the Metropolitan Medical Society of Kansas City, I would like to thank Chairman Shays and Vice-Chairman Snowbarger for inviting comment on this critical issue: Medicare Cures for Billing Code Complexity.

Physicians and health care professionals are at a critical juncture as the evolution in Medicare continues. The private practice of medicine is imperiled like never before and the ability of physicians to advocate for their patients is becoming increasingly limited. Upon the inception of Medicare in 1965, it was clear that Congress acted with the intent that there would be no Federal interference in the practice of medicine. Section 801 stated: "nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the matter in which medical services are provided..." Our aging population, the demands of all involved interest groups, changing demographics, the explosion of technology, and the increasing complexity of health care over time all threaten the economic viability of this critical program. Cost containment is legitimate, but it must be balanced against the legitimate medical needs of our elderly and infirm.

Presently, over 800 million Medicare claims are filed annually. Annual expenditures for the 38 million elderly recipients now total approximately 208 billion dollars. Medicaid, which covers the 36 million indigent patients and disabled now spends $147 billion annually. The recent federal expansion of health coverage for children in our society will meet the average $500 per year cost for many of our indigent youth. It has been estimated that if Medicare is expanded as the President has proposed by extending coverage for up to 3 million more 45-55 year olds, their annual medical costs will average $5,000 each.

The United States Health Care System is simply the most complex and expensive in the world, yet it still fails to extend coverage for over 40 million citizens in our country. Access to health care coverage in the commercial area is at crisis, and if the present initiatives are finalized in their present form, access to care for Medicare patients will dramatically worsen. Nearly 50% of physicians, when surveyed, relate that they restrict services to Medicare patients. Three-fourths of the physicians who restrict services do so because of cuts in reimbursement, relaying that Medicare generally pays only 50% of physician's actual fees. That same percentage of physicians restrict Medicare service because of hassles and regulations. Currently, there are over 47 thousand pages of documents which are related to the system; 3 times the size of the IRS code. Summation documents alone from Medicare number 2000 pages. This is prior to the release of the anticipated "mega reg," scheduled to be out on June 1, which will establish rules for the new Medicare choice plans. In an era when many in government call for paper work simplification and reduction, no relief is in sight in the medical arena.

Virtually every interest group within the health care system (patients, doctors, hospitals, insurers, the legal profession, governmental entities, pharmaceutical companies and other ancillary providers) has contributed to this crazy quilt system. It is legitimate and critical for us to try to find consensus, to determine a uniform definition in health care coding, and to control costs. Presently, there are 10,000 different E and M codes that can literally be combined into 99,000 different possibilities for describing physicians' services. One can easily appreciate how vague and inexact this system is. Code determination will be made by lay personnel rather than by practicing doctors. In the past, common law and Medicare/Medicaid regulations defined fraud as an intentional deception or misrepresentation that resulted in some unauthorized benefit. This was consistent in both public and private sectors. Courts in the past had to find that a defendant knowingly and willfully committed the act. Abuse has always been much less well defined. It is characterized by Medicare/ Medicaid regulations as practices that are inconsistent with accepted medical practices where unnecessary services may be provided, although not intentionally misrepresented. This area is not at all clearly or consistently defined. In a time when Medical Directors (not patients or treating physicians) are defining what is "medically necessary," "over-utilization," and failure to follow "practice guidelines", a huge conflict exists. We feel that physicians and their patients should be the ultimate arbiters in determining what is medically necessary. Patients should have coverage understanding at the start of the process, not at the end. The standard for fraud should be maintained as deliberate misrepresentation in medical services billing. To attach civil monetary penalty and/or criminal prosecution when there are large areas of disagreement in coding is simply not fair or acceptable. Physicians want true fraud and billing for services not rendered prosecuted to the highest degree, so that the monetary drain on taxpayers is eliminated. That does not equate to differences in defining charges for care rendered in good faith.

There is huge concern that if the guidelines are enacted in their present form, already scarce patient and doctor time together will be diminished, as doctors sacrifice patient time for charting activity. Pilot compliance attempts in our region have found that physicians pursuing documentation as proposed will see five fewer Medicare patients per day and increase staff time by as much as 2 hours per day. Ancillary costs and physician overhead will continue to escalate while reimbursement shrinks. The sickest patients run the risk of increased avoidance by physicians due to time and liability demands. In order for physicians and patients to spend more time together to ensure quality care, implementation of these guidelines should be delayed in order that they may be markedly simplified. Many also fear that the Medicare records format requirement forces redundant information at each visit, and may actually make the most pertinent clinical assessments even harder to find within a patient chart. These dynamics imperil the private practice of medicine for most middle Americans.

In an era of consolidation, when all health care entities are becoming larger and employed physicians are now the majority, physician advocacy for patients becomes increasingly clouded. The areas of primary care, rural practice, urban indigent care delivery and specialities caring for the chronically ill are especially hard hit under this scenario, because of the depth and breadth of required care and the lowest reimbursement levels, historically.

In 1997, the OIG reviewed a fraction of Medicare claims: 5,300 for only 600 Medicare beneficiaries. From that small sampling the study estimated overpayments in the range of $23 billion for the entirety of the Medicare program, representing 14% of all Medicare spending. Inspector Brown did admit that the department could not quantify what portion of the rate was attributable to fraud. It is estimated that 47%of those payments were deemed inappropriate because of "insufficient" or unsupplied documentation, and 37% were described as "medically

unnecessary" services as defined by Medical Directors. "Incorrect coding" accounted for another 9% of the total. Practicing physicians feel this is a marked over-estimation.

In contrast to the above study, the National Health and Fraud Association, made up of 50 payor and law enforcement groups, estimated true fraud at a more conservative 3-5%. They made this determination after reviewing 27,000 different health care fraud investigations from their member companies. One health care lawyer, Edwin Hopkins of Florida, estimated that approximately 1/10 of 1% of active physicians are involved in outright theft. However, these few often pursue claims on a very large scale.

Unfortunately, certain areas of the country have had concentrated fraud and abuse, such as New Jersey, Florida and other coastal areas. The regional director of BC/BS, Dr. Pat Price, has reviewed over 3000 claims in Kansas and the greater Kansas City, Missouri area. He relates finding a 4% upcode rate and a 2% downcode rate in contrast to other regions which show certain pockets of up to 50% of upcoding. Dr. Price found that the same providers were involved in both upcoding and downcoding, underscoring the confusion in the system. Many would suggest that a pilot project in problem regions may recover the most losses without creating a nationwide massive bureaucracy. There is no existing mechanism for payers to disperse undercoded claims back to providers for the care they are rendering, as a fair system would dictate. There is also no authoritative source that can guarantee a safe harbor for physicians with coding questions.

The OIG study estimated that approximately 40% of overpayments were made to lab, durable medical, nursing home and other ancillary services; 32% were to hospitals; and 22% were divided among dentists, chiropractors, nurse practitioners, physician assistants, podiatrists and medical doctors. Despite the accusations of large criminal elements stealing from seniors, an estimated 40% of "over-reimbursement" for home care spending labeled as improper went for services that were provided at patient request.

The FBI has stated publicly that physicians are not responsible for the vast majority of health care fraud and abuse, and that only a small number of physicians seek to gain through fraudulent practice. The AMA continues to collaborate with FBI and all interested agencies to improve fraud detection and enforcement.

With the passage of HIPPA, many changes to federal fraud and abuse laws occur. The past practice of using common law and mail fraud definitions, which define fraud as knowingly and willfully engaging illegal contact, precluded the prosecution of an innocent mistake. Health care fraud is now considered an independent federal crime. Civil monetary penalties have been raised to $10,000 per occurrence with treble damages. Program exclusions have been enlarged. Despite the efforts of the OIG and the Department of Justice, Congress lowered the intent standard for fraud prosecutions. Money laundering charges and racketeering parameters can also be brought. A bounty system has been created which would allow whistle blowers, (including disgruntled employees) to share a portion of the settlement amount. Settlement funds do not return to the general fund but can be given to auditing and prosecution arms. If it is found that disputed funds actually go to legal representation of an accused person, those funds could also be seized.

All these actions have created the unintended consequence of the most hostile environment to the private practice of medicine yet known. Physicians, faced with massive liability and complexity, will simply not be able to sustain private practice in the foreseeable future. The

base physician/patient relationship, where an individual physician has responsibility to the individual patient is seriously undermined with these trends. There is tremendous coercion to settle disputed claims as the government seeks a steady revenue source.

All major medical organizations have gone on record against the July implementation date. Massive efforts at education by all medical societies is currently underway. There are desirable solutions on the horizon.

1. Studies should be done to accurately define the extent and scope of real health care fraud and how best to allocate auditing and prosecution functions to ensure maximal value on the part of beneficiaries and taxpayers.

2. Delay in the implementation of guidelines as they stand is paramount. Massive revision and simplification must be undertaken.

3. Civil monetary penalty and criminal prosecution should not be allowed unless the physician knowingly and intentionally bills for patient services not given, lab or procedures not done, or equipment not delivered. In particular, prohibition of prosecutions involving evaluation of management codes for office visits should be placed under moratorium.

4. A pilot project in one region of the country should be undertaken prior to a nationwide implementation, to see if fraud and abuse may be reduced by any significant amount.

5. Co-pays would bring patients back into the responsible self-auditing position of ensuring that a given home health visit, lab test, office visit, or procedure is actually being done. Waivers of co-pays for the truly indigent should be allowed.

6. Medical savings accounts should be expanded so that patients themselves can define what is "medically necessary" with their own budgeted account, individualizing their values and needs.

7. Doctors should be allowed to code in their charts significant positives and negatives in the most concise form to minimize redundant charting.

8. Advisory opinions on safe harbor definitions and physician legal immunity for reporting episodes of fraud and abuse must expanded and protected.

9. EOB's should be written so that beneficiaries can understand them and therefore audit their own care.

10. Overzealous law enforcement activities such as unwarranted forceful entry, bounty hunting and display of deadly weapons in circumstances where no harm to officers is occurring should be prohibited.

11. Passage of the Administrative Civil Rights Act to ensure due process on the part of physicians should be enacted.

12. Physicians should be allowed to voluntarily accept assignment for low income beneficiaries and to waive Medicare's co-payment deductible on a case by case basis, without the accusation of fraud.

13. Physicians must continue to cooperate with and oversee the medical necessity of DME, hospice and home health.

14. Joint principles by organized medicine, HCFA, and insurance carriers should be developed

15. The trend toward recreating HCFA with its attendant agencies into a "medical IRS" must be abandoned.

16. If physicians show a pattern of repeated upcoding, carriers should be allowed to reimburse then at a lower fee. Physicians' offices should be allowed to appeal and prove a higher level of care if appropriately delivered and reliably documented.

17. The bipartisan Congressional Commission should examine this issue in detail for comprehensive Medicare reform before guidelines are finalized.

Health care is a business, but it is a business like no other. Care rendered in good faith should be examined without coercion. Physicians want wrong-doers to be prosecuted and trust funds to be safeguarded. The actual record of the overwhelming number of physicians in this country is one of compliance and of the highest ethical and legal conduct. We intend to be part of the solution rather than merely complainers. Critical action is needed if private practice is to be maintained in any meaningful sense in this country. Your interest and cooperation is greatly appreciated.

Dr. COOLEY. Thank you. My name is David Cooley.

Mr. SHAYS. I would have you tip the mic up a bit.

Dr. COOLEY. I am a subspecialist in the practice of rheumatology for 25 years, 18 of which have been in the greater Kansas City metropolitan area. I am board certified in both internal medicine and rheumatology, having taken my medical training at Washington University/Barnes Hospital in St. Louis and the Mayo Clinic in Rochester, MN.

Mr. SHAYS. Doctor, I am really sorry, I am really having trouble hearing you. There is an echo that is hard. Can you move that mic a little closer. Unfortunately these mics are geared to talk in this way [Indicates a direction].

Dr. COOLEY. I appreciate the opportunity to speak to this subcommittee.

I have been especially interested in CPT, evaluation and management coding, for many years. I served as a delegate from the American College of Rheumatology to the American Medical Association at the initial meeting in Chicago in 1991 at which time the present coding system was inaugurated. Most medical specialties were represented at that meeting. Previously, I was one of several authors of a manual on CPT coding developed by the American College of Rheumatology for distribution to practicing rheumatologists.

In 1997, approximately 50 patient charts from my office were audited by the Medicare carrier for the State of Kansas. I was asked to pull each of these records and to comment regarding each of the visits. I was told that the reason for the audit was that too many of my office visits were coded 99214 compared to other rheumatologists in the community.

As background for this testimony, I would like to point out that there are presently five levels of coding for the evaluation and management services for an established followup office visit. 99211 is a brief office visit by a nurse or other paramedical person with a straight-forward visit. 99213 is a visit concerning a problem of "low to moderate severity"; 99214 moderate to high severity; 99215 moderate to high severity with the physician spending more time with the patient. An AMA CPT validated example of a 99213 visit would be office visit for a 63-year-old female established patient with rheumatoid arthritis on gold, seen for a followup visit. 99214 validated example would be followup office visit for a 45-year-old patient with rheumatoid arthritis on gold, methotrexate or immunosuppressive therapy and a 99215 validated example would be a followup visit for mother of three, acute rheumatoid arthritis with deteriorating function.

I would like to point out to the committee that a 99213 visit is reimbursed to a Medicare participating provider at a rate of $36.99 and that a 99214 visit is reimbursed at $55.92.

All the patients coded 99214 in this audit had rheumatoid arthritis and were on either gold, methotrexate or immunosuppressive therapy. The status of each of the patients was dissimilar in terms of severity of their illness as well as their response to medications. All patients were felt to be at somewhat high risk due to the type of medications they were taking. The monetary difference between billed charges and reimbursed charges for the 50 patients was approximately $400, which represented an average disparity of

around $7 per patient. This audit also dealt with two laboratory studies which were disallowed. And so for evaluation and management codes, the discrepancy was closer to $4 per patient. I was sent a bill from Medicare for approximately $5,800 as they extrapolated these findings to a 6-month time period and I was advised that if I paid the money back to Medicare they would continue to monitor my records for an additional time period and that if it appeared that I was no longer an outlier, the case would be closed. No penalties or interest were assessed on the case.

Since the audit, I have coded almost every single followup Medicare encounter 99213, regardless of the complexity of decision-making, length of time spent with the patient or other factors. On March 20, I was sent a letter which stated that I had corrected my billing errors and that Medicare was closing my file. [Laughter.]

Unfortunately, it is impossible for me to distinguish among these several levels of service with any certainty. I made that point to the American Medical Association in 1991 when five levels of evaluation and management service were construed, and at that time I predicted that we would eventually be caught in our own web. As I have a large practice and see a large volume of Medicare patients, I have most likely now reset the curve for other rheumatologists who will now be found to be outliers and will be set up for audits in the same way I was.

I believe the current CPT coding methodology is fatally flawed. There are too many levels of service, there are too many I's to dot and T's to cross. While one can easily understand when a nurse or paramedical person performs a service under the supervision of a physician or when the patient is returning for a complete exam, the intermediate levels of service are simply too subjective for most of us. At best, we have to guess what the reviewer will want in the note, and because of that, we are often more concerned with how the office visit will look on paper than how the patient is doing.

Far from being an issue of fraud and abuse, the current system has begun to bury the physician in so many details that he can no longer get his work accomplished for the day in any coherent manner. While all of us deplore obvious examples of fraud and abuse in the medical system such as billing for services which were never rendered, performing laboratory studies which were never ordered by physicians, or providing durable medical equipment to patients who are deceased, we would urge HCFA and the American Medical Association to revisit the issue on evaluation and management codes in an effort to simplify and streamline the machinery by which physicians communicate to payers what they are doing.

I would urge HCFA to eliminate the fraud and abuse provisions regarding evaluation and management coding as this entire area of medical practice is in so much state of flux. I would urge the American Medical Association to listen to specialty and subspecialty medical societies as these groups streamline and simplify the coding mechanism for cognitive care.

I and the many physicians I speak for thank the subcommittee very much for your interest and attention to the subjects addressed above. [Applause.]

Mr. SHAYS. Thank you very much, Dr. Cooley.

Dr. Rosenberg, among my colleagues, you are not first among equals, but between you and me, you are first among equals. You may begin.

[The prepared statement of Dr. Cooley follows:]

WRITTEN TESTIMONY TO THE CONGRESS OF THE UNITED STATES

HOUSE OF REPRESENTATIVES SUBCOMMITTEE ON HUMAN RESOURCES

WITH OVERSIGHT RESPONSIBILITIES FOR THE DEPARTMENT

OF HEALTH AND HUMAN SERVICES

Presented April 9, 1998 at Battenfield Auditorium,
University of Kansas Medical School, Kansas City Kansas

My name is David A. Cooley, M.D., F.A.C.P., and I am a subspecialist in the practice of rheumatology for twenty-five years, eighteen of which have been in the greater Kansas City metropolitan area. I am board certified in both internal medicine and rheumatology, having taken my medical training at Washington University/Barnes Hospital in St. Louis and the Mayo Clinic in Rochester, Minnesota. My curriculum vitae accompanies this testimony. I have been asked to speak to this subcommittee by the Johnson County Medical Society and the Metropolitan Medical Society of Greater Kansas City, Missouri.

I have been especially interested in CPT (evaluation and management) coding for many years. I served as a delegate from the American College of Rheumatology to the American Medical Association at the initial meeting in Chicago in 1991, at which time the present coding system was inaugurated. Most medical specialties were represented at that meeting. Previously, I was one of several authors of a manual on CPT coding developed by the American College of Rheumatology for distribution to practicing rheumatologists.

In 1997, approximately fifty patient charts from my office were audited by the Medicare carrier for the state of Kansas. I was asked to pull each of these records and to comment regarding each of the visits. I was told that the reason for the audit was that too many of my office visits were coded 99214 compared to other rheumatologists in the community.

As background for this testimony I would like to point out that there are presently five levels of coding for evaluation and management services for an established follow-up office visit. 99211 is a brief visit by a nurse or other paramedical person working under the supervision of a physician. 99212 is a code for a simple, straight-forward, brief visit. 99213 is a visit concerning a problem of "low to moderate severity". 99214 is a visit concerning a problem of "moderate to high severity" and, likewise, 99215 concerns a problem again of moderate to high severity with a physician spending more time with a patient. An AMA/CPT validated example of a 99213 visit would be "office visit for a sixty-three year old female established patient with rheumatoid arthritis on gold and ibuprofen seen for routine follow-up visit". A 99214 AMA/CPT validated example would be "follow-up office visit for a forty-five year old patient with rheumatoid arthritis on gold, methotrexate or immunosuppressive therapy". 99215 AMA/CPT validated example would be

"follow-up visit forty year old mother of three with acute rheumatoid arthritis, anatomical stage III, ARA functional class III, rheumatoid arthritis and deteriorating function.

I would like to point out to the committee that a 99213 visit is reimbursed to a Medicare participating provider at a rate of $36.99 and that a 99214 visit is reimbursed at $55.92.

All of the patients coded 99214 in this audit had rheumatoid arthritis and were on either gold, methotrexate or immunosuppressive therapy. The status of each of the patients was dissimilar in terms of severity of their illness as well as their response to medications. All patients were felt to be at somewhat high risk for side effects due to the type of medications that they required. At the conclusion of the audit it was felt by the Medicare reviewer that approximately half the patients in the audit satisfied the definition of moderate to high severity problem, whereas others only satisfied the criteria of low to moderate severity. The monetary difference between billed charges and reimbursed charges for the approximately fifty patients was about $400.00, which represented an average disparity in charges of around $7.00 per patient. This audit also dealt with two laboratory tests of inflammation which the reviewers felt unnecessary for routine follow-up of patients, and all of these laboratory tests were disallowed so that the actual monetary difference between Medicare charges and reimbursement for evaluation and management codes was closer to $4.00 per patient. I was sent a bill from Medicare for approximately $5,800.00, as they extrapolated these findings to a six month time period, and I was advised that if I paid the money back to Medicare that they would continue to monitor my records for an additional time period and that if it appeared that I was no longer an outlier, the case would be closed. No penalties or interest were assessed on the case

Since the audit I have coded almost every single Medicare encounter 99213 regardless of the complexity of decision making, length of time spent with the patient or other factors. On March 20, 1998, I was sent a letter which stated that I had corrected my billing errors and that Medicare was closing my file.

Unfortunately, it is impossible for me to distinguish among these several levels of service with any certainty. I made that point to the American Medical Association in 1991 when five levels of evaluation and management services were construed, and at that time I predicted that we would eventually be caught in our own web. As I have a large practice and see a large volume of Medicare patients, I have most likely now reset the curve for other rheumatologists who will now be found to be "outliers" and will be set up for audits in the same way I was.

In no other field of medicine are physicians asked to judge the complexity of their decision making with regard to reimbursement and with the threat of fraud and abuse with potential penalties resulting from that subjective guess. Pathologists may read a complicated slide with relative ease or have difficulty making a judgment about a case, but at no time are they asked to judge whether this was a difficult decision. Radiologists may read a complicated x-ray of a bone tumor in a leg or a simple fracture and are simply reimbursed on the basis of their claimed submission. Extremely well-trained physicians may diagnosis and manage difficult problems easily, whereas less experienced physicians have difficulty with the most rudimentary cases, and it is impossible

to know where one stands in this regard. Particularly difficult is the accurate coding and documentation to support this during a day in which thirty to forty patients are evaluated. Since the audit I have found it much easier to simply down-code Medicare patients, spend whatever time is necessary with them but not to rechallange the system. I believe that many of my colleagues across the country are reacting in the same manner. Some have chosen to no longer see new Medicare patients because of the potential risk for fraud and abuse, the knowledge that they are under constant surveillance and feeling that the ambiguities in the system are simply too much to deal with.

I believe the current CPT coding methodology is fatally flawed. There are too many levels of service, and there are too many i's to dot and t's to cross. While one can easily understand when a nurse or paramedical person performs a service under the supervision of a physician or when the patient is returning for a yearly complete exam, the intermediate levels of service are simply too subjective for most of us. At best, we have to guess what the reviewer will want in the note, and because of that we are often more concerned with how the office visit will look on paper than how the patient is doing. Far from being an issue of fraud and abuse, the current system has begun to bury the physician in so many details that he can no longer get his work accomplished for the day in any coherent manner. While all of us deplore obvious examples of fraud and abuse in the medical system, such as billing for services which were never rendered, performing laboratory studies which were never ordered by physicians or providing durable medical equipment to patients who are deceased, we would urge HCFA and the American Medical Association to revisit the issue of evaluation and management codes in an effort to simplify and streamline the machinery by which physicians communicate to payers what they are doing. I would urge HCFA to eliminate the fraud and abuse provisions regarding evaluation and management coding, as this entire area of medical practice is in so much state of flux. I would urge the American Medical Association to listen to specialty and subspecialty medical societies, as these groups streamline and simplify the coding mechanism for cognitive care. I, and the many physicians I speak for, thank the Subcommittee very much for your interest and attention to the subjects discussed above. If I can answer any questions you might have regarding the above or provide you with any further testimony, written or otherwise, at a later date, please feel free to ask, and I will try to comply with your wishes.

Sincerely yours,

David A. Cooley, M.D., F.A.C.P.
Mid-America Rheumatology Consultants
5701 W. 119th St., Suite 209
Shawnee Mission, KS 66209

DISCLAIMER: I have not received any Federal grants.

DAC/gs
Enclosure

Dr. ROSENBERG. Thank you, Chairman Shays, thank you for the invitation to this conference. Good morning, Vice Chairman Snowbarger and members of the subcommittee.

My name is Arthur Rosenberg and I have been practicing internal medicine, hematology and oncology in Greenwich, CT, since 1965. I am here to testify on the current state of affairs concerning the evaluation and management coding documentation guidelines utilized by Medicare and the associated fraud and abuse audits conducted by its fiscal intermediaries. I am testifying both as an individual and on behalf of the almost 2,000 physicians who belong to the Fairfield County Medical Association in Connecticut.

The coding documentation guidelines, although probably well-intentioned when formulated by the Health Care Financing Administration and the American Medical Association, have become an administrative nightmare for practicing physicians. Doctors are angry, frustrated and fearful, and rightly so. Here is what is wrong.

First, the basic underlying problem with the current documentation guidelines is that they were designed primarily for reimbursement reasons and not for the improvement of delivery of quality patient care. The extent of documentation required is often of little relevance to the patient's complaints and treatment. Instead of concise, pertinent notes, physicians must now supply reams of unnecessary data just to comply with Government regulations. Unfortunately, documentation is now more for the benefit of Government auditors rather than for our patients.

Second, the guidelines are extremely complex, so much so that HCFA needs 50 pages to explain them. Reimbursement is based on levels of care. In order to determine the appropriate level of care for reimbursement purposes, the physician must add up items in three categories; medical history taking, physical examination and degree of medical decisionmaking. I do not have the time to explain any more about the complexity, you can get some of that from the additional pages that I have in the material I submitted to the committee.

To understand this system and how to apply it, a whole new industry has been borne, which might be called the how to seminars. Only last week, my office manager and I spent an entire day at a seminar sponsored by the Fairfield County Medical Association. Because the association had to bring in a coding expert, the seminar registration fee was of considerable cost to me, not to mention the lost day of seeing patients. The seminar reinforced my belief that adherence to these guidelines are a serious impediment to my ability to deliver quality medical care. The documentation and scoring process is extremely time-consuming, time which would be better spent working on patients' medical problems.

Third, the regulations and documentation requirements are forcing physicians into an adversarial position with our Government. Physicians are practicing in fear, we are being intimidated with constant threats of heavy fines for noncompliance and concerns over fraud and abuse charges. The vast majority of physicians, like most members of society, are honest, hard-working individuals. Most coding errors are unintentional and physicians should not be

treated like criminals. If I do 30 codes in 1 day, we should and could have some honest differences of opinion.

Several months ago, a few outstanding physicians on our hospital staff in Greenwich had their charts audited by the Medicare fiscal intermediary. These audits were done without the physicians' knowledge and for no apparent cause. As a result of the audit, the physicians were ordered to return to the Medicare Program what was claimed to be overcharges. The moneys had to be returned within 30 days or a heavy interest penalty of 15 percent would be attached. The moneys had to be returned prior to even initiating the appeal. And sadly, if the physicians are successful in their appeals—and I think they will be—the moneys are returned, but without interest. Where is the justice equity in this arrangement? Is this the way you want your physician to be treated? The Government warns against physician fraud, but it is the ever-present threats of audits and fines for variance from the guidelines which are abusive to physicians. As a result, these policies are affecting physician attitudes toward Medicare patients, and I fear this may result in some physicians declining to care for our senior citizens. And I am not alone in these concerns. As the AMA and others will attest, they have received a firestorm of strong protest from physicians all over the United States.

As an individual and not as a spokesperson for the Fairfield County Medical Association, I would like to offer the following solution. At the risk of sounding overly simplistic, I propose abandoning the concept of levels of care. I realize that on the surface, reimbursement based on levels of care is desirable, but the implementation of the system is causing more problems than it is worth.

I propose a single predetermined reimbursement for each of the common services provided by a physician. In other words, office visits, consultations, re-evals, et cetera. Naturally the fees would have to be fairly and carefully determined by all concerned parties and allow for regional variations in cost of living, liability insurance, practice costs, et cetera. And the fees could be simply adjusted each year for inflation.

Ideally, adoption of this system would eliminate the problem in one fell swoop. Physicians would be free again to maintain their medical records as they deem adequate and free them from the perusal of random audits. Of course, clear cases of abuse would have to be investigated. However, routine and random audits would not be necessary. The ever-increasing bureaucracy could be scaled back with significant savings to the Government. And best of all, physician morale would be restored. Their time and energy would once again be focused on their patients' well-being; and in the end, honorable Congressmen, it is you and your constituents who will benefit the most.

I thank you for your time. I will be pleased to answer any questions which you may have concerning these matters.

Mr. SHAYS. Thank you, Dr. Rosenberg. [Applause.]

Ms. Vance.

[The prepared statement of Dr. Rosenberg follows:]

Testimony of

Arthur H. Rosenberg, MD

to the

Sub-Committee on Human Resources
Committee on Government Reform and Oversight

April 9, 1998

Regarding

MEDICARE: CURES FOR BILLING CODE COMPLEXITY

Good day, Chairman Shays, Vice Chairman Snowbarger, and members of the Sub-Committee. My name is Arthur H. Rosenberg, MD.

I have been practicing internal medicine –hematology/oncology in Greenwich, CT since 1965. I am here to testify on the current state of affairs concerning the Evaluation and Management coding documentation guidelines utilized by Medicare, and the associated fraud and abuse audits conducted by its fiscal intermediaries. I am testifying both as an individual, and on behalf of the almost 2000 physicians who belong to the Fairfield County Medical Association in Connecticut.

The coding documentation guidelines, although probably well intentioned when formulated by the Health Care Financing Administration (HCFA) and the American Medical Association (AMA), have become an administrative nightmare for practicing physicians. Doctors are angry, frustrated, and fearful, and rightfully so. Here's what is wrong:

1. The basic underlying problem with the current documentation guidelines is that they were designed primarily for reimbursement reasons and not necessarily for the improvement of the delivery of quality patient care. The extent of documentation required is often of little relevance to the patient's complaints and treatment. Instead of concise, pertinent notes,

physicians must now supply reams of unnecessary data solely to comply with government regulations.

Unfortunately, documentation is now more for the benefit of government auditors rather than for our patients.

2. The guidelines are extremely complex, so much so that HCFA needs 50 pages to explain them. Reimbursement is based on levels of care. In order to determine the appropriate level of care for reimbursement purposes, the physician must add up items in 3 categories: medical history taking, physical examination, and degree of medical decision making.

   To understand this system and how to apply it, a whole new industry has been born, which might be called the "how to" seminars. Only last week, my office manager and I spent an entire day at a seminar sponsored by the Fairfield County Medical Association. Because the Association had to bring in a coding expert, the seminar registration fee was of considerable cost to me, not to mention the lost day of seeing patients. The seminar also reinforced my belief that adherence to the guidelines are a serious impediment to my ability to deliver quality medical care. The documentation and scoring process is extremely time consuming, time which could be better spent working on patients' medical problems.

3. The regulations and documentation requirements are forcing physicians into an adversarial position with the government. Physicians are practicing in fear. We are being intimidated with constant threats of heavy fines for non-compliance, and concerns over fraud and abuse charges. The vast majority of physicians, like most members of society, are honest and hard working individuals. Most coding errors are unintentional and physicians shouldn't be treated like criminals. If I do 30 codes in one day, we could have some honest difference of opinion.

   Several months ago, a few outstanding physicians on our hospital medical staff in Greenwich had their charts audited by the Medicare fiscal intermediary. These audits were done without the physicians' knowledge and for no apparent cause. As a result of the audit, the physicians were ordered to return to the Medicare program what was claimed to be

overcharges. The monies had to be returned within 30 days or a heavy interest penalty of 15% would be attached. The monies had to be returned prior to even initiating the appeal. And sadly, if the physicians are successful in their appeals, the monies are returned, but without interest! Where is the justice-equity in this arrangement? Is this the way you want your physician to be treated? The government warns against physician fraud, but it is the ever-present threats of **audits** and **fines** for variance from the guidelines which are abusive to physicians. As a result, these policies are affecting physician attitudes toward Medicare patients, and I fear this may result in some physicians declining to care for our senior citizens. I am not alone in these concerns. As the AMA and others will attest, they have received a firestorm of strong protests from physicians all over the United States.

As an individual and not as a spokesperson for the Fairfield County Medical Association, I would like to offer the following solution for resolving this dilemma. At the risk of sounding overly simplistic, I propose abandoning the concept of levels of care. I realize that on the surface, reimbursement based on levels of care is desirable, but the implementation of the system is causing more problems than it is worth.

I propose a single, predetermined reimbursement for each of the common services provided by a physician, i.e. office visits, consultations, re-evaluations, hospital admissions and visits, emergency room visits, house calls, nursing home visits, etc. Naturally, the fees would have to be fairly and carefully determined by all concerned parties, and allow for regional variations in cost of living, professional liability insurance, practice cost, etc. Thereafter, the fees could be simply adjusted each year for inflation.

Ideally, adoption of this system would eliminate the problem in one fell swoop. Physicians would be free again to maintain their medical records as they deem adequate, and free them from the perusal of random audits. Of course, clear cases of abuse would have to be investigated. However, routine and random audits would not be necessary. The ever-

increasing bureaucracy could be scaled back with significant savings to the government. And best of all, physician morale would be restored. Their time and energy would once again be entirely focused on their patients' wellbeing; and in the end, honorable congressmen, it is you and your constituents who will benefit the most. I thank you for your time and I will be pleased to answer any questions which you may have concerning these matters.

4/2/98

MST:nr

nr/mst/rosenberg testimony

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Physicians' Current Procedural Terminology

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The Official American Medical Association CPT

Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the **Introduction**, several other items unique to this section are defined or identified here.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See "Levels of E/M Services," page 2, for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (A detailed discussion of time is provided on page 4.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

New and Established Patient

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

Concurrent Care

Concurrent care is the provision of similar services, eg, hospital visits, to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Modifier '-75' has been deleted.

Counseling

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction; and
- patient and family education.

(For psychotherapy, see 90841-90857)

Family History

A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children;
- specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
- diseases of family members which may be hereditary or place the patient at risk.

History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

Levels of E/M Services

Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are *not* interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (eg, office and other outpatient setting, emergency department, nursing facility, etc.). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (history, examination, and medical decision making) are considered the **key** components in selecting a level of E/M services. (See "Determine the Extent of History Obtained", page ~)

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail (see page 4).

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic

tests/studies for which specific *CPT* codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate *CPT* code with the modifier -26 appended.

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

Minimal: A problem that may not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited or minor: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

Low severity: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

Past History

A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (eg, drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

Social History

An age appropriate review of past and current activities that includes significant information about:

- marital status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

System Review (Review of Systems)

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purposes of CPT the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of *CPT*. The inclusion of time as an explicit factor beginning in *CPT 1992* is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is *not* a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services. Since "work" is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians' estimates of their "work". It has been demonstrated that physicians' estimations of **intra-service time** (as explained below), both within and across specialties, is a variable that is predictive of the "work" of E/M services. This same research has shown there is a strong relationship between intra-service time and total time for E/M services. Intra-service time, rather than total time, was chosen for inclusion with the codes because of its relative ease of measurement and because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.

Intra-service times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Physicians also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This *non*-face-to-face time for office services—also called pre- and post-encounter time—is not included in the time component described in the E/M codes. However, the pre- and post-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

Unit/floor time (hospital observation services, inpatient hospital care, initial and follow-up hospital consultations, nursing facility): For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys.

Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

Unlisted Service

An E/M service may be provided that is not listed in this section of *CPT*. When reporting such a service, the appropriate "Unlisted" code may be used to indicate the service, identifying it by "Special Report", as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

99429 Unlisted preventive medicine service

99499 Unlisted evaluation and management service

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

Clinical Examples

Clinical examples of the codes for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code. Each example was developed by physicians in the specialties shown.

The same problem, when seen by physicians in different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

The examples have been tested for validity and approved by the CPT Editorial Panel. Physicians were given the examples and asked to assign a code or assess the amount of time and work involved. Only those examples that were rated consistently have been included.

Modifiers

Listed services may be modified under certain circumstances. When applicable, the modifying circumstance against general guidelines should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two digit number placed after the usual procedure number, from which it is separated by a hyphen. Or, the modifier may be reported by a separate five digit code that is used in addition to the procedure code. Modifiers available in E/M are as follows:

-21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of E/M service within a given category, it may be identified by adding modifier '-21' to the E/M code number or by use of the separate five digit modifier code 09921. A report may also be appropriate.

-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier '-24' to the appropriate level of E/M service, or the separate five digit modifier 09924 may be used.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier '-57'.

-32 Mandated Services: Services related to *mandated* consultation and/or related services (eg, PRO, 3rd party payor) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.

-52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52,' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be used as an alternative to modifier '-52.'

-57 Decision for Surgery. An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier '-57' to the appropriate level of E/M service, or the separate five digit modifier 09957 may be used.

Instructions for Selecting a Level of E/M Service

Identify the Category and Subcategory of Service

The categories and subcategories of codes available for reporting E/M services are shown in Table 1 below.

Review the Reporting Instructions for the Selected Category or Subcategory

Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Inpatient Hospital Care", special instructions will be presented preceding the levels of E/M services.

Table 1
Categories and Subcategories of Service

Category/Subcategory	Code Numbers
Office or Other Outpatient Services	
New Patient	99201-99205
Established Patient	99211-99215
Hospital Observation Discharge Services	99217
Hospital Observation Services	99218-99220
Hospital Inpatient Services	
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Hospital Discharge Services	99238
Consultations	
Office Consultations	99241-99245
Initial Inpatient Consultations	99251-99255
Follow-up Inpatient Consultations	99261-99263
Confirmatory Consultations	99271-99275
Emergency Department Services	99281-99288
Critical Care Services	99291-99292
Neonatal Intensive Care	99295-99297
Nursing Facility Services	
Comprehensive Nursing Facility Assessments	99301-99303
Subsequent Nursing Facility Care	99311-99313
Domiciliary, Rest Home or Custodial Care Services	
New Patient	99321-99323
Established Patient	99331-99333
Home Services	
New Patient	99341-99343
Established Patient	99351-99353
Prolonged Services	
With Direct Patient Contact	99354-99357
Without Direct Patient Contact	99358-99359
Standby Services	99360
Case Management Services	
Team Conferences	99361-99362
Telephone Calls	99371-99373
Care Plan Oversight Services	99375-99376
Preventive Medicine Services	
New Patient	99381-99387
Established Patient	99391-99397
Individual Counseling	99401-99404
Group Counseling	99411-99412
Other	99420-99429
Newborn Care	99431-99440
Special E/M Services	99450-99456
Other E/M Services	99499

Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (ie, history, examination, and medical decision making) should be considered the **key** components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care (See numbered paragraph 3, page 8.)

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

Determine the Extent of History Obtained

The extent of the history is dependent upon clinical judgement and on the nature of the presenting problems(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem focused: chief complaint; brief history of present illness or problem.

Expanded problem focused: chief complaint; brief history of present illness; problem pertinent system review.

Detailed: chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history *directly related to the patient's problems.*

Comprehensive: chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

Determine the Extent of Examination Performed

The extent of the examination performed is dependent on clinical judgement and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem focused: a limited examination of the affected body area or organ system.

Expanded problem focused: a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed: an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive: a general multi-system examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.

For the purposes of these CPT definitions, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

For the purposes of these CPT definitions, the following organ systems are recognized:

- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular

- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Determine the Complexity of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problems(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in Table 2 below must be met or exceeded.

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* their presence significantly increases the complexity of the medical decision making.

Select the Appropriate Level of E/M Services Based on the Following

1. For the following categories/subcategories, **all of the key components,** ie, history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.

2. For the following categories/subcategories, **two of the three key components** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; follow-up inpatient consultations; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

3. In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the medical record.

Table 2

Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
minimal	minimal or none	minimal	**straightforward**
limited	limited	low	**low complexity**
multiple	moderate	moderate	**moderate complexity**
extensive	extensive	high	**high complexity**

A BLUEPRINT FOR DOCUMENTING YOUR E&M SERVICES: REVISED

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THE HISTORY

Chief Complaint (CC). Document what the patient states is the reason for the visit.

History of Present Illness (HPI). Include a chronological description of the development of the patient's present illness. The HPI includes eight elements.

1. Location
2. Quality
3. Severity
4. Duration
5. Timing
6. Context
7. Modifying Factors
8. Associated Signs and Symptoms

If you cannot obtain this history from the patient, note here why.

An HPI is required for all types of history.

Medicare Parameters for Auditing HPI

Brief HPI - documentation of one to three of the above eight elements.

Extended HPI - documentation of four or more elements or the status of at least three chronic or inactive conditions.

Note: The CC, Review of Systems (ROS) and Past, Family and/or Social History (PFSH) may be included in the description of the HPI, and not necessarily listed as separate elements of history.

THE HISTORY (continued)

Review of Systems (ROS). By asking the patient a series of questions about any signs or symptoms experienced, in the past or currently, you are reviewing body systems. There are fourteen systems.

1. Constitutional Symptoms (e.g. fever, weight loss)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary (male and female)
8. MusculoSkeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematology/Lymphatic
14. Allergy/Immunology

Medicare Parameters for Auditing ROS

Problem Pertinent ROS - positive and pertinent negatives for the system related to the problem.

Extended ROS - positive and pertinent negatives for two to nine systems.

Complete ROS - review of at least ten systems. Individually document systems with positive and pertinent negatives. For the remaining systems, noting that all other systems are negative is allowed. In the absence of such a note, at least ten systems must be individually documented.

THE HISTORY (continued)

Past, Family, and/or Social History (PFSH). Note the patient's past experience with illness, surgeries, injuries, etc. Also document the patient's family history of diseases. The social history should be "age-appropriate" and include review of past and current activities or life-style.

For a subsequent visit (by you or any number of physicians in an institutional setting), you do not have to re-record the ROS and/or PFSH, previously noted. If there have not been any changes since the last entry, make that notation. If there have been changes, describe the new information. In both cases, document the date and location of the earlier ROS and/or PFSH.

For subsequent hospital and nursing facility care, and follow-up inpatient consults – which include only an interval history – it is not necessary to record PFSH information.

Medicare Parameters for Auditing PFSH

Pertinent PFSH - specific information for one of the history areas (the patient's past history, family history or the patient's social history), directly related to the problem identified in the HPI.

Complete PFSH - specific information for:

- One specific item from two of the three history areas for established patient services (office/other outpatient, domiciliary care, home care) and ER services.
- One specific item from each of the three history areas for: new patient services (office/other outpatient, domiciliary care, home care); hospital observation; inpatient services, initial care; consults; comprehensive nursing facility assessments.

Note: Ancillary staff can record the ROS and/or PFSH, or the patient may complete the form. The physician should make a note supplementing or confirming the information recorded by others.

THE HISTORY (continued)

Medicare Parameters for Determining the Type of History

Now that the intensities of History of Present Illness (HPI), Review Of Systems (ROS), and Past, Family, Social History (PFSH) have been identified, the type of history that was documented can be determined. Refer to the chart below.

- If all three intensities are met in one column, look at the bottom of that column for the type of history.
- If no column has all three intensities circled, choose the type of history that has a circled intensity farthest to the left.

DETERMINING THE TYPE OF HISTORY

HPI	Brief	Brief	Extended	Extended
ROS	None	Problem Pertinent	Extended	Complete
PFSH	None	None	Pertinent	Complete
Type of History	*Problem Focused History*	*Expanded Problem Focused History*	*Detailed History*	*Comprehensive History*

For example, if a brief HPI and a problem-pertinent ROS were documented, and no PFSH was documented, an "Expanded Problem Focused History" was performed.

In another example, if an extended HPI and an extended ROS were documented, and no PFSH was documented, an "Expanded Problem Focused History" was performed.

THE PHYSICAL EXAMINATION

There are four intensities of the physical examination:

- Problem Focused. A limited exam of the affected body area or organ system.
- Expanded Problem Focused. A limited exam of the affected body area or organ system, and any other symptomatic or related body area(s) or organ system(s).
- Detailed. An extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- Comprehensive. A general multi-system exam, or complete exam of a single organ system and other symptomatic or related body area(s) or organ system(s).

Eleven types of physical examinations are specified:

1. General, multi-system
2. Cardiovascular
3. Ear, Nose,Throat
4. Eyes
5. Genitourinary (female and male)
6. Skin
7. Musculoskeletal
8. Neurological
9. Psychiatric
10. Respiratory
11. Hemato/Lymphatic/Immunologic

There are fourteen System/Body Areas that may be considered when determining the level of the "general, multi-system exam" and fifteen System/Body areas considered for the "single organ system exams". These are listed separately on the following pages that describe the elements of each of the exams.

THE PHYSICAL EXAMINATION (continued)

Specific clinical elements further define each of the System/Body Areas. These elements are "bulleted" and represent physical findings within the System/Body Area that should be documented, to support the level of service you are billing.

The System/Body Areas and their respective bulleted elements are each enclosed in a box. For the single organ system exams, some boxes are shaded, others are not. As you read the Medicare parameters for choosing the intensity of the exam, the type of box (shaded or unshaded) will help qualify your decision.

Explain specific abnormal and relevant negative findings from your examination of the affected or symptomatic System/Body Area. Do not simply note "abnormal" and not explain.

For the examination of Systems/Body Areas that are not affected or asymptomatic, note any abnormal or unexpected findings. If there are negative findings when these Systems/Body Areas are examined, you may simply note "negative" or "normal" for each one you examined.

Documentation must satisfy the numeric parameters (e.g. "Measurement of any 3 of the following 7") or at least one component when no numeric parameters are set (e.g. "Examination of liver and spleen").

Choosing the level of physical exam can be a very confusing exercise. If you are a specialist, you may only perform one of the ten organ-specific exams. However, you may, also, perform the general, multi-system exam. The type and content of the exam should be based on the physician's clinical judgement, the patient's history, and nature of the presenting problem(s). Familiarize yourself with the documentation requirements for both.

HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC EXAMINATION
1. Constitutional
• Measurement of **any three of the following seven vital signs**: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
2. Head and Face
• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
3. Eyes
• Inspection of conjunctivae and lids
4. Ears, Nose, Mouth and Throat
• Otoscopic examination of external auditory canals and tympanic membranes
• Inspection of nasal mucosa, septum and turbinates
• Inspection of teeth and gums
• Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
5. Neck
• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)
• Examination of thyroid (eg, enlargement, tenderness, mass)
6. Respiratory
• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
• Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
7. Cardiovascular
• Auscultation of heart with notation of abnormal sounds and murmurs
• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
8. Chest (Breasts)
9. Gastrointestinal (Abdomen)
• Examination of abdomen with notation of presence of masses or tenderness
• Examination of liver and spleen
10. Genitourinary
11. Lymphatic
• Palpation of lymph nodes in neck, axillae, groin, and/or other location
12. Musculoskeletal
13. Extremities
• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

A BLUEPRINT FOR DOCUMENTING YOUR E&M SERVICES: REVISED
The Physical Exam

19

HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC EXAMINATION

14. Skin

- Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)

15. Neurological/Psychiatric

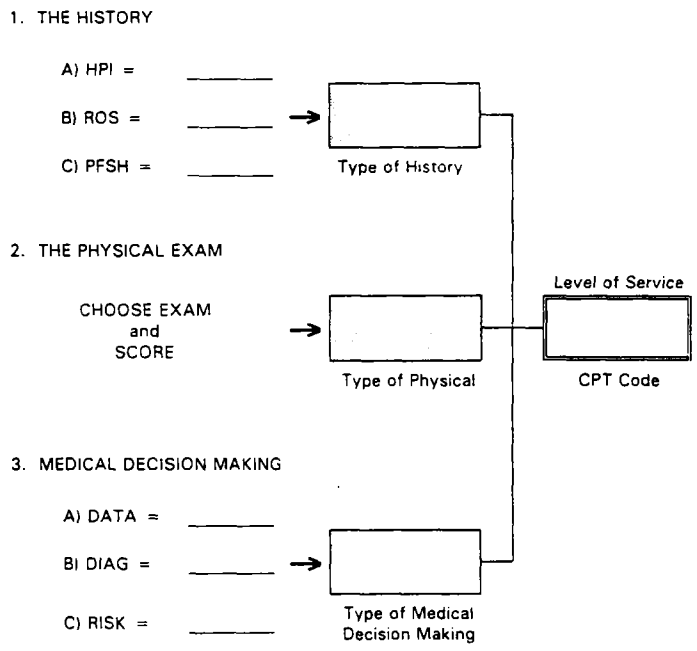
Brief assessment of mental status, including:

- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, agitation)

MEDICARE PARAMETERS FOR AUDITING
HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC EXAMINATION

Level of Exam	Perform and Document:
Problem Focused	**One to five elements** identified by a bullet.
Expanded Problem Focused	**At least six elements** identified by a bullet.
Detailed	**At least twelve elements** identified by a bullet.
Comprehensive	**Perform all elements** identified by a bullet; **document every element** in a **shaded box** and **at least one element** in **each unshaded box.**

THE THREE MAJOR COMPONENTS OF THE E&M SERVICE CODES



Medicare Parameters for Determining the Level of Decision Making

Now that the intensities of the number of diagnoses/management options, amount and complexity of data, and overall risk have been identified, the level of Decision Making that was documented can be determined. Refer to the chart below.

- Circle the intensities of the three components. If two or three circles appear in one column, look at the bottom of that column for the type of Decision Making.

  For example, if the number of diagnoses was "limited", the amount of data was "limited", and the overall risk was "moderate", the type of Decision Making is "Low Complexity".

- If there is only one circled intensity per column, choose the column with the second circle from the left.

  For example, if the number of diagnoses was "multiple", the amount of data was "limited" and overall risk was "minimal", the type of Decision Making is "Low Complexity".

DETERMINING THE LEVEL OF DECISION MAKING

Number of Diagnoses or Management Options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
Amount and Complexity of Data	≤ 1 Minimal or none	2 Limited	3 Moderate	≥ 4 Extensive
Overall Risk	1 Minimal	2 Low	3 Moderate	4 High
Type of Decision Making	*Straight-forward*	*Low Complexity*	*Moderate Complexity*	*High Complexity*

Level of History: _____

Level of Exam: _____

Level of Medical Decision Making: _____

Decision Matrix for Established Patient Visits

Code	History	Exam	Medical Decision Making	Counsel	Problem	Time
99211					minimal	5 min
99212	Problem Focused	Problem Focused	Straight Forward	Consis-tent	limited/ minor	10 min
99213	Expanded Problem Focused	Expanded Problem Focused	Low Complex	Consis-tent	Low to Moderate Severity	15 min
99214	Detailed	Detailed	Moderate Complex	Consis-tent	Moderate to High	25 min
99215	Compre-hensive	Compre-hensive	High Complex	Consis-tent	Moderate to High Severity	40 min

Note: Two of the Three Key Components must be met

Level of Service: _____

I'm a Doctor, Not a Paper Pusher

By Jody Robinson

Starting this July, under the federal government's new Medicare Correct Coding Policy, doctors will be spending a lot more time on paperwork rather than patient care. In fact, documentation requirements are on the verge of subsuming medical care itself. These regulations started as a legitimate effort to determine that services government pays for have actually been delivered. But they've developed into a Rube Goldberg system in which auditors with little or no medical training will determine if doctors are actually doing their jobs instead of committing fraud all day long.

Under little-publicized provisions of the 1996 Health Insurance Portability and Accountability Act (the Kennedy-Kassebaum law), enforcement responsibility will rest with 450 FBI agents hired specifically for this purpose. This also means that if you are a Medicare patient, the FBI will have unfettered access to your medical records.

The new regulations, issued by the Health Care Financing Administration, are so heavy-handed that it is clear they have little or nothing to do with the care of the patient. For example, to justify a 25-minute visit with a Medicare patient, a physician will have to generate a written record including—just try to follow this—the chief complaint, an extended history of the present illness (four or more elements, or the status of at least three chronic or inactive conditions); a review of systems (an inventory of two to nine bodily systems); pertinent past medical, family and social history; plus either a detailed examination (including at least six organ systems or body areas with at least two elements each or at least 12 elements in two or more organ systems or body areas), as well as two out of three of either multiple diagnoses or management options, a moderate amount or complexity of data to be reviewed, along with the risk of complications or morbidity or mortality.

There's more. Somewhere along the line, a numbingly complex matrix of required elements must be consulted for each medical interaction to determine which level of office-visit service should be coded for billing to Medicare. Failure to do so with consistent accuracy can subject the miscreant physician to fines of up to $10,000 an incident. So the physician must turn to elaborate tables of symptoms and body parts to be sure that the reported number of findings are distributed among the right number of body systems and duly recorded.

The effective date of these new regulations was delayed to July from January after a howl of protest from physicians. But there is little indication that they will be substantially modified. They should be dumped altogether.

The concept of standardizing the work to be expected with various levels of care seems reasonable at first glance. Medical records, after all, once consisted of little more than scanty scribbled observations. But the days of undocumented medical treatment have long since passed. Physicians, who have labored for at least 30 years under the threat of malpractice litigation, long ago became conscientious at recording the details of significant findings and treatments.

A look at the new regulations leads to the unavoidable conclusion that a disproportionate amount of time will be consumed by pedantic record keeping, at the expense of the patient. The information mandated is so voluminous—lots of chaff for little or no wheat—that it's of no use to the next person to use the medical record, either.

Such a single-minded focus on documentation may satisfy the bureaucrat and the accountant, but it can be hazardous to the patient. After all, a doctor can do only so much in 15 to 30 minutes. Every unnecessary or arbitrary documentation mandate takes away from the time available to evaluate symptoms, formulate a diagnosis or a treatment plan, explain the problem, write prescriptions . . . and, oh yes, comfort and console the patient. These requirements are demeaning to physicians, surely among the most skilled, educated and ethical professionals in our society.

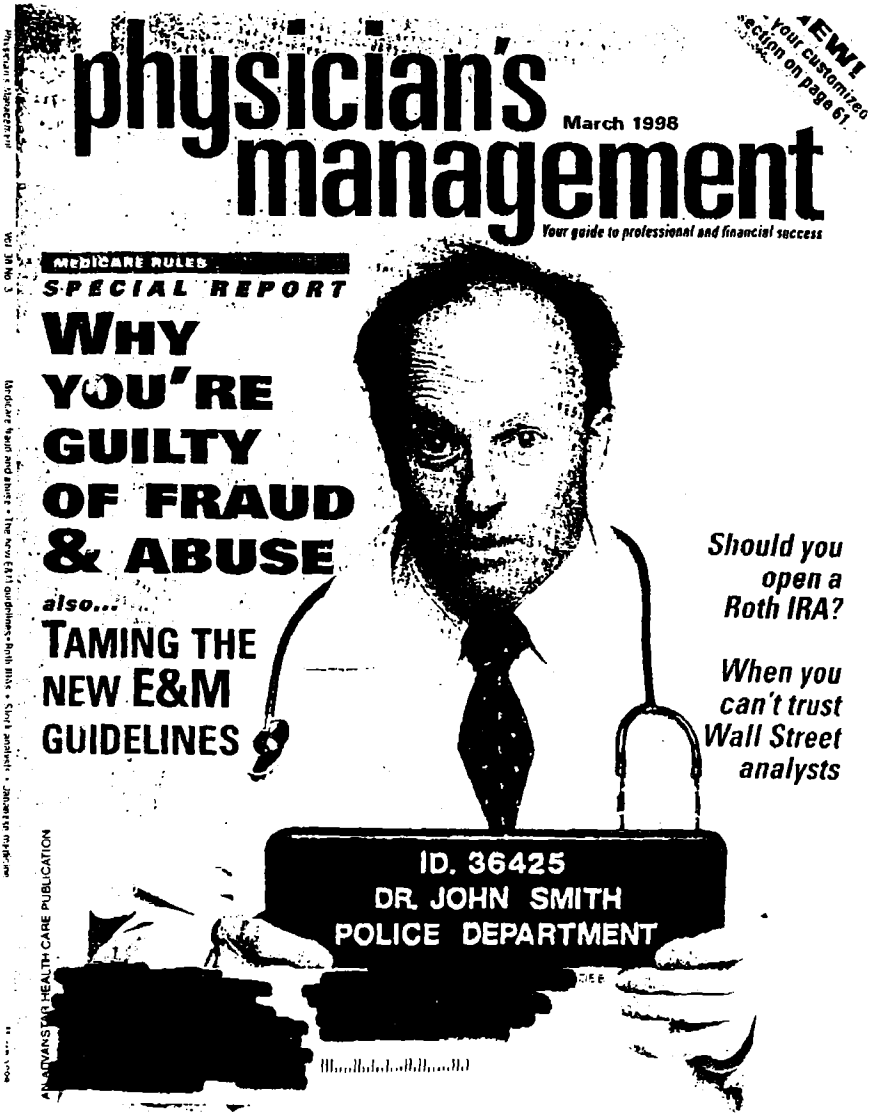
The real purpose of these regulations is to find ways to reduce the payment for services provided to patients by applying the rule: *If it isn't documented, it didn't happen.*

How can a doctor keep the patient's needs foremost in mind when every interaction is laden with administrative burden and fraught with legal peril? "The secret of caring for the patient is to care for the patient," said the great early-20th-century physician William Osler. To put it in contemporary lingo, it's the patient, not the chart. Documentation should not become the tail that wags the dog.

On the other hand, if this is good medicine for doctors, perhaps every government official and employee should be subject to similar work-substantiation requirements. It might be instructive to have each of our public servants report minute-to-minute activities and accomplishments in comparable detail, so we could all see just where our tax dollars are going.

Dr. Robinson practices internal medicine in Washington, D.C.

WSJ 4/2/98


physician's management
March 1998
Your guide to professional and financial success
NEW! your customized section on page 61
MEDICARE RULES
SPECIAL REPORT
WHY YOU'RE GUILTY OF FRAUD & ABUSE
also...
TAMING THE NEW E&M GUIDELINES
Should you open a Roth IRA?
When you can't trust Wall Street analysts
ID. 36425
DR. JOHN SMITH
POLICE DEPARTMENT
AN ADVANSTAR HEALTH CARE PUBLICATION

Ms. VANCE. Mr. Chairman, members of the committee, thank you for the opportunity to testify before you today to discuss the complexity of the Medicare billing process.

I am here as an administrator to talk about the hands-on administrative hassles of the problems of dealing with the different regulations in the program. By way of introduction, I am an administrator of an internal medicine practice based out of Kansas City, MO. About 50 percent of our patients are Medicare patients. I am presently serving as president-elect of Greater Kansas City Medical Managers Association, which is affiliated with the Medical Group Management Association, a national organization. I am certified as a medical practice executive and I am 10 hours away from a masters' degree in business administration. I returned to school at the age of 50 because I felt that the practice of medicine has become so complex that our physicians needed that additional training.

To give you an idea of some of the regulations that we deal with daily, we deal with the Clinical Laboratory Improvement Act, evaluation and management coding and documentation guidelines, laboratory coding complexity requiring the use of algorithms, ICD–9 diagnosis and CPT–4 procedure cross-reference, compliance plans, coordination of benefits, Stark I and II, fraud and abuse, advanced beneficiary notices, antitrust, OSHA, bloodborne pathogens, hazardous waste, resource based relative value system, balance billing, private contracting, billing regulations surrounding nurse practitioners and physician assistants, physician incident to rules. That is just a few of what we have to become experts in in a small office.

It is time-intensive and expensive to stay up to date on changing regulations. Employees who have kept up with training in these various regulations are highly sought after and they demand and receive higher compensation, further challenging the physician in his or her efforts to hold down costs of medical care. We purchase multiple publications, compliance software, we attend seminars to educate ourselves so that the practices are in compliance with the laws. Managers are struggling to keep up with these changes, to absorb the legal issues, to summarize and educate their physicians. Physicians are attending seminars on how to address regulations rather than new medical treatments and patient care. All of these expenditures are to protect good doctors who wish only to practice medicine and receive fair compensation.

Our medical coder who has 11 years of experience estimates that it takes her twice as long to code Medicare claims as any other insurance carrier. In my testimony, I have some examples of Medicare diagnosis code problems that we deal with with Medicare. Medicare has their own diagnosis code list that links to procedures that are different than what other insurance carriers use and our coder has to keep that list on her lap. If the diagnosis that the physician gave to the employee is different than what is in the—than what is covered in the diagnosis list, the employee has to go to the doctor, the doctor has to look at an alternate diagnosis and the difficulty with that is that now we have a diagnosis going in that is different than what the physician originally placed in the chart.

Laboratory directives have become so complex that algorithms have been published by Medicare. I believe there is an algorithm table that has been published that is in your materials that you

might look at. This, as you can see, is the algorithm for one test that we would have to explain to a patient. Let me quickly tell you that we have had to add a form to track whether the patient is on medication for control, whether the test result is above or below target level, how old the patient is, when their last test was performed, whether that was performed in our office or another physician's office or a reference lab, and whether the patient wanted the test even if it is noncovered by Medicare. That is to get reimbursed for one test. Consider the opportunities for error when there are this many considerations for one test and the medical practice processes hundreds of line items a day.

Directives that we get from Medicare are—we have written and verbal directives. When we call to Medicare, sometimes those answers are different than what we get in written communication. Which directive does our staff follow? Do we act as patient advocates and try to get coverage for our Medicare beneficiaries so they are not forced to pay out of pocket? If we follow verbal instruction and are later audited, are the doctors charged with fraud?

Every day, our staff deals with the fear their errors or misunderstandings will financially or criminally affect their physician employers. Rules vary from day to day and are dependent upon the interpretation of the Medicare contractor employee with whom you speak.

In an effort to ensure Medicare is not inappropriately billed for tests not performed, our office has instituted a corporate compliance policy of reviewing all charges against actual testing done each day. This compliance model adds heavy administrative burdens to personnel to review hundreds of charges daily. However, the penalties of Medicare fraud and abuse are so great, the office has tremendously increased its cost and administrative efforts in order to protect its physicians against inadvertent coding errors which could place them in jail. This is a heavy-handed corrective action to uncover relatively few errors, but the consequences of errors are too high.

I see that my time is out. I would like to—perhaps in questioning, I have some recommendations to the committee. One last thing, our relationship with Medicare needs to be cooperative and educational rather than punitive and threatening. As a primary care office for multiple HMO and PPO products, we experience regular chart audits and reviews for HEDIS requirements for eight different HMO's. We welcome their input because it is provided to us in an environment of mutual concern for increasing the quality of the patient record and for meeting quality targets. We learn, we improve, they learn, they improve and the patient wins.

Mr. SHAYS. Thank you very much, Ms. Vance. Applause.]

[The prepared statement of Ms. Vance follows:]

Testimony of Kathryn S. Vance, CMPE
to the Subcommittee on Human Resources
for the Department of Health and Human Services
Field Hearing "Medicare: Cures for Billing Code Complexity"
April 9, 1998

Mr. Chairman, members of the committee, thank you for the opportunity to testify before you to discuss the complexity of the Medicare billing process. By way of introduction, I am the administrator of a private internal medicine practice in Kansas City, Missouri. Our practice provides care to a patient population which is fifty percent Medicare. We also provide to our patients an in-office laboratory which is CLIA-certified and considered highly complex.

I have managed this practice for twelve years. I am currently serving as President-Elect of Greater Kansas City Medical Managers Association, a 400-member organization which is affiliated with the national Medical Group Management Association (MGMA). I have tested and attained the status of Certified Medical Practice Executive (CMPE) through MGMA and I am ten credit hours from completing a Master in Business Administration from the University of Kansas.

It is my opinion that health care today, and especially the Medicare program, requires more sophisticated management and leadership than at any time in the past. It is imperative that managers and staff continue professional development to address the complex environment of the administrative side of medicine. Managers as well as staff must be more highly trained to guide the medical practice through the regulatory maze associated with Medicare. The Medicare program brings with it

- Clinical Laboratory Improvement Act (CLIA) Compliance
- Evaluation and Management Coding and Documentation Guidelines
- Laboratory coding complexities requiring the use of multiple algorithms
- ICD-9 diagnosis and CPT-4 procedure cross-reference
- Compliance Plans
- Coordination of Benefits to non-Medicare payers (Secondary Payer)
- Stark I & II (Self-Referral Guidelines)
- Fraud and Abuse
- Advanced Beneficiary Notices
- Antitrust
- OSHA
- Bloodborne pathogens
- Hazardous waste
- Resource Based Relative Value System (Part B RBRVS)
- Balance billing regulations
- Private contracting issues, etc.

Training to keep up with new changes in the health care regulatory environment has become essential. It is time intensive and expensive to stay up to date with the

changing regulations. Employees who have kept up with training in these various regulations are highly sought after, and demand and receive higher compensation, further challenging the physician in his/her efforts to hold down costs of medical care. We purchase multiple publications which try to summarize and explain Medicare rules, we purchase compliance primers to help us address regulatory issues which are constantly changing, and we attend seminars quite often not held in Kansas City, thus necessitating travel and additional lodging costs, to educate ourselves so that our practices are in compliance with the laws. Managers are struggling to keep up with these changes, to absorb legal issues, to summarize and educate their physicians. Physicians are attending seminars on how to address regulations rather than new medical treatments and patient care. We are spending more on consultants to review our coding and business practices to protect physicians from inadvertent errors which will put them at risk in an onerous environment which threatens their very livelihoods. All of these expenditures are to protect good doctors who wish only to practice medicine and receive fair compensation.

ADMINISTRATIVE COMPLEXITY

Coding Difficulties - Our medical coder, who has eleven years of experience in the industry, has found the increasing difficulty of Medicare coding has forced her to separate Medicare claims from commercial claims prior to processing, and estimates it takes her twice as long to code Medicare than other insurance carrier claims. This, of course, reduces her output and increases costs to the physician to see Medicare patients.

One of the major problems in coding Medicare claims versus other insurance is the issuance by Medicare of their own diagnosis code lists which designate the only available diagnoses they will cover for certain tests or procedures. These Medicare code lists are incomplete and do not allow payment for tests and procedures under ICD-9 diagnosis codes which would be considered medically appropriate under any other insurance system.

> A specific example of this would be allowing payment for a spirometry under the diagnosis "shortness of breath," but not "COPD" (chronic obstructive pulmonary disease). COPD is a much more severe diagnosis, and all patients with this diagnosis have shortness of breath. COPD should logically be a diagnosis which would cover the spirometry test; however, Medicare does not have COPD in their diagnosis code list.

As a result, coders must resort to asking physicians for an alternate diagnosis which is still appropriate for the patient, but that is contained on Medicare's list. This wastes valuable time and creates the uncomfortable situation of changing the original diagnosis code which the physician designated. When Medicare is questioned regarding the need to add diagnosis code links to procedures, we are told the code is not on the list and they cannot change the list.

These missing diagnosis code links are numerous and cause the coder to stop in her processing, look in her records to see if the physician designated diagnosis exists on her list for the procedure performed, find it is not, go to the doctor for an alternate code, and reprocess. Because this process is so cumbersome, what may happen in the reality of business and processing hundreds of claims, is the coder may change the diagnosis code to a similar code which is different than the physician assigned, putting the doctor at risk for a diagnosis which he did not designate.

We need, as medical practices, to be able to work with Medicare quickly and efficiently in an appeal process which can develop code links which include all diagnosis codes that would reasonably be available to a physician as medically necessary, so that coders are not forced to enter charges with a code book open on their laps. Appeal processes should be open and swift to change diagnosis lists.

Laboratory Complexities - Laboratory directives have become so complex that algorithms have been published by Medicare.

> Our practice has had to develop a new patient record form to follow complex rules surrounding the coverage guidelines of lipid profiles (see Exhibit B). The rules governing coverage for this simple test are difficult to remember and almost impossible to explain to beneficiaries. In order for our office to properly bill Medicare for this one lab test alone, we have had to add a form, track whether the patient is on medication for control, whether their test result is above or below a target level, how old the patient is, when their last test was performed (whether performed in our office or any other physician's office or reference lab), and whether the patient wanted the test even if it might be non-covered by Medicare.

Please consider the time involved, with several different employees, and with education of the patient, to be reimbursed for one test. Consider the opportunities for error when there are this many considerations to process only one item, and the medical practice processes hundreds of line items per day.

INCONSISTENT DIRECTIVES

Using the above example, again, of the lipid profile, we have been issued the published algorithm as guidelines for coverage under the Medicare program. This allows for the test to be performed every three to four months dependent upon control and medication. However, when our office calls Medicare, we are told that the payment guidelines followed by the claims processors indicate payment can be made every thirty days.

Which directive does our staff follow? Do we act as patient advocates and try to get coverage for our Medicare beneficiaries so they are not forced to pay out of pocket? If we follow verbal instruction and are later audited, are the doctors charged with fraud?

Everyday, our staff deals with the fear their errors will financially or criminally affect their physician employers. Rules vary from day to day and are dependent upon the interpretation of the Medicare contractor employee with whom you speak. If we make three attempts at clarification of a ruling, we receive three varying responses, and yet we are held accountable by the Department of Justice to the most stringent interpretation of the rules. Communication for appropriate administration is slow and susceptable to misinterpretation between the local carriers and HCFA.

An additional complication occurs when our patients call Medicare to ask why a test has not been covered and are told that Medicare would pay if only their physician had coded the claim with a correct diagnosis code. This response moves the call through the Medicare system faster than a lengthy and sometimes uncomfortable explanation to the beneficiary. Medicare does not take the time to educate the patient that the Medicare program does not cover screening tests, what constitutes screening under Medicare's interpretation, and that only certain diagnoses linked to a test will be covered. Patients then call us indicating we have billed incorrectly, per Medicare.

CORPORATE COMPLIANCE

In an effort to ensure Medicare is not inappropriately billed for tests not performed, our office has instituted a corporate compliance policy of reviewing all laboratory, x-ray, electrocardiograph, and pulmonary testing charges against actual testing done each day. This compliance model adds heavy administrative burdens to personnel to review hundreds of charges daily. However, the penalties of Medicare fraud and abuse are so great, the office has tremendously increased its costs and administrative efforts in order to protect its physicians against inadvertent coding errors which could place them in jail. This is a heavy-handed corrective action to uncover relatively few errors, but the consequences of errors are too high.

In an era when physicians are being asked to control the costs of medical care, measures such as these are consuming health care dollars which could be better spent on caring for patients rather than on administrative oversight.

EVALUATION AND MANAGEMENT CODING

Our experience in regard to E/M Coding and Documentation Guidelines is that physicians find the guidelines impossible to understand and implement without errors. As a result, physicians tend to undercode themselves in an effort to protect themselves in the event of audit. We are only requesting fair compensation for good medical care. It is my concern that overall physician coding practices will ratchet down to lower mean codes as a protective mechanism, and the system will reactively ratchet down, instead of compensating physicians for reasonable charges without the threat of criminal investigation. If the system of reimbursement is perceived to be unfair, good physicians will leave the profession, and the risk may be that marginal physicians may game the system in order to receive a fair compensation.

ADDITIONAL COSTS

In addition to the added costs experienced with corporate compliance and coding complexities, our office has had to assign one employee full time to do nothing but handle Medicare electronic claims and Medicare patient calls regarding unpaid claims. Patients do not understand the complexities of the system, and they require constant feedback. They read negative reports in the news indicating there is fraud and abuse rampant in the program, and they want to be reassured they are not being taken advantage of. It is hard to regain their trust when they are barraged with negative publicity.

COMPARISON OF MEDICARE TO COMMERCIAL PPO AND HMO PRODUCTS

Our relationship with Medicare needs to be cooperative and educational rather than punitive and threatening. As a primary care office for multiple HMO and PPO products, we experience regular chart audits and reviews for HEDIS requirements for eight different HMOs. We welcome their input because it is provided to us in an environment of mutual concern for increasing the quality of the patient record and meeting quality targets. We learn, we improve; they learn, they improve; and most importantly, the patient wins.

If you have a system like Medicare which has approximately 18,000 pages of regulations and instructions, the system is so complex that good physicians practicing good medicine are at risk of being non-compliant as a result of inadvertent coding and billing errors. These regulations have been established to circumvent a small percentage of abusers, but the system as a whole experiences the increased costs associated with response to these regulations.

RECOMMENDATIONS

If we wish to increase the value of the health care dollar in America, we need to work together in an environment that assumes the vast majority of physicians want to provide high quality care in a cost-effective manner. As practice administrators, we are advocates of

- a non-punitive method of assuring compliance with E/M Coding as well as other coding and billing regulations. Chart audits which are educational in nature will be more productive of consistency in coding than threats of fines or criminal prosecution.

- regulations which are reasonable and cost-effective for the physician to implement.

physicians who show significant outlier behavior be identified, informed, educated, and if still non-compliant, expelled from the Medicare program "with cause" and on public record.

- consideration of bonuses to physicians who have proven to be compliant which can be a much more productive method of compliance rather than threat of punishment. Bonuses can be financial or they can be in some other form such as waivers from educational audits for periods of time.

- responsible media coverage which is supportive of the positive attributes and contributions of the Medicare program to the elderly rather than assuming physicians are gaming the system. Patients fear they are being taken advantage of and this destroys the physician/patient rapport which is critical to optimal care. We must together build a system which is trusted and positive in its position to the public.

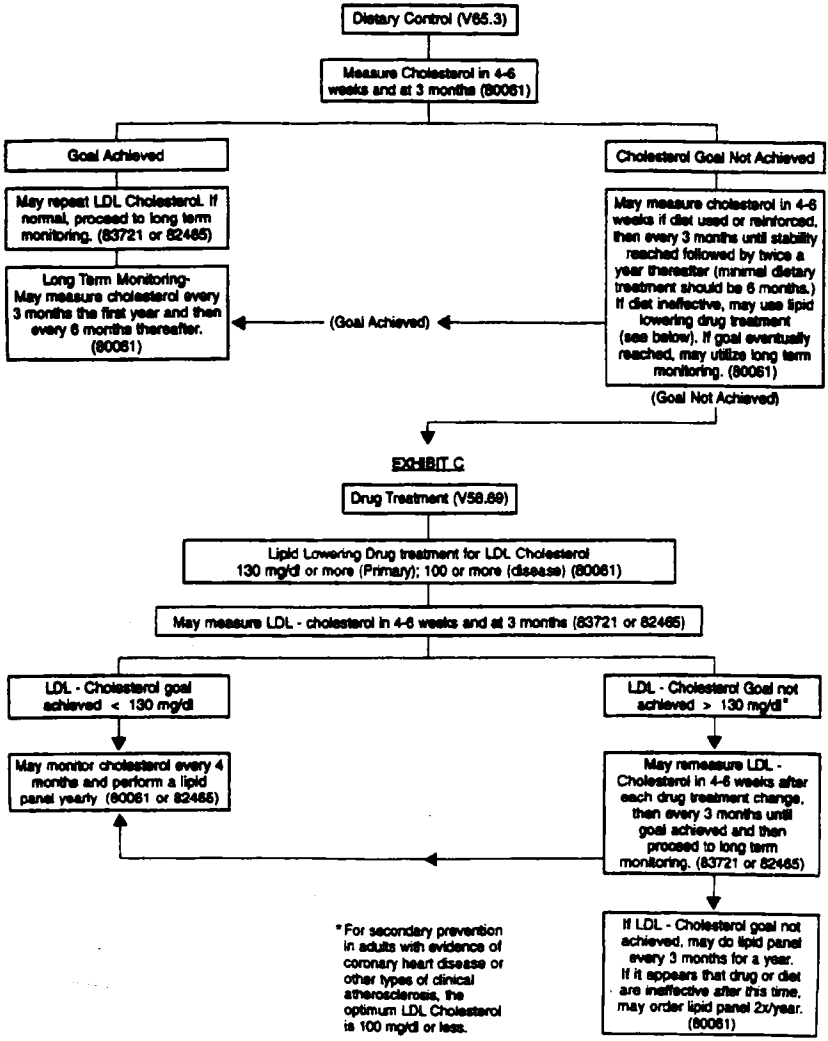
CONCERNS

If medicine becomes so onerous that our best and brightest choose not to go into the profession because of its risks, hassles, intensity, and increasingly lower compensation, we are going to look at a system in ten years that no longer provides the best health care in the world. Physicians represent the entrepreneurial spirit and small business development upon which America has been built. We are systematically destroying medicine's very infrastructure by destroying the spirit of the physicians who underlie it.

It is the very essence of business practice today that empowers men and women to act, to train and educate in order that good decisions are made, and not to threaten for efforts which are responsible but not perfect.

Thank you for the opportunity to voice our concerns about a system which is becoming increasingly complex and where dollars are being directed to administrative oversight rather than patient care.

EXHIBIT B
ALGORITHM FOR MEDICARE APPROVED LIPID ANALYSIS
DIETARY AND/OR DRUG TREATMENT INTERVENTION



HYPERLIPIDEMIA THERAPY

Name ____________________ Diagnosis ____________________

DATE	CHOL	TRI	HDL	LDL	CK/SGOT	MEDICATION	RE-CHECK

Mr. SHAYS. What we are going to do is each of us is going to have 10 minutes of questioning and we will start with Mr. Snowbarger. I am going to do a 5-minute light and just flip it over again. Mr. Snowbarger.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Mr. Robertson, I would like to start with a question to you that may apply to the remaining members of the panel as well.

Obviously, in a hospital setting, in the doctor's office setting, you are dependent on a number of different third party payers. Medicare is just one of those third party payers. And I was wondering if you could briefly give me an idea of the comparison between the difficulties with Medicare and other insurance or third party payers.

Mr. ROBERTSON. Managed care companies do not require—third party payers do not require a whole series of issues that Medicare does. A good example is level of care. When a patient is admitted under Medicare, what happens is we have to make sure they are—you know, are they classified as an outpatient in a bed, are they an inpatient or are they skilled nursing—that whole series of issues has to be monitored and we have an RN staff that has to monitor that continually. Commercial payers and managed care companies are not particularly concerned about that level of issue. So that is one issue that is very different.

Another issue is that when there is concern around a billing issue, the third party payer works with us to resolve that rather than it ending up going to an agency that may file criminal charges with that.

The third issue is that when the claim is paid with a commercial payer, it is paid and we have to wait obviously for cost reports which may be 5 years later to actually get the final settlement on things.

So those are three issues that are very different that we have to deal with. And there are numerous others that occur on either a smaller scale or a larger scale, depending on what the issue is.

Mr. SNOWBARGER. For the remaining panelists, would that be true in your practice as well, that it is fairly easy to—well, particularly Ms. Vance—is it easier to deal with the other third party payers than it is Medicare?

Ms. VANCE. Oh, yes, and part of the problem is the penalty involved with error. It is so punitive in the Medicare Program that I think that we experience downcoding in our practice, I think our physicians, in order to make sure that they do not—that they may not meet criteria for an audit, they code themselves lower than they should.

Mr. SNOWBARGER. By the way, when you downclaim, does Medicare come and pay you?

Ms. VANCE. I am sorry?

Mr. SNOWBARGER. If they find that you have downcoded something as opposed to upcoded something, do you get paid extra when they come and audit you? [Laughter.]

Did not think so, but just thought I would ask. And again, I will let anybody on the panel answer this.

As you have gone through trying to bill a particular claim, have you ever had occasion to ask for assistance either from HCFA or

from their intermediary? Do you do that on a regular basis or is that kind of unusual or——

Dr. ROSENBERG. All the time, every day.

Mr. SNOWBARGER. And you get consistent answers when you call them? [Laughter.]

Ms. VANCE. No, sir.

Dr. ROSENBERG. Very inconsistent, very confusing, very often they do not know themselves the answer. I could give you some examples if you would like.

Mr. SHAYS. Dr. Rosenberg, put the mic closer to you. I do not even mind if you pick it up out of the stem. In fact I would encourage you for the questions, to just pull it out.

Dr. ROSENBERG. Almost every day we are on the phone with Medicare. For instance, last week, as an oncologist, we often have patients on ambulatory pumps. Now to operate an ambulatory pump, my nurse has to do a preparation of the pump, flushing and so forth. Now this is saving Medicare a lot of dough because otherwise the patient has got to be in the hospital to get the infusion, which is a constant infusion, they last for 4 days or more.

Well, in their infinite wisdom, they have decided they are not paying, they are not reimbursing for the pump preparation. We called and asked them about that and sort of got a half-baked reply which was very confusing. I still do not know exactly where they stand on it or why. But this goes on almost every day, questions, constant denials, not necessarily our fault, occasionally our fault because the coding may not be exactly what they asked for.

Mr. SNOWBARGER. Any of the rest of you want to respond? Dr. Buie.

Dr. BUIE. That is where the rubber meets the road. When you have a doctor who wants to comply say how do I code this, when you call up they say I do not know or probably so. When they cannot even tell you affirmatively yea or nay, thumbs up, thumbs down and say yes, you are fine, that is a safe harbor, you are trying to comply, they cannot even give an answer, in an IRS manner, that tells you this process—that is the base process here—it has failed. You have got docs that want to comply and they cannot do it in any safe harbor fashion, and that needs to change. You are going to penalize the good guys, not going to get the bad guys.

Mr. SNOWBARGER. What are the consequences if you call in and ask for advice about how to code a claim and you do it in that manner and someone else down the line changes their mind, what is the consequence to you as a physician or institution, either one?

Mr. ROBERTSON. The risk is carried by the provider relative to that. A good example is that in 1997, HCFA announced that hospitals had a choice whether to bundle lab fees or not, and they reversed themselves a little later in the year and said do not bundle them. And at the same time, the Department of Justice was sending out letters saying that we were in violation of the law because we were not bundling. So HCFA and the Department of Justice were looking at these things totally differently.

Mr. SNOWBARGER. Dr. Leitch.

Dr. LEITCH. One of the problems I have addressed in my written efforts is that the people that are teaching us in the private sector how to code and how to do this put in a disclaimer that I think

everyone should appreciate, this came out of Family Practice Management in the recent issue, and I quote, "While coding challenges represent our best efforts to provide accurate information and useful advice, we cannot guarantee that third party payers will accept the coding recommended." And that is absolutely the case. You can do your best effort and you are going to get turned down. And these are the people that are teaching us how to do it.

Mr. SNOWBARGER. Dr. Cooley—and you may not be the right person, so anybody else that cares to answer it, please feel free to, but I need to get a handle on why—at least from your perspective, why these codes have expanded so that we are dealing with—I cannot even remember the numbers, 7,500 or something like that versus a much smaller number of codes, why for an office visit—I cannot remember which one mentioned it, that an office—there were five codes for one kind of office visit, five codes for another.

Dr. COOLEY. Well part of that was our fault. When the American Medical Association began to develop guidelines, there were people who thought that there should be more levels of service that you could indicate to people what you were doing. In practicality, it becomes very difficult to differentiate the gray zones, to know what is low to moderate, what is moderate to severe; and what may be moderate to severe to you may be rudimentary to someone who is much better at taking care of that problem. So it becomes a very subjective sort of thing. And what we got into or what my office got into a problem with is the difference between two codes that were very close together and actually looked as if they satisfied one criteria, but they told us that it did not. In some cases, it did.

So I think part of it was physician driven, probably there was a monumental misunderstanding at the very beginning between what the AMA thought we could do and what we actually can do in practice, and so in a way, we are caught in our own web. And I think what we need to do is to back off and make it simpler.

Mr. SNOWBARGER. Anybody else care to respond to that question?

Dr. LEITCH. I would agree to that, at least on—I am just discussing office care, I think we ought to throw five away and get down to three. Take the first one, 211, take the second one, 213, and take the third one, a 215. And there will be very little disagreement on documentation, on evaluation and what it is worth, if you will get down to three. Five is a no man's land and you are going to sit there and go to court or somebody is going to get fined over it.

Dr. ROSENBERG. I would like to say we go down to one. And you know, it was not too long ago that a physician would have one charge for his office visit, let us say $35, whatever, one charge for a hospital visit. Now in the long run, it is going to even out, you have some patients come in, you may spend 5 minutes with them. Another thing about Medicare, they do not realize when a patient comes in, you may shoot the breeze with them for 15 minutes about their family. This is part of the practice of medicine. You cannot document everything that you contribute to a patient's care, it is impossible, because so much of it is what I would call nondocumentary.

If you have one fee, it will even out, but you have got to make sure that HCFA does not cheat you and get the lowest fee for that service, get something in between the high and the low. Look what

that will do, you eliminate this whole bureaucracy. HCFA could still audit, let them come in and audit just to see if we saw the patient, but this whole argument of whether you provided a level 4 or a level 3, and the whole pressure on the doctor, the time spent in documentation would be gone.

I will tell you another problem that has come up recently—not recently, but is very much a problem. If you are a physician in a teaching hospital, which I happen to be, we have a house staff and we have interns and residents, it is very unclear what the obligation of the attending physician is as far as documentation. So that in general, I may write several lines, like two or three lines or four lines that I saw the patient, he is better today, we are going to continue him on the regimen. It is the intern and resident who write the extensive note and yet what happens when they come in and audit and say your note does not document the level of care—and it is happening. And that is something that has really got to be looked at fast.

Thank you.

Mr. SNOWBARGER. Thank you, Mr. Chairman. [Applause.]

Ms. VANCE. May I add?

Mr. SHAYS. Yes, I would be happy to have you add something, Ms. Vance, and then we will go to—this is the first panel, I would say, that I have ever heard applaud other people on the panel. [Laughter.]

Ms. Vance.

Dr. LEITCH. I would like to echo what——

Ms. VANCE. I am sorry.

Mr. SHAYS. I am sorry. Dr. Leitch.

Dr. LEITCH. I just want to add that not only is his experience with house staff true, we have that same problem in teaching family practice residents or medical students out in private practice—I mean out in the sticks. The same documentation problems exist.

Mr. SHAYS. I hear you, I think we all do. Yes, Ms. Vance.

Ms. VANCE. I just wanted to add that beyond the E&M coding issues, the coding that is involved——

Mr. SHAYS. Move the microphone a little closer. Not as close as Dr. Rosenberg because then you get the feedback, but if you can lift it out and talk like this and just keep it about 3 inches from you. My sense is that people in the very back can hear because you have speakers this way. Our problem is the speakers go this way, so we are kind of in this—and I think the first and second row probably have the hardest time here. If you move back a few rows, you will hear better.

Ms. VANCE. I was going to say that beyond the E&M coding issues, the coding complexity that Medicare is adding to the system for all other diagnosis codes and procedures codes, such as what I have added to your list here, which is on the lipid profiles, this is one test that we have had to institute a form in our office to follow only this test, and it is so complex that the doctors have to look at the algorithm each time they order the test. And it is impossible to explain to a beneficiary. This is I think for an $11 or $12 reimbursement that we have to put this into the file. This is actually published by Medicare because they do not want to pay for too many lipid profiles. We have the same coding complexities for

PSA's. They are insisting that we have two diagnosis codes and the electronic claims will not allow us to transmit that.

So we are dealing with—beyond E&M coding, we are dealing with coding complexities that create barriers all the way through the system, in order to try to save costs.

Mr. SHAYS. Dr. Cooley and Dr. Rosenberg look like they have never seen that before, and you guys are probably going to jail if you have not been filing that, so— [laughter.]

Mr. SNOWBARGER. They are not laughing either.

Dr. ROSENBERG. You promised you would visit, Chris.

Mr. SHAYS. Mr. Barrett.

Mr. BARRETT. Thank you very much, Mr. Chairman, and I appreciate hearing what all of you have to say, it is similar to what we would be hearing if we held this hearing in my own district. So I think that this is a problem that is pervasive throughout the country.

But I do not see any constituents of mine here, so maybe I have to play the role a little bit of the devil's advocate, if I could since it is hard for me to lose votes if there is nobody here who would vote for me anyway. But we have heard that the cost of the Medicare Program in 1967 was $3.17 billion, I was in seventh grade then, it was 2 years before we had the last balanced budget before this year's balanced budget. In 1998, $211 billion. What is that, 6,000-, 7,000-percent increase?

Some of the biggest battles we have in Congress are over the fight—our fights over the level of funding for Medicare. People who support it, others who attack it, say it is a system out of control.

Ms. Vance, you did a very good job I think of talking about all the different procedures and problems that you have had in your office, that you have experienced, virtually every one of which was designed to keep the cost of this system down. So assuming that there is at least some marginal utility to some of those, God only knows what the figure would be above $211 billion, if those were not in effect. So that is sort of the backdrop, but again, I am sympathetic because I am not someone who likes to fill out forms. I have not filled out my taxes for this year because of the changes that we made in the tax laws this year. So I am extremely sympathetic to that.

Mr. SHAYS. Will the record show he did pay his taxes——

Mr. BARRETT. That is right, yes. [Laughter.]

I guess my question is how do we control the cost of the system that is just galloping and at the same time not destroy your ability to deliver the goods.

We had a hearing yesterday in Milwaukee and I said at that time that—there is a fight over transplants and I said this is an economic issue. People dress it up one way or another but it comes down to economics, and I think the same thing is going on today.

Doctor.

Dr. BUIE. Well, cost is legitimate, there is no question, and we can do better than we do now, no question. And the idea of expanding medical saving accounts—the patient does not self-audit the system now. They are spending someone else's money. Copay is for administration, right now, there is no copay on a home health visit. Sure, doctor, give me 30 of them, you know. I mean, there is the

demand, it is elastic. So the patient has got to be in the loop. Folks that are truly indigent, certainly those fees should be waived and not be calculated as fraud or abuse. There are indigents on fixed income in this age group that are at critical measure, month-to-month pay check. But that can be dealt with.

So you can get at the elastic marginal demand without criminalizing the practice of medicine.

Mr. BARRETT. How much demand in this area have you seen for the MSA's, for the medical savings accounts? Has it been an item that has been under great demand?

Dr. BUIE. I think in areas like home health, the very marginal, very fuzzy definition, folks want more and more and it is very tough to define. Even in Canada—40 percent of the home health visits paid for by Medicare were given and requested by the patient, but defined by Medicare as inappropriate visits.

Mr. BARRETT. OK, but again, my question—how much of an increase in demand have you seen for the medical savings accounts? When you made the reference to medical savings accounts, that was a creation of an act of Congress. Have you seen a great demand for that? I am just curious.

Dr. BUIE. It has been mild. It is new, but I think, again, education on the issue. Folks are not in the loop yet, they do not really realize that it could be to their benefit.

Mr. BARRETT. Dr. Rosenberg.

Dr. ROSENBERG. I think it is a very complex thing when you talk about the expense. Technology alone has gotten to a point—the American public is very demanding in their medical care, for one thing. They want the best, they want it as fast as possible. We may have 20 MRI machines in a county and Canada probably has 3 in the country or something like that. The public itself has to be educated. We talk about rationing of health care and it may have to come. To take it off all on the doctors, to get the money back by devising a system that is so crazy that a physician now has to downgrade everything to the lowest level of care to get money back—and that is what I think this system is trying to do really—you know, physicians right now, the reimbursement that they get from Medicare, in my opinion, is marginal. And in some communities, the reimbursement is barely able to cover office expenses.

Mr. BARRETT. That brings me to my next question, if I may.

Dr. ROSENBERG. I mean it really is, and Congressman Shays will avow, I am from a very, very wealthy community, the average home in Greenwich is $1 million now. People drive up to my office in Rolls Royces and they go out with a $32 office visit. There is something crazy about the system here. Something should be done to make adjustments and people who can afford it, to pay more in the system than people who cannot. Something has to be done with the system to allow physicians who are stuck in areas of high cost of living to enable them to earn a reasonable return on their efforts.

Congressman Shays may not be aware of it, but I will tell you, we are having trouble recruiting young doctors now to come into Greenwich. A lot of the young doctors that have come into our community are not even living in our town any more, they cannot afford it.

Mr. BARRETT. Let me ask another question. Devoid of the paperwork, which is obviously the big issue that we are dealing with here today, but paperwork aside, which might be hard for you to do—reimbursement rates, who gives the best reimbursement rates, Medicare, HMO's, private insurance? I guess I would ask all the providers.

Dr. ROSENBERG. They are all coming down, and HMO's are coming down to approach Medicare reimbursement. In some areas of the country I understand they are even less than Medicare reimbursements.

Mr. BARRETT. So you would still put HMO's above Medicare?

Dr. ROSENBERG. Yes.

Mr. BARRETT. Dr. Cooley.

Dr. COOLEY. Yes, in our area, most commercial insurance companies pay above Medicare rates.

Mr. BARRETT. HMO's also?

Dr. COOLEY. Yes. But I agree they are coming down toward Medicare rates.

Mr. BARRETT. Dr. Buie.

Dr. BUIE. Same.

Mr. BARRETT. Dr. Leitch.

Dr. LEITCH. I live in a small area, we have Medicare patients and we have private pay patients. We have very little anything else. We charge what we think is a good rate for our services, Medicare pays us 60 percent of what we charge, the private people pay us what we charge. If people have Blue Cross and Blue Shield, we have to take whatever they pay and what they say is right. Blue Cross and Blue Shield is ratcheting down what they reimburse, it is still better than Medicare. I am not complaining about that.

Mr. BARRETT. Mr. Robertson.

Mr. ROBERTSON. We view the payer population kind of as a portfolio and we have different kinds of payers. Some HMO's pay better, some do not pay as well. Clearly Medicaid is the lowest payer. Medicare has been viewed as the floor many times as to what we are willing to do, but it is mixed around.

Mr. BARRETT. Do you agree that the managed care trend is downward, are you getting squeezed more?

Mr. ROBERTSON. Absolutely. And it is even toward pushing the risk onto the provider system so that it is a risk for, you know, high utilization when there is a bad case that just takes a lot of extra resources. So we are moving even into capitation at this point. But the trend is down on managed care.

Mr. BARRETT. Dr. Rosenberg, you sort of hit a hot button with me and this is not exactly on the topic, but with the Medicare reimbursement rates because I represent a State, Wisconsin, which is considerably below average in the Medicare reimbursement, as I would not be surprised if Kansas was. And the view in our State is we are all paying the same level of taxes, but there are some providers that are getting paid more. And again to use an economic analogy, it strikes some of us in Wisconsin that you have got a situation where the areas that are perceived by upper income people to be the most attractive to live, we are giving them the highest reimbursement rate; the areas where Marshfield Clinic in Wiscon-

sin, for example, a well-respected clinic, has a much lower reimbursement rate and you end up with shortages in those areas. So from an economic standpoint, it almost seems like we should be paying higher in those areas where physicians do not want to go than paying higher in those areas where physicians do want to go.

Dr. ROSENBERG. I doubt if the reason that Medicare is reimbursing a few extra dollars, whatever it may be, to be in a high living cost area, I doubt if that would be a reason that would attract a doctor to practice in that area. I do not think that is an argument—if I understood you correctly.

Mr. SHAYS. I am not picking you up as well, just put the mic a little closer. What was your point?

Dr. ROSENBERG. If I understood the Congressman, he implied that doctors are not going into less—lower cost of living areas as opposed to more attractive high cost of living areas because Medicare reimburses more in the high cost of living areas. Was that your——

Mr. BARRETT. Yes.

Dr. ROSENBERG. I think that is fallacious.

Mr. BARRETT. But what I do hear is I hear the reverse—physicians in Wisconsin saying they do not go into low reimbursement areas because the reimbursement is too low, just so you know. I just want to sort of let you know a view from the other side. Very quickly because I see my time is just about up.

Dr. Cooley, I found your comments and I think it was in your testimony, Dr. Rosenberg as well, I did not realize that there was this inter-relationship developing these rules or guidelines between HCFA and AMA. Who was the driving force for the horror story that Dr. Leitch referred to, the five different levels? Is that something that HCFA wanted or is it something that AMA was looking for?

Dr. COOLEY. Well, unfortunately——

Mr. BARRETT. You are both smiling, so I don't know what that means.

Dr. COOLEY. Unfortunately, I think when we began with the AMA, there was some push for making more levels of service, rather than fewer. And so we probably inadvertently shot ourselves in the foot by making so many levels of service that none of us could figure out what to do with it after it was made, and making the shading very gray.

And I would like to echo what Dr. Rosenberg has said also, I think if we simplified it and made allowance that over the long haul some people are going to be more complicated, some less, it is going to balance out, and to make it more simple, then we take the onus away from all of this nit-picking which just causes anger and frustration and hostility, basically not only toward HCFA and the Government, but also to the patient.

Mr. BARRETT. Was it your testimony where you said you have now gone to the lowest common denominator?

Dr. COOLEY. Yes. Because I do not know on their—they are picking us up on screens and so they are looking for outliers and they want it to look like a bell-shaped curve.

Mr. BARRETT. I understand.

Dr. COOLEY. And you know that if you code too many of such a code, they are going to pick you up and come in and audit you. So to avoid the threat of another audit, I have simply gone to a lower coding. But then I reset the thermostat for the next doctor.

Mr. BARRETT. I understand that.

Dr. COOLEY. And the next time someone does that, it makes that—it flattens out that bell-shaped curve, so pretty soon, anybody is an outlier.

Mr. BARRETT. One last question because my time is up. Has the improvement in your mental health offset the loss in income by going down? And that is a serious question.

Dr. COOLEY. I am sorry, what?

Mr. BARRETT. Has the improvement in your mental health, that you are not having to hassle about that, is that worth the $7 or $12 per——

Dr. COOLEY. Oh, absolutely.

Mr. BARRETT. OK. I think my time is up.

Mr. SHAYS. What I have noticed from all of you is that you all have complimented each other and you have not even been redundant. It is almost amazing. Did you all get together beforehand and talk about your presentation? Because if you did, it was tremendously well organized. Each of you had a specific point that reinforced the others without contradicting.

I do not know if it was you, Dr. Leitch, that talked about how in 1975, you had two lines and then you went in 1985 to four lines and then in 1995 to 1 page and you said from 1995 to 1997 it went to like 10 pages?

Dr. LEITCH. That is correct.

Mr. SHAYS. Now you are under oath now—do you literally have to fill out—[laughter.]

Dr. LEITCH. You have copies of my office notes on one patient in your file. Everything from exhibit 4 through exhibit 14 relate to one patient encounter that I think is needed for documentation under HCFA's guidelines in that pink book over there, it is in your record. Those are in each one of my Medicare beneficiary charts starting in October.

Mr. SHAYS. Thank you.

Mr. Robertson, you pointed out that hospitals are able to cope better than individual practitioners, but in a way though, you are still requiring your nurses, your administrators, your doctors to fill out these forms. My understanding is that the doctors are still having to fill out forms to back up your own billings, is that not correct?

Mr. ROBERTSON. That is correct. In the last 5 years, we have added 50 percent to the staff that manages this complexity.

Mr. SHAYS. Have any of you—now one individual before we began this hearing said that as an individual practitioner, his administrative costs were about 25 percent and now his administrative costs are about 65 percent.

Dr. BUIE. The overhead for a physician's office practice in 1972 was 27 cents of the dollar. Nationally now it is 62 cents on the dollar, with no other definite change. And it will grow continually whether this is implemented or not.

Dr. COOLEY. I will give you an even more striking example. When I was a sophomore medical student in St. Louis at Barnes Hospital, my 23-year-old wife was the sole insurance clerk and transcriptionist for seven of the busiest internists at Barnes Hospital. It was not because she was that smart. [Laughter.]

I now have 26 employees——

Mr. SNOWBARGER. You had better bring her flowers on the way home tonight.

Mr. SHAYS. Dr. Cooley, I do not think flowers will do it. [Laughter.]

Are we allowed to strike that from the record?

Dr. COOLEY. But the problem was at that time, there really was not very much to do. An occasional patient had an insurance form for a hospitalization, we now have four physicians and a staff of 26 to try to do the things that Ms. Vance is telling you about. So the overhead is literally eating us alive to try to comply.

Mr. SHAYS. You have four physicians who do most of the administrative work?

Dr. COOLEY. No, we have 4 physicians, and 26 staff, half of that staff are simply doing insurance, transcription, talking with insurance companies and doing the paperwork behind it. So we have gone from a ratio of seven internists and one insurance girl, clerk, woman—[laughter.]

Now we have about four, we have one to one.

Dr. BUIE. And I think that really needs to be underscored. I mean this is not money that is going to grandmother's wheelchair, your grandchild's shot, a preventive measure to prevent a cost that will incur to the system. This is money that is basically shifted off budget. It is away from direct patient care, which is what I think everybody would have a uniform wish about. I mean, it goes away from direct medical care and that is the fastest growing segment of that dollar.

Mr. SHAYS. Speaking in response, with the same basic approach that my colleague from Wisconsin has taken, when we have had hearings—I have been on this committee now for nearly 11 years and we have had hearings that would outrage anyone as to the incredible ripoffs that take place. We do basically audit between 1 and 3 percent of the bills of Medicare and around 5 percent of the billing charges. For an unscrupulous physician, hospital, and so on, there is a tremendous incentive that you can maybe get away with it for a period of time. In many cases, at one time, it was not a criminal offense. So we wanted to respond to some of that.

The acknowledged amount of Medicare fraud in $200 billion of billing is about 10 percent, but we have had people tell us that they would not be surprised if it was close to 20 percent. Now, you know, that is kind of a factor in this process. I mean it is an amazing amount of waste and fraud and abuse. But what you are talking about, in my judgment, is waste.

What happens in this political process is that when "60 Minutes" does a program about how someone ripped off the system, the pressure is on the executive branch. How could they let this happen? So to deal with the 1 percent who would do these outrageous things, they hurt the 99 percent. But I consider waste as bad as

fraud, they both kind of—the opportunity cost is we cannot spend the money where it is needed.

Dr. Rosenberg basically talked about simplifying the codes and others alluded to the levels. Dr. Cooley, you were describing such gray areas that, you know, a little bit more and you get $2 more. I do not think it is worth it even in a low cost area, to ratchet it up. So you basically—Dr. Rosenberg, when I met with you earlier, you told me that you almost do not want to even charge some Medicare patients. You just let them come in for free, because it is not worth it in some cases. That is practically your attitude.

Dr. ROSENBERG. That is right.

Mr. SHAYS. So I think I sense some unanimity and it is important that I clarify this. If in fact you were able to find the common denominator of the billing charge between the low and the high so that ultimately HCFA is not—the Government is not paying much more, if any more, but we could eliminate a lot of the billing, subjective billing efforts. Would reducing the codes—there is agreement that reducing the number of variations, the amount of variation—nodding of heads will not do it. I am going to ask each of you because I want it recorded.

Mr. Robertson.

Mr. ROBERTSON. You can look at waste in a lot of ways and I would say that complexity creates waste in and of itself because it adds cost. If we can take the cost of the complexity——

Mr. SHAYS. Right, we all agree on that. So the question is if we reduce the number of choices, simplify the coding, not have as many levels, would that be something you or your organization would be in favor of?

Mr. ROBERTSON. I think what we would want to be careful of is saying that on average, we are feeling better when we have one hand in a refrigerator and one hand on the stove. So that is what my concern would be with that.

Mr. SHAYS. Well, you sound like a politician, not a—[laughter.]

I am going to come back and try to pin you down. Dr. Leitch.

Dr. LEITCH. I am not a politician. I would go to three codes and I am talking only about office management.

Mr. SHAYS. Three codes as opposed to how many codes?

Dr. LEITCH. Five.

Mr. SHAYS. OK, so you would basically cut it in half. Dr. Buie.

Dr. BUIE. I wish one size would fit all, but I do not think you can probably simplify it that much.

Mr. SHAYS. I am sorry.

Dr. BUIE. I would favor Dr. Leitch's approach. I wish one size would fit all, I do not know that you can condense it that much.

Mr. SHAYS. OK. Dr. Cooley.

Dr. COOLEY. Well, we have levels of care, for instance, where someone is acting under the supervision of a physician; that is a very brief level of service, it may be a nurse, that is a clearly defined event. There is also a level of care where we see a new patient, where we gather a lot of information, we allow time to do that; and then there are patients that are seen on a yearly basis to update things that need to be updated, that is a much more complicated sort of care. It is the middle group that ought to be consolidated down to one blended rate and then we would not have to

worry about whether it is a little sicker or a little less sick each time we see someone. So I would favor three rates.

Mr. SHAYS. Dr. Rosenberg, how do you respond?

Dr. ROSENBERG. Well, just so there is no misunderstanding, I did not mean to say there would be one fee for everything. I think you would have one fee for every common service that a physician offers, so that there would be a fee for an initial visit, a consultation would have a fee, a followup on a cancer patient that is coming in to be followed for colon cancer or breast cancer where you have to write a note to the referring physician. Those—you would have a fee; consult, say would be $100; an office visit would be $35 to $40; a house call would be $50. That is what I am saying. But each of those services would have one set fee and that fee would be fairly determined. And what I am saying is over the long run, for the physician, it is going to even out. Over the long run, it should even out for the Government and you could do away with all of this machinery, you could do away with this entire industry that has been built up and you could do away with this constant threat of fraud and abuse. It is just not worth it.

Mr. SHAYS. Ms. Vance.

Dr. ROSENBERG. You know, the ASIM, they wanted to reward doctors for cognitive services.

Mr. SHAYS. I do not want to get too much off subject here.

Dr. ROSENBERG. Pardon?

Mr. SHAYS. I just want to stay on this line just for a second, with the indulgence of the members. So the bottom line is you are saying that you would reduce the levels, but there are different types of episodes that, types of visits that you would note differently. That is the answer.

Dr. ROSENBERG. Take the most common services a physician——

Mr. SHAYS. I think I heard you, I think I heard you.

Dr. ROSENBERG. And that is it, and you just have one fee for that. Then there is no argument.

Mr. SHAYS. Ms. Vance.

Dr. ROSENBERG. People cannot come in and say you charged too much for that visit because that is what the fee is, it is already—it has been predetermined.

Mr. SHAYS. Dr. Rosenberg, I did hear you. Ms. Vance.

Ms. VANCE. I think sometimes it is not so much the number of services but it is the amount of complexity that you require in the documentation for each of those services. I think if you go down to three, if you still have to have 10 pages to document that you want the highest level, you have not gained anything. So I think it is the complexity of taking—and I think everybody was trying to take the subjectivity out of people who were auditing charts and I think that they went way beyond anybody's expectations in that regard. Somehow we have got to move it back and perhaps have auditors who are M.D.'s or D.O.'s, as was suggested, so that not so much documentation has to be put into a chart for each code.

Mr. SHAYS. Thank you, Ms. Vance. I am going to come back to you, Mr. Robertson, and then I am going to give the floor to——

Mr. ROBERTSON. I really do not think for me to speak to how the physicians code is probably my place, I am a hospital administrator.

Mr. SHAYS. OK.

Mr. ROBERTSON. But from a hospital perspective, the DRG's that we deal with, which is also a coding issue, there is over 500 of them now and I do not see that reducing that list would necessarily change the rigor with which we have to do things. It is reducing the issues of if we do make a mistake, what is the penalty for doing that.

Mr. SHAYS. I am going to respond as someone from the outside. I think it is incredible that you would have so many variations and so many different intensity levels. I would think it leaves too much subjective dialog between you and the person auditing you and it puts all of you at risk. That is the view that I am getting. So I am sensitive to the fact that maybe you cannot have one level and I do not think you were saying that, as you elaborated, but one of the recommendations that may come out of this subcommittee, and we will talk to my colleagues here, would be that they truly do reduce the levels of choices in this process and not always choose the lower cost reimbursement. But if we can get you—I mean, Dr. Cooley, you have basically said you have 4 physicians and 26 people working in your office, and a number of them are doing just paperwork. I mean that is inane, it seems to me. [Applause.]

Dr. COOLEY. I think in answer to—[applause.]

I think in answer to Mr. Barrett, who is rightfully concerned about the cost of medical care and the escalation in the cost of medical care, we are to the point in our office where we now spend 72 percent of our reimbursement for overhead and if we could get rid of some of that overhead, our fees would not have to be as high as they are now and everybody would win. We are just chasing paper these days.

Mr. SHAYS. Mr. Snowbarger.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

I want to kind of follow up on Dr. Cooley's description of the practice that he is dealing with. And what I would like to do, it seems to me that we probably have multiple examples here, but I would like to talk about it in a hospital setting, what you have had to do in terms of staffing and preparing your employees to do this billing; Ms. Vance, I would like you to talk about the same kind of issue in your setting, and finally, Dr. Leitch, I would like to hear from you and the number of people you have on staff and that kind of thing. But Mr. Robertson, if you could kind of go first, you mentioned in your testimony that I think you have 17 people that are dedicated solely to Medicare claims, if I remember your testimony correctly.

Mr. ROBERTSON. That is correct. We have a staff, 11 of whom are coders. They are college-educated individuals who specialize in going through stacks of medical records, this big and bigger, to extract from that data the code, the diagnosis, which is why there is 500 diagnoses. I mean it is not a level of care, it is what disease did someone have. And those individuals are college educated. We spend thousands of dollars every year in terms of inservice education. We bring in outside auditors every year to help them learn better about what is going on. So that is just on the coding side. We also have software that is updated routinely.

In the billing department, we have six people who are dedicated to just looking at the Medicare claims on an inpatient basis. That is a lot of people; they look at every claim that comes through, make sure that it is billed correctly.

That is just the billing and coding part. There are approximately 10 percent of your staff in the administrative function at Shawnee Mission Medical Center that deal with billing and collecting. You would think that with 36 percent of our business, that 36 percent of those would be directed toward Medicare, that is about what our business is. But it is disproportionate because of the added complexity. And so those are dollars that are being funded to—we fund dollars there to make sure we do that correctly. So there is a large number of people addressing this every day, not 250 but at least 36 percent of the 250.

Mr. SNOWBARGER. OK. Ms. Vance, same kind of question. What kind of staff do you have, how much of it may be dedicated to Medicare claims, what kind of training do they have to go through, how often—things of that nature.

Ms. VANCE. We are putting more and more resources toward administrative costs in our office. We have one person who does nothing—this is a five-man office, so we have one person who does nothing but Medicare billing and answering Medicare patient questions. The Medicare patients need a lot of feedback because they read a lot of media that indicates that there is a lot of fraud in the system. They are concerned that any coding error that we might make, that we are trying to harm them in some way, and it takes a lot of contact with them to try to make them understand why Medicare no longer pays for their tests where they used to. We spend a lot of time with waiver letters so that patients understand that they are going to have a test that they may want but that Medicare may not pay.

I would say that in our office, we have increased staff by 5 over the last 5 years that do nothing but administration and have nothing to do with patient care.

Mr. SNOWBARGER. Dr. Leitch.

Dr. LEITCH. I am a solo practitioner in a one-horse town. I have one employee that has worked in that office for over 40 years, she has worked for me for 31-plus years. I have another employee that has worked for me for 20 years and my nurse has worked for me 18 years.

I had one person who worked in my office up until a year ago that worked for another practitioner in the office and I hired her when he retired. She had a total of 30 years of experience. These people have been trained by me, they go to Medicare symposiums, they go to Blue Cross and Blue Shield symposiums. They have done the same work satisfactorily for a long time. They went through the crisis of being computerized where we added a computer. We use the computer primarily for billing and insurance purposes. I have one girl that does that full time. I have one girl that works half time. My nurse works two times she will tell you, day and night.

HCFA and at least our State medical society is saying I am going to have to hire a compliance officer just to tell me that I am doing it right. I ain't going to do that. I think I know how to do it and

I have a good safety net in my nurse that tells me when I do not do it. And I think between the two of us we are doing it right. But we certainly are not doing fraud and abuse. I do not look that I am going to increase my office staff a bit because I cannot afford it.

I make a good living and I am not crying that I am poor, but if you take balances of overhead versus what you are taking home, I am not making a whole lot. And I am putting in one hell of a lot of hours—excuse me, but I am. I do not have any alternative and I have a physician leaving the community, my physician population is going from four to three, that is a 25-percent loss. Who is going to pick up that 25 percent? Well, I do not know. It took us 2 years to find somebody—I do not know about upstate Wisconsin, but it took us 2 years to find somebody to come in and fill a hole when we lost two physicians, boom, boom. You talk about real problems, we are talking about real sick people and nobody to look after them and you cannot deal with that with the added paperwork. If it takes me an hour more a day to do paperwork, I still have the same number of people to see and I still have people banging on the door outside wanting to be taken care of. And what happens to those people is, if you are not in the office, they go to the emergency room. And then I do not have to tell you what that increases the cost.

Mr. SNOWBARGER. Thank you, Dr. Leitch. Ms. Vance, let me come back to you for the remainder of my time, and it may be fairly short, but you had indicated as you gave your oral testimony that you had some recommendations for changes that you would like to share with us during the questioning period. So my question to you is what are those changes.

Ms. VANCE. Well, I said that, but most of those have been hit on by the physicians here. One of course is nonpunitive method of compliance, so that we do this in a cooperative manner where Medicare and the physicians are learning together and we provide records that are adequate for auditing purposes but that are not punitive in nature, which is the way the rest of the industry works.

Mr. SNOWBARGER. Can I just follow up with the rest of the panel? Do you all feel that you are in an adversarial relationship with HCFA? [Laughter and applause.]

Mr. Chairman, I yield back.

Dr. ROSENBERG. May I say something in that regard?

Mr. SHAYS. Before you respond, it was a question to all of you. For the record, I would like an answer, yes or no, to Mr. Snowbarger's question. Mr. Robertson.

Mr. ROBERTSON. There are adversarial relationships, yes. I would like to say that in Kansas we have been very fortunate with the U.S. attorney's office, they have approached the issues with a very cooperative——

Mr. SHAYS. Let me just say, you are not casting stones and they are not going to go after you if you say yes.

Mr. ROBERTSON. I am not concerned about that.

Mr. SHAYS. It is just an answer. They may say the same thing.

Dr. LEITCH. Yes, adversarial.

Mr. BARRETT. No question.

Dr. COOLEY. The same.

Dr. ROSENBERG. Most certainly.

Ms. VANCE. Certainly. Even for the employees. I mean I think the employees are fearful as well.

Dr. ROSENBERG. Could I just say one thing?

Mr. SHAYS. Real brief because we want to get to the next panel and we are going to close down at 3:45, so we want to make sure the audience can speak as well. Did you have a quick comment to make?

Dr. ROSENBERG. Well, I just do not understand why HCFA, if they are going to audit, cannot say to the doc, look, we do not think you are doing it right, instead of just sending them a letter out of the clear blue and saying you owe us this much money and then you have to wait 4 or 5 months to get an appeal. I mean why can they not just come in and say, you know, something is wrong here, let us sit down and talk it over.

Mr. SHAYS. Fair enough.

Just to let the second panel know, we are going to conclude with Congressman Barrett and then we are going to take no more than a 5-minute break just for setup and we are going to begin right away with the second panel.

Mr. BARRETT. Mr. Robertson, you talked about the Health Care Claims Guidance Act and it brings to mind the Medicare DRG 3-day window, the PATH audits, and the unbundling. Of those three, which do you consider the most onerous or unfair?

Mr. ROBERTSON. The 72-hour window is a very difficult issue to implement. We have figured out how to do it, by and large. Each one of those has their complexities around them and I am not sure which one of them I would say would be the most difficult to deal with, they just are different issues to be dealt with.

Mr. BARRETT. Obviously one of the underlying tenets of this bill is that the treble damage is inappropriate and I think that there certainly are situations where it is inappropriate. On the flip side, it strikes me that a law that would say that if you inappropriately bill, that the remedy for that would be paying the amount that is due plus interest would create no incentive at all for a physician or a hospital to maintain their charges, because as Mr. Shays said, there is a belief out there—or the perception among us, whether it is true or not, that providers can, either intentionally or unintentionally, avoid an audit for some period. So if the only remedy is past payment plus interest, I would be more than happy to take that money and invest it, knowing that if they catch me, I will pay it. What should be the appropriate penalty? I assume that you think there should be more than just past payment plus interest, is that correct?

Mr. ROBERTSON. I think the issue is when it is clear that fraud was intended. Errors happen in human life every day and those are the things where we create significant burdens on the staff. So I think what the act is dealing with is trying to create a narrowing of what is really fraud versus what is just an error.

Mr. BARRETT. Well, let us stay with the errors because I think there is even an issue with errors. If a hospital or a physician erroneously did not pay for 3 years, do you think that the proper penalty for that would be reimbursement plus interest, or do you think there should be more than that?

Mr. ROBERTSON. I think there should be more than that.

Mr. BARRETT. And it would be helpful for me to know what that extra would be. Again, I do not think it should be treble damages, but I do not think that simply saying pay it back with interest sends any message other than "Oh, that is OK." And I think we have to do more than that.

Mr. ROBERTSON. I agree that we have to do more than that, although I would say that Shawnee Mission implemented the double coding long before the criminal charges were available. We did that because we were committed to doing it correctly. And I believe that is pervasive in the industry, doing it correctly is the desire. So what are the penalties? I think—what are the economics you have to look at? What community are they serving? Do you kill the provider community when that happens in that community? I think it has to take into consideration what is happening around that environment for that community.

Mr. BARRETT. Finally, I just want to say that one of the most surprising things here for me today was hearing again the involvement of HCFA and the AMA. And the AMA and the American Hospital Association are not exactly small players in this debate in Washington, and my unsolicited advice is that they should be more aggressive, frankly with HCFA. I think if AMA was involved with HCFA, that they could play a role in reducing this five layer confusion that we have. The one thing I am certain of, you do not want me setting this stuff. I do not know if Chris feels confident or Congressman Snowbarger feels confident, but you do not want the politicians to come in here and start setting levels because then you will really be mad. And you are far better off, I think, having—working with HCFA to do so, because I just think we can gum up this thing faster than you can say Jack Robinson.

Mr. SHAYS. We can provide incentives though.

Mr. BARRETT. Yes.

Dr. BUIE. Whatever system we pick, the delineation is the intent standard. You know, the AMA never went on board to say we ought to criminalize this, we ought to, you know, make sure there are areas that will have civil monetary penalties for folks giving care in good faith. That was never agreed upon. I think there is a lot of confusion on that. I mean Dr. Dickey can clarify it when she comes, but that is the distinction. Yes, we will have codes, there will be some system. It will be imperfect, we will try to reach consensus and agree. It is the intent standard that needs to be guarded vigorously.

Dr. COOLEY. And I do not think you would have any difficulty with physicians, and I do not want to speak for hospitals because it may even be more complicated, but a physician knows when he is doing a complete exam and a physician knows when he is doing an office visit and he knows when a nurse is acting under his supervision. Those are clear cut areas. If they are billing for something that was not performed, then there should be penalties, but that is a very simplistic way to measure it, and then we can all go about our business of taking care of more or less sick patients on a day-by-day basis.

Mr. BARRETT. Thank you.

Mr. SHAYS. I would like to announce the second panel. It is Jackie Williams, U.S. attorney, District of Kansas, U.S. Department of Justice; James Kopf, Director, Criminal Investigations Division, Office of Inspector General, U.S. Department of Health and Human Services; Joe Tilghman, Consortium Administrator, Kansas and Chicago Regional Offices, HCFA, U.S. Department of Health and Human Services; Leslie Watson, director of medicare payment safeguards, Blue Cross and Blue Shield of Kansas; and Dr. Nancy Dickey, president-elect of the American Medical Association.

I would invite them to come up. We will start in 5 minutes and I would like to thank this first panel. You have done an excellent job and you have complimented each other well. Thank you very much. [Applause.]

[Recess.]

Mr. SHAYS. I have already introduced our witnesses, if they would stand, I would like to swear them in and then we can begin with testimony.

[Witnesses sworn.]

Mr. SHAYS. For the record, all our witnesses have responded in the affirmative.

We are going to be pretty strict about the 5-minute rule. Our other panel—and if you could have told me I could have gotten the number of doctors and administrators to stay strict with the 5-minute rule, I would have said I am not so sure. But they did a great job, a wonderful panel.

We look forward to your testimony and we will ask questions. I am going to ask in a second how many in our audience may want to speak afterwards because it gives me a sense of time. Well, I will ask now, since some of you are raising your hands—eight. I will ask again and we will see how that number changes. But you will have time. The question is will it be 2 minutes or 4 minutes or 1 minute. We will figure that out when we know the limit to the number of people participating.

I think we will go right down the row and we will end with you, Dr. Dickey. Mr. Williams, you have got the floor. I would ask you to speak loudly and into the mic, if you would.

STATEMENTS OF JACKIE N. WILLIAMS, DEPARTMENT OF JUSTICE, U.S. ATTORNEY, DISTRICT OF KANSAS; JAMES A. KOPF, DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, CRIMINAL INVESTIGATIONS DIVISION; JOE L. TILGHMAN, HEALTH CARE FINANCING ADMINISTRATION CONSORTIUM ADMINISTRATOR, KANSAS AND CHICAGO REGIONAL OFFICES; LESLIE D. WATSON, DIRECTOR OF MEDICARE PAYMENT SAFEGUARDS, BLUE CROSS AND BLUE SHIELD OF KANSAS; AND NANCY DICKEY, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Mr. WILLIAMS. Thank you, Chairman Shays, Vice Chairman Snowbarger and Congressman Barrett, I am Jackie Williams, U.S. attorney for Kansas. As Congressman Snowbarger knows, we cover the entire State, we have offices in Wichita, Topeka, and Kansas City.

I am very pleased to be here today to tell you about our efforts to combat fraud, waste, and abuse in the Medicare system. As you

know, Medicare pays out more than $1.5 billion in the State of Kansas each year. We recognize that the majority of physicians, hospitals, and other health care providers are honest, hard-working, and dedicated to providing the very best health care possible to Medicare beneficiaries. However, there are providers who engage in improper billing practices which cause immeasurable damage that threaten the financial integrity and the public's faith in the Medicare system.

The primary purpose of my remarks today is to describe how we use the tools available to us to pursue fraud and abuse, and briefly discuss some of the results that we have achieved in Kansas.

In general, there are three types of false billing practices that our investigations have uncovered. The first is billing for services not rendered; the second is billing for a higher level of service than actually performed, which is commonly known, as you know, as upcoding; and the third improper billing practice involves providing kickbacks and bribery in exchange for referrals. While these are not the only types of matters we see, they do make up the majority of cases currently being worked in the district.

In the U.S. attorney's office, we have two primary venues to eliminate Medicare fraud and abuse. We can pursue false billing, either criminally or civilly. The Department of Health and Human Services, in particular the inspector general, have additional administrative remedies for addressing improper conduct. In all our criminal cases, we have the proof of an intent to defraud, which is an essential element to a conviction. We pursue criminal cases when the evidence as to intent is present and the conduct at issue is significant enough to warrant a criminal prosecution.

I would like to give you some examples of successful criminal prosecutions we have had in the last 2 or 3 years. The first case is a Florida medical equipment supplier that billed 30 cent diapers as $9 female urinary collection devices and he made over $80 million in the course of 1 year. The supplier, Mr. Ben Carroll, knew that Medicare would not reimburse for the diapers and instructed employees to refer to and bill the diapers as prosthetic devices. Mr. Carroll pleaded guilty last year to fraud and is now serving 10 years in Federal prison. He also forfeited $36.5 million which is all the funds that he had left at that time.

If I could, I would like to show you the diaper. This is one of the actual diapers that we introduced before the grand jury. It costs 30 cents and he was billing at $9 to the various nursing homes and things.

In November, a Kansas City psychiatrist was convicted for billing his services for up to 26 hours a day, including billing for patient psychiatric care while he was on vacation in Cancun, Mexico. His sentencing will be later this month in Federal court in Kansas City, KS.

In Topeka, a hospital administrator and a contractor responsible for the hospital's marketing were convicted and sentenced to 3 years in Federal prison for paying nearly $50,000 in bribes to an employee assistance counselor in Corpus Christi, TX. The bribes were paid in exchange for the counselor's referral of patients from Corpus Christi to their psychiatric hospital in Topeka. As a result

of the bribery scheme, the hospital received more than $600,000 in revenue from various insurance companies.

On the civil side, our primary civil statute for recovering funds improperly charged to the Medicare trust fund is the False Claims Act, the FCA. The FCA is primarily used when the facts indicate that false billing was a result of a reckless disregard or deliberate ignorance of the rules and regulations governing the Medicare system.

In analyzing the applicability of the FCA, we give consideration to various factors relating to the issue of culpability, including such things as the guidance provided by HCFA, whether the violations occurred over a period of time and whether any steps were taken to assure compliance with HCFA regulations in general. The determination of whether a matter if actionable under the FCA or alternatively constitutes a simple, honest billing error, rests on an individualized review of all relevant facts related to the provider, which go to the issue of culpability.

When the civil investigation leads to evidence of an FCA violation, the provider is notified about the allegations in detail. And further, as with all of our affirmative civil enforcement matters, potential defendants are given an opportunity prior to filing suit to come in and raise any and all defenses or other mitigating factors such as ability-to-pay issues.

This district has not and will not pursue cases involving simple mistakes. And again I want to say, my office has not and will not pursue cases involving honest mistakes, nor have we been asked to.

Cases not worth or appropriate for FCA action; that is, the simple billing errors, are routinely referred either to Health and Human Services or the fiscal intermediate for their internal remedies.

We have recently completed a number of civil matters under the False Claims Act. A few examples: In September 1997, a Kansas City medical center agreed to settle a matter for $17.5 million involving allegations that the hospital had received more than $40 million in Medicare funds in exchange for paying more than $1 million in bribes to another health care provider and physicians in return for their referrals of Medicare-eligible patients.

Also last year, another Kansas City hospital agreed to pay more than $1.2 million to settle a matter involving allegations that the hospital received more than $4 million in Medicare funds as a result of an illegal patient referral kickback scheme.

While we believe our efforts are important, ultimately the integrity of the Medicare trust fund will depend in large measure upon the provider community. This is because our civil enforcement efforts can respond only to the portion of the false claims that come to our attention. In this computerized age, responsibility lies with providers to ensure that they have systems in place to bill accurately and in accordance with Medicare rules.

We hope that our efforts under the False Claims Act will encourage providers to adopt those systems and we look forward to working with them to explore other means of improving compliance with the law. I want everyone to know that my door is always open to dialog and talking.

In conclusion, we take our responsibility for protecting the Medicare trust fund from health care fraud and abuse seriously. We understand our role is to investigate and take appropriate action against those who would undermine the integrity of this essential health care program, not to harass honest health care providers.

I want to thank you again for allowing me to testify here today and I will be happy to answer questions.

Mr. SHAYS. Thank you, Mr. Williams. Mr. Kopf.

Mr. KOPF. Good afternoon, Mr. Chairman. I am James Kopf, Director of the Criminal Investigations Division in the Office of Inspector General at the U.S. Department of Health and Human Services.

The Office of Inspector General is the agency within the Department that is responsible for investigating suspected fraud and abuse. With annual expenditures of over $200 billion, the Medicare Program presents a sizable target to those who seek to unjustly enrich themselves at the taxpayers' expense. The OIG special agents act as fact-finders and information-gatherers. We work in partnership with the Health Care Financing Administration and its contractors, the Department of Justice and the U.S. attorneys offices and other law enforcement entities, to identify and curb abusive, fraudulent billing practices.

Also the percent of Medicare outlays that are lost to clearly identifiable fraud has not been quantified by this office, we do know that approximately 14 percent of Medicare payments made in fiscal year 1996 were improper. By improper payments, we mean for example that there was insufficient or in some cases no documentation to support what was claimed by the health care provider.

In general, we believe that the vast majority of providers who bill the Medicare Program for their professional services do so in accordance with the rules and regulations. Nevertheless, we recognize that even well-intentioned providers make mistakes. Fraud, however, is very different from unintentional errors. The OIG receives allegations of wrongdoing from a number of sources, including beneficiaries, ex-employees of providers, competitors, contractors, and Qui Tam complaints. Each of these complaints is taken seriously and evaluated as quickly and thoroughly as possible. Often the allegations are referred to the Medicare contractors for further factual development. This is done to determine if there was a pattern of questionable billing or if a one-time mistake has been made by the provider. If it is an isolated instance, the contractor seeks reimbursement directly from the party which was erroneously paid. If a pattern of questionable billing is found, the next step in our investigation is to determine whether it resulted from an intentional, knowing disregard of the rules and regulations governing the Medicare Program, a potential predicate for fraud.

To determine the extent to which there is an intentional, knowing disregard of the rules, the OIG typically obtains information through a combination of investigative techniques tailored to each type of case. Once this information is gathered, it is presented to the U.S. attorney whose office will evaluate the information and, with input from the OIG, make a final decision on whether the conduct constitutes criminal or civil fraud. If the evidence demonstrates an intentional violation of the law, the U.S. attorney may

opt to present the case to a Federal grand jury for potential criminal action. If no intent can be shown, but there is evidence of knowledge that the false claims were being submitted, then a civil False Claims Act case can be authorized.

We do not devote investigative resources to cases unless we strongly suspect a pattern of abuse or particularly egregious situation. There is no shortage of fairly obvious and serious cases awaiting our attention.

For example, an anesthetist group at a New York hospital agreed to pay $800,000 to settle allegations of claiming one-on-one patient services when evidence indicated that more than one patient was being treated at a time. The co-owner of a Florida clinic agreed to pay more than $1 million to settle billing Medicare for services never rendered to patients who had received inducements to cooperate in the scheme. A Pennsylvania osteopath agreed to pay $100,000 to settle for billing noncovered chelation therapy in the form of covered components such as veni-puncture and saline intravenous therapy. An Iowa chiropractor was sentenced to a year and a day in prison and signed a civil agreement to pay $60,000 because she billed for spinal manipulation or physical therapy when the actual services included only the sale of placebos, vitamins, and other nonreimbursable items and services. Clearly, our law enforcement efforts are focused on improper claims that are made intentionally or with the reckless disregard for the truth or deliberate ignorance of the truth. When those types of claims are filed, enforcement actions are appropriate.

For physicians, we believe the best source of information and advice on billing questions continues to be the Medicare carriers.

Mr. Chairman, we appreciate your inviting us to participate in this field hearing, and I welcome your questions.

Mr. SHAYS. Thank you very much. Mr. Tilghman.

[The prepared statement of Mr. Kopf follows:]

Testimony of
James A. Kopf, Director
Criminal Investigations Division
Office of Inspector General, HHS

Good morning Mr. Chairman. I am James A. Kopf, Director of the Criminal Investigations Division in the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS). The Office of Inspector General is the agency within the Department that is responsible for investigating suspected fraud and abuse.

With annual expenditures of over $200 billion, the Medicare program presents a sizeable target to those who seek to unjustly enrich themselves at the taxpayers' expense. The OIG Special Agents act as fact finders and information gatherers working in partnership with the Health Care Financing Administration and its contractors, the Department of Justice and its United States Attorneys' Offices, and other law enforcement entities to identify and curb abusive and fraudulent billing practices.

Improper Payments

Although the percent of Medicare outlays that are lost to clearly identifiable fraud has not been quantified by this office, we do know that approximately 14 percent of Medicare payments made in FY 1996 were improper. By improper payments, we mean, for example, that there was insufficient or, in some cases, no documentation to support what was claimed by the health care provider. Medicare contractors pay claims based on the information presented on the claim form. We found that 99 percent of the paid claims we checked had no identifiable errors. The errors were discovered only after a more in-depth review of the supporting documentation.

To measure the level of improper Medicare payments, last year our office reviewed a sample of over 5,000 claims paid in FY 1996. Medical review personnel from HCFA's Medicare contractors, and from Peer Review Organizations, assisted the OIG's review process by assessing medical records to determine whether services billed were reasonable, medically necessary, adequately documented, and correctly coded. Concurrent with the medical review, we undertook additional claims analyses. We focused on past incorrect billing practices in order to determine whether: (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all of Medicare's eligibility requirements; (3) the contractor had not made duplicate payments or payments for which another primary insurer should have been responsible; and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations. By projecting the payments for claims that did not meet Medicare laws and regulations to the total FY 1996 fee-for-service Medicare benefit payments, we estimated that the range of improper payments, at a 95 percent confidence level, was between $17.8 billion and $28.6 billion. The midpoint in this projection of $23.2

billion represents about 14 percent of the $168.6 billion in processed fee-for-service Medicare payments made for FY 1996 which were deemed improper.

These midpoint figures do not take into account the category of waste, such as excessive pricing, or numerous kinds of outright fraud, such as phony records or kickbacks. For purposes of the audit, we classified and analyzed the errors in terms of an improper payment (i.e., error) level for which the Medicare program should not have reimbursed the provider.

Most of the errors we found fell into four general categories: (1) insufficient or no documentation; (2) lack of medical necessity: (3) incorrect coding; and (4) noncovered or unallowable services. To reiterate, 99 percent of the improper payments were detected through medical records review of supporting documentation. Accordingly, one of our recommendations to HCFA was to direct its contractors to conduct follow-up evaluations of specific procedure codes we identified with high error rates and to consider whether identified providers should be placed on prepayment medical review.

In general, we believe that the vast majority of providers who bill the Medicare program for their professional services do so in accordance with the program rules and regulations and only for the true and accurate services they provide. Many use the resources available to them, such as contractor bulletins, fact sheets, educational seminars and contractor provider relations staff, to answer questions they may have about billing. Nevertheless, we recognize that even well-intentioned providers make mistakes. Those errors that do not appear to be fraudulent are resolved by the Health Care Financing Administration.

Allegations of Wrongdoing

The OIG receives allegations of wrongdoing from a number of sources including beneficiaries, ex-employees of providers, competitors, contractors, and Qui Tam complaints. Each of these complaints is taken seriously and evaluated as quickly and thoroughly as possible. Often, the allegations are referred to the Medicare contractors for further factual development. For example, if a Medicare beneficiary advises an OIG Field Office that his/her Explanation of Medicare Benefits shows the program paid for a service that he/she does not recall receiving, it is likely that this matter would be referred to the contractor for initial review. The contractor would be asked to develop the complaint further (i.e., gather pertinent information) to determine if the service was actually performed and, if not, to see if this is perhaps one of many similar complaints against that particular provider. Development is done to determine if there is a pattern of questionable billing. If it is an isolated instance, the contractor seeks reimbursement directly from the party which was erroneously paid. If, however, a pattern of questionable billing is found, the next step in our investigation is to determine whether the practice resulted from an intentional, knowing disregard of the rules and regulations governing the Medicare program—a potential predicate for fraud.

Intentional, Knowing Disregard of Rules

To determine the extent to which there is an intentional, knowing disregard of rules, the OIG typically obtains information through a combination of investigative techniques tailored to each case. Once this information is gathered, it is presented to a United States Attorney whose office will evaluate the information and, with input from the OIG, make a final decision on whether the conduct constitutes criminal or civil fraud. Simple mistakes, a lack of understanding or a misunderstanding of the rules and regulations does not constitute fraud. If the evidence demonstrates an intentional violation of the law, the U.S. Attorney may opt to present the case to a federal grand jury for potential criminal action. If no intent can be shown, but there is evidence of knowledge (including reckless disregard for, or deliberate ignorance of, the truth) that the false claims were being submitted, then a Civil False Claims Act case may be authorized.

The concept of knowledge is one of the major factors in determining whether the conduct constitutes fraud. Knowledge typically has two aspects: (1) a provider's knowledge of the rules and regulations governing the program, and (2) a provider's knowledge that the illicit conduct was committed. To evaluate a provider's knowledge of the rules of the program, we consider evidence that the provider knew the correct way to bill, either through the documented attendance at contractor training, correspondence between the provider and the contractor concerning the issue in question, or via reimbursement policy information sent to the provider by the Medicare contractor. Evidence that the provider "legally knew" of wrongdoing is a major factor when determining if the questioned billings constitute fraud.

If there is evidence that the provider knew the rules and "knew" that the conduct was on-going, the last determining factor is whether or not the provider was "intentionally" defrauding the Medicare program. If evidence of criminal intent is discovered, then the potential for a criminal fraud prosecution is present.

We do not devote investigative resources to cases unless we strongly suspect a pattern of abuse or a particularly egregious situation. There is no shortage of fairly obvious and serious cases awaiting our attention. Honest providers who keep good records and follow the rules are not the subject of our investigations.

Recent Enforcement Efforts

In response to the serious problems of fraud and abuse in health care programs, the Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which provided powerful new criminal and civil enforcement tools and expanded resources to fight against health care fraud. As a result, civil and criminal health care fraud enforcement actions increased significantly in 1997. Federal prosecutors filed 282 criminal indictments in health care fraud cases in 1997, a 15 percent increase over the previous year. The number of civil health care matters also increased in 1997 with Federal prosecutors opening 4,010 civil matters, a 61 percent increase over 1996. In 1997, the Federal Government won or negotiated more than $1 billion in

judgments, settlements, and administrative impositions in health care fraud cases and proceedings. More than $968 million was recovered by the Medicare Trust Fund. An additional $31 million was recovered as the Federal share of Medicaid restitution. Also in 1997, the OIG excluded more than 2,700 individuals and entities from federally sponsored health care programs--a 93 percent increase over 1996.

Examples of Wrongdoing

In the Appendix to this testimony are several cases of Medicare Part B fraud cases. These cases did not arise from simple billing errors or inadvertent mistakes or misunderstanding. For example, an anesthetist group at a New York hospital agreed to pay $800,000 to settle allegations of claiming one-on-one patient services when evidence indicated more than one patient was being treated at a time. The co-owner of a Florida clinic agreed to pay more than $1 million to settle billing Medicare for services never rendered to patients who had received inducements to cooperate in the scheme. A Pennsylvania Osteopath agreed to pay $100,000 to settle for billing non-covered chelation therapy in the form of covered components such as venipuncture and saline intravenous therapy. An Iowa chiropractor was sentenced to a year and a day in prison, and signed a civil agreement to pay $60,000, because she billed for spinal manipulations or physical therapy when the actual services included only the sale of placebos, vitamins and other nonreimbursable items and services. Clearly, our law enforcement efforts are focused on improper claims that are made intentionally, or with reckless disregard for the truth, or deliberate ignorance of the truth. When those types of claims are filed, enforcement actions are appropriate.

OIG Information for Providers and the Public

Our office communicates with the public and the provider community in several ways. For example, the OIG, in consultation with the Attorney General, issued regulations stipulating a process for issuing written advisory opinions to the public on various legal issues such as the Anti-Kickback statute and the Civil Monetary Penalties laws. A number of advisory opinion requests have been received and answered. In addition, we issue special fraud alerts and compliance guidelines, as well as make presentations to associations and other groups. We encourage physicians, and other providers, and the public to visit the OIG's internet site. The site includes information about OIG activities; the results of our audits and inspections; compliance guidelines; program exclusions; semiannual reports to the Congress; annual work plans; rule makings; and other items. The Internet address is *http://www.dhhs.gov/progorg/oig*. We update this site continuously to make our work easily accessible to both providers and the public. For physicians, the best source of information and advice on billing questions continues to be the Medicare carriers. It is important that issues of clarification be addressed with the carriers and that providers should then document those communications.

Mr. Chairman, we appreciate your inviting us to participate in this field hearing, and I welcome your questions.

Appendix

Case Examples

1. Keith Chilgren. The investigation of Dr. Chilgren was initiated when several of his employees contacted the State of Minnesota Attorney General's Office to complain that they felt Dr. Chilgren's patients were not receiving proper medical care because of the vast number of patients he was seeing during the course of a day. A search warrant was executed and the records seized showed that Dr. Chilgren was treating up to 150 patients in one day. For these patients, he either billed an "Intermediate Office Visit" or "Extended Office Visits." For the former, the normal amount of time spent with the patient averages 15 minutes; for the latter, as much as one hour should be spent with the patient. In reality, Dr. Chilgren spent no more than 2-3 minutes with each patient. Five medical experts reviewed the medical records obtained during the search and each concluded that the majority of claims submitted by Dr. Chilgren were either for services not rendered at all, were upcoded, or were medically unnecessary.

   Dr. Chilgren agreed to a "Pre-Trial Diversion" under which he surrendered his license to practice medicine, paid $250,000 in restitution, and was placed on probation for 5 years. This was agreed to by the prosecutors due to Dr. Chilgren's progressing dementia and doubts that he would be able to stand trial.

2. Andrew Shankman. Dr. Shankman was the owner of several psychiatric clinics in Georgia and Florida. The clinics were run under the name Shankman/Davidson Psychiatric Management, Inc. The Business Manager of the group was Michael Davidson. Thomas Davidson was the President and CEO of the business. May Pedrick was the Vice President. The allegations in this matter were received by the OIG from the United States Attorney's Office from the Southern District of Georgia. The allegations were that the medical group was submitting claims to Medicare, Medicaid and CHAMPUS for non-rendered and upcoded services. Part of the upcoded services were related to services rendered by non-certified individuals being billed as if the physicians were actually providing the services.

   The investigation revealed that there was a pattern of such billing. The pattern involved the billing of services under Dr. Shankman's provider number even though the vast majority of the services were rendered by unqualified, unlicenced personnel. Even when some of the services were performed by a certified non-MD, the claim form would attest to Dr. Shankman actually performing the service because, had the truth been known, the reimbursement for the services would have been less. There were also numerous instances where no services had been rendered. These services were allegedly performed in the offices run by the company as well as in nursing homes in both Georgia and Florida.

Between 1992 and 1996 the group was paid a total of $5.2 million by Medicare, Medicaid and CHAMPUS as a result of these false claims. On March 13, 1997, Dr. Shankman, the Davidsons and Ms. Pedrick were indicted along with the company on numerous counts, including Conspiracy, Mail Fraud, Wire Fraud and Money Laundering as a result of their involvement in this scheme. The Davidsons pled guilty and agreed to cooperate against Dr. Shankman and Ms. Pedrick. Dr. Shankman and Pedrick were found guilty on all counts. Dr. Shankman was sentenced to 87 months incarceration, 3 years of probation and 400 hours of community service. Michael Davidson was sentenced to 33 months of jail time and 3 years of probation along with Ms. Pedrick. Thomas Davidson is awaiting sentencing.

3. Jeffrey Schwartz. This case was initiated as a result of a letter to First Lady Hillary Rodham Clinton from a patient of Dr. Schwartz's who had concerns about the information she received on her Explanations of Medicare Benefits related to the claims submitted by the doctor. The investigation uncovered that Dr. Schwartz, a "Physiatrist" who specializes in physical rehabilitation therapy, billed for 13,400 procedures which were never conducted. These included many instances when the patients for whom the services were billed were deceased at the time the services were purportedly rendered. Dr. Schwartz was indicted for filing false claims for which he was reimbursed over $1 million by the Medicare and State of New York Medicaid programs.

   On January 8, 1998, Dr. Schwartz pled guilty to two State charges related to his conduct. He is awaiting sentencing.

4. Modern Medical Center. The OIG was contacted by a carrier in Florida in 1995 with information concerning potential false claims being submitted by Modern Medical Center. The carrier had received several complaints from patients of the center alleging billing for services not rendered. The OIG and FBI initiated a joint investigation into the matter. Three doctors were operating the clinic under the ownership of Jose and Jesus Gonzales. The normal way that the clinic conducted business was that a Physician's Assistant would perform the services and one of three doctors would sign the chart as if they had conducted the services. The doctors and the Physician's Assistant were paid by the number of charts processed.

   The daughter of one of the clinic's owners ran a billing service and suggested that the clinic should be conducting more tests to generate more revenue. The Physician's Assistant was asked to order more tests, but he refused and quit. The doctors agreed to see the patients and order more tests such as sonograms, nerve conduction tests, chest x-rays and EKGs. The vast majority of these tests were unnecessary. Some of the tests were never performed but all were billed.

   The two owners of the clinic pled guilty and settled civilly with the Government. The United States Attorney's Office made the decision to file civil suits against the staff

physicians. All three have settled. One physician, Dr. Rafibal Elnecer, agreed to pay $70,000 and to transfer real estate to the United States. He also agreed to be excluded from the Medicare and Medicaid programs for five years. This amount is approximately double what Dr. Elnecer received as a result of the false claims submitted.

Mr. TILGHMAN. Chairman Shays, Representative Snowbarger, and Representative Barrett, thank you for convening this hearing. My name is Joe Tilghman, I am the HCFA Consortium Administrator and responsible for the administration of the Medicare and the Medicaid Programs in a 10-State area that includes both Kansas and Missouri.

This hearing is very timely, as I know from personal experience this topic is of great concern to the physician community, not just in Kansas City but throughout the country and this should be a great opportunity for all of us to air our concerns.

You might be interested in knowing that we had staff up in Anchorage, AK, on Tuesday of this week to talk about the same type of issue on E&M documentation.

Mr. SHAYS. I am going to ask you to slow down a little bit. Even though you want to try to make the time limit, I want to follow you.

Mr. TILGHMAN. OK. I know you want a short, concise summary of my formal testimony, so I am going to focus my remarks on last year's CFO audit of the Medicare Program because that lays the foundation for much of today's discussion. Although I hope to have an opportunity later to also discuss the current status of the E&M guidelines as well as the prepayment reviews now being done by our carriers, because both of these items were of great concern to the earlier panel and I think I can shed some light on these.

Last year, the CFO audit of Medicare looked at the payments it had made in fiscal year 1996. It was conducted by the OIG.

Mr. SHAYS. I need you to slow down, honestly. I am going to give you a little more than 5 minutes if necessary, but just slow down.

Mr. TILGHMAN. OK good, thank you. I timed it this morning and I had it to 5 minutes.

Mr. SHAYS. We are going to hit the clock, 5 minutes starts now and the deal is you have got to slow down.

Mr. TILGHMAN. Gotcha, OK.

That year, we paid out $191 billion in benefits. Before I get into the specific findings of the audit, you first have to understand how the audit was done. In Medicare, we process over 800 million claims a year on behalf of 39 million Medicare beneficiaries. We do not require that documentation be submitted with each of these claims because the administrative cost in doing our claims processing that way would be overwhelming. We do, however, require providers to retain supporting documentation for the services that they bill us for and we require that they make this available upon request.

What the CFO audit found was that our claims process was in fact 99 percent accurate based solely on the information provided on the 5,000 sample claims that they reviewed. However, the auditors also requested the supporting documentation for these claims from the billing providers. And based largely on their review of this information, they found a 14-percent error rate and total overpayments of approximately $23 billion.

More to the purpose of today's hearing, they found that over one-fifth of the total projected overpayment, or about $5 billion, was tied to physicians—was tied to payments made to physicians. Now of the $5 billion in physician overpayments, you can parse this

down into three areas. Over $800 million was for having no documentation whatever to support the claims that were in the sample, $1.9 billion was for insufficient documentation, and $1 billion was for incorrect coding. Now it is important to note that the decision as to whether the documentation was adequate and whether the coding was correct was not made by accountants, it was made by the nurses and physicians at our carriers who were working with the auditors on this review. It is also important to note that the criteria used for determining whether documentation was adequate for E&M services was based on the guidelines published in 1994, not the guidance passed or issued in 1997.

In summary, our accountant, in this case the OIG, told us at HCFA that our business has a 14-percent error rate. And as you know, we are working very hard to correct that error rate, we are trying to fix it. In fact, we have had a lot of interest expressed both in the White House and from the Congress to see that we fix it sooner rather than later, and we are working very hard to do that.

We at HCFA have a fiduciary responsibility to make sure that Medicare payments are made in accordance with the 400 pages of law that govern our program and we have to be accountable for how we are spending $190 billion of the taxpayers' money. Similarly, providers have to be accountable for the $190 billion in payments to them that they are asking for from the Medicare Program. Of this total, about $40 billion a year goes to physicians and about $56 million goes to the physicians in Johnson County. I grew up here and that is serious money even by Johnson County standards.

I know many of the doctors that practice in Kansas City and like the vast majority of physicians in this country, I know that they are honest, hard-working, conscientious professionals providing a valuable public service. And this is a point that I think you heard over and over from the panel this morning—no one here in HCFA, the OIG, the DOJ is interested in hauling physicians, hospitals, or anybody else to court because of simple billing errors. I am sorry there is so much paranoia on this particular issue and if we do not do anything else today, I hope we clear the air on that particular issue.

In very simple terms, what we are looking for at HCFA is a process that on the one hand does not impose an unreasonable administrative burden on the provider community but on the other hand allows us to assure the taxpayers, the Congress and our 39 million Medicare beneficiaries that the $190 billion we spend every year is being spent wisely and in accordance with the law. At a very minimum, this means there has to be change. We hope to work closely with the provider community to make this change happen soon and happen in such a way that makes sense to all parties involved.

Thank you for the opportunity to testify and I look forward to your questions.

Mr. SHAYS. Thank you, Mr. Tilghman. Mr. Watson.

[The prepared statement of Mr. Tilghman follows:]

"MEDICARE BILLING CODE COMPLEXITY"
JOE L. TILGHMAN, REGIONAL DIRECTOR, KANSAS CITY
APRIL 9, 1998

Chairman Shays, Representative Snowbarger, thank you for convening this hearing on Medicare billing. This is very timely as we are working closely and diligently with physicians to improve guidelines for proper billing, and we appreciate any insights that you and other witnesses can provide.

If Medicare billing codes seem complex, it is because medicine is complex. The codes we use were developed by, and in fact belong to, the American Medical Association. Physicians, who better than anyone understand the complexities of medicine and the clinical importance of proper documentation, devised and maintain this system. The AMA maintains the coding system, which is known as CPT or the Current Procedural Terminology, and adds new codes each year. The AMA has ongoing programs to educate physicians and provide expert advice about their coding system.

Current billing code concerns focus on the revisions to our guidelines on documentation that must accompany fee-for-service physician office visit and consultation claims. We are working with the AMA to revise our documentation guidelines in a way that is consistent with the AMA's codes. We and the AMA want physicians to know how to document those elements in the medical record that will justify billing under the appropriate code.

Medicare spends some $40 billion each year on physician services. Moreover, physicians order most other medical services. There is no question that we must require physicians to properly document the care that taxpayers pay for. Documentation to support what that $40 billion in taxpayer dollars purchases is an essential part of running a public program. It is essential not just to fight waste, fraud and abuse. Proper documentation is also a key part of providing quality care.

Unfortunately, proper documentation is often lacking. The first-ever comprehensive audit of Medicare, done under the Chief Financial Officers Act in 1996, shows that nearly half of inappropriate payments by Medicare involve insufficient documentation to tell whether the claim is appropriate or whether the care is medically necessary. The CFO audit found that 14 percent of Medicare payments, or an estimated $23 billion, were inappropriate. Twenty two percent of these inappropriate payments were to physicians, and more than half of these inappropriate payments to physicians were improper because the physician did not have adequate documentation.

The CFO audit results prompted us to begin a targeted prepayment audit looking at documentation for a random sample of physician evaluation and management claims, more commonly known as office visits – the claim most often submitted by physicians.

We have completed reviews of claims from the first quarter of this fiscal year, and preliminary results are disturbing. They suggest that documentation is woefully inadequate and does not support three out of every five claims submitted to us. These are not trivial oversights but serious gaps that potentially compromise both clinical care and financial accountability. This simply is not acceptable. Medicare, its beneficiaries, and taxpayers have a need and a right to hold physicians accountable.

Proper documentation does take time, and Medicare payments to physicians take this into account. Just last year we increased the amount paid to physicians for the time it takes for proper documentation.

As I mentioned, we are in the process of refining our documentation guidelines for physician office visits. These are often referred to as our "evaluation and management" or "E and M" guidelines. They cover such things as taking the patient's history, conducting a physical exam, and medical decision-making by physicians. The amount Medicare pays for these services depends on the extent and complexity of the service provided.

"Upcoding" of office visit claims, or billing for these services at a higher level than actually delivered, is a significant problem that the guidelines are designed to address. They guide physicians on how to document evaluation and management elements in the medical record in order to justify the level of service billed. The guidelines are used by our contractors when they review physician claims to make sure that reported services were actually rendered and medically necessary.

We developed the guidelines with the AMA and major medical and surgical specialty societies starting back in the late 1980s and early 1990s. Physicians from all specialties were actively involved in reviewing drafts, providing extensive specific comments, and participating in pilot testing and focus group discussions on the guidelines. They first went into effect in September 1995, following a 10-month education campaign.

The core of the guidelines remains unchanged. Physicians asked us to refine and expand them so that the level of care provided can be described more precisely, and so specialists can show that the work of their exams is comparable to the work of exams performed by primary care physicians. For example, one of our claims processing contractors was denying upper level payments to ophthalmologists for comprehensive eye examinations because there was no established definition. We were asked to include specific single organ system examination definitions to address this type of situation, and 10 such single system examinations are now included in the revised guidelines.

We also were asked to include greater clinical specificity regarding the general multi-system examination commonly performed by internists and family physicians. The revised guidelines now include definitions for each level of service, and call for documentation of the status of both chronic and acute problems in medical histories.

We worked closely with the AMA and other physician groups in making these revisions. The revised guidelines were reviewed extensively and approved by representatives of nearly all national medical specialty societies. They were released last summer, and in September we and the AMA began to train physicians and others in their use.

Despite the extensive input from and vetting by physician groups before the revised guidelines were released, physicians in the field found them unworkable. In hindsight, everyone agrees that they are simply too cumbersome.

That's why we delayed implementation of these guidelines from January to July, 1998. Until the new guidelines are final, our contractors have been instructed to review claims using either the old version or the new version, whichever is most advantageous for the physician. Specialists are most likely to be helped by the revised guidelines.

We are continuing to work closely with the AMA and medical societies throughout the country to refine the new version of these guidelines before they go into effect. We believe we can make them easier to use. We can simplify the charts. We can make the procedure for determining the complexity of decision making by the physician easier to understand. And we can sharpen the focus so that only documentation directly related to the care provided is required. We welcome and encourage input from physicians through their individual specialty societies in this process.

Through the AMA, we are getting valuable input from physicians on how to make these needed changes. We will participate in a meeting the AMA is hosting later this month with leaders and billing experts from the national medical specialty societies. We are committed to doing this right, so the guidelines work both for us and for physicians.

Once the guidelines are final, we will work with the AMA and other physician groups to educate physicians and their billing staff on how to use these guidelines. We all want these guidelines to work so that there is consistency across the country, so we can promote high quality care and so we can help physicians avoid honest billing errors.

If physicians do make billing errors, we do want to find those errors, preferably before we make payment. We are significantly increasing our efforts to screen claims before they are paid, to review them afterwards, and to audit providers with billing patterns that are out of the ordinary. And we are using increasingly sophisticated claims analysis software to search out unusual billing patterns that suggest where we need to take a closer look. This is not to pick on physicians. We know that most physicians are honest and conscientious. But we must protect taxpayers who demand that we promote quality care and we need to have zero tolerance for waste, fraud and abuse.

If we find errors after we make payment, make no mistake about it, we do want the money back. But we are not looking to put anyone in jail for honest mistakes, and we are not going to refer physicians to the Inspector General for occasional errors. We have to believe there is some level of fraudulent intent before we make any referrals.

We are not going to waste anyone's time making a federal case out of a doctor submitting a claim for a level four visit when the documentation supports only a level two visit. We are going to take a hard look, however, if every claim a doctor submits is for a level five visit.

The Health Insurance Portability and Accountability Act allows use of the False Claims Act to prosecute fraudulent providers. This is a much needed tool in our fight against fraud, and the new law specifically addresses the kind of upcoding the guidelines are designed to prevent. A false claim charge may be levied against physicians who engage in a pattern of practice of submitting claims based on codes that they know or should know will result in more pay than they deserve.

Adhering to the E and M guidelines should help steer physicians into a position where they, Medicare, and the taxpayers can be more confident that claims and payments are appropriate.

The guidelines also will help ensure the accuracy and thoroughness of history taking and examinations, and thus enhance the quality of care received by Medicare beneficiaries. Proper documentation also will help ensure that medical records and complete, and that will help patients obtain the services they need. Concerns that the guidelines will somehow adversely impact patient care are not supported by the experience with the original version.

We are confident that consensus can be achieved on what documentation is needed without compromising accuracy or thoroughness. The result will be better care for patients, peace of mind for honest, conscientious physicians, and accountability for taxpayers who demand and deserve that we do everything we can to stop waste, fraud and abuse.

# # #

Mr. WATSON. Thank you, Chairman Shays, Representative Snowbarger, and Representative Barrett. I am Les Watson, director of Medicare payment safeguards at Blue Cross and Blue Shield of Kansas. As a carrier, our role includes the State of Kansas, the Kansas City metropolitan area, some other counties in western Missouri, and the State of Nebraska. As an intermediary, we cover all of the State of Kansas.

We take very seriously our role as a carrier/intermediary in these jurisdictions. We are committed to administering the Medicare Program accurately, efficiently and provide a high degree of customer service to the Medicare beneficiaries, the Medicare providers and suppliers and the Health Care Financing Administration.

My oral testimony today will highlight the four areas of my written testimony; namely, medical review, fraud and abuse, medical policy development, and funding for contractor operations.

Medical review. The Medicare statute is fairly general in describing what is covered under Medicare. The law requires coverage of broad categories of benefits; for example, hospital, physician services, home health, but generally does not specify what individual items and services are covered. The law prohibits Medicare payments for services that are not medically necessary for the diagnosing and treatment of medical illnesses. The Medicare contractors operate under specific guidelines from HCFA in determining appropriate payments for Medicare services.

Generally, the medical review department is the primary resource used by the carrier or intermediary for an in-depth review of information submitted for reimbursement on a claim. In certain situations, the claims are targeted for review prior to payment. This will occur even though the information on the claim appears complete. There is something about the claim information that triggers the need for a more in-depth review.

During the prepayment review, the carrier and the intermediary will request medical records to support the information on the claim. When received, the information is reviewed by a trained staff including registered nurse consultants. The carrier and intermediary's medical directors, who are physicians, work closely with the reviewers to establish review protocols that are based upon sound medical principles.

Postpay or comprehensive medical reviews are conducted on specific providers or supplier claims for a specific period of time. The decision to select a provider or supplier for a comprehensive medical review is based upon the analysis of utilization patterns in comparison to similar providers and suppliers. This is a review or comprehensive examination of the supporting medical documents for the claims paid to the provider. In almost all instances where the medical review decision is made against the provider, there is an opportunity for the provider to appeal the decision. The staff that hears these appeals are knowledgeable of Medicare rules and regulations and policies and are organizationally independent of the medical review staff.

Fraud and abuse. The fraud unit is trained to thoroughly and confidentially examine the allegations and ascertain facts. Many times these examinations find simple billing errors, misunderstandings of the services rendered or a misinterpretation of the

Medicare requirements. Allegations of this nature do not constitute fraud. These allegations are resolved quickly and with a minimum amount of provider involvement.

Examinations with outcomes other than those may require additional review and other corrective actions, including referrals to the Office of Inspector General, or the OIG.

Th fraud unit maintains a close coordination with HCFA and the G on cases developed and referred to the OIG. The OIG reviews each case to determine what action should be taken. It is the OIG's decision if a referred case is to be actively investigated for criminal or civil prosecution. It is important to point out that only the OIG, not the carrier or the intermediary, can perform the criminal investigation of Medicare fraud.

Medical review policy development. Medicare contractors apply HCFA guidelines for the development of Medicare medical policy decisions, using a combination of national and local criteria. It should be noted that the medical policy guides the determination whether a given service or procedure will be covered. It does not replace the judgment of the practicing physician in deciding on the appropriate course of treatment. The goal of a medical policy is to make sure that the beneficiaries receive care that will most effectively and efficiently meet their needs.

In the absence of national medical policy standards, the local contractor or carrier is responsible for developing appropriate medical policies using the processes specified by HCFA that requires considerable consultation with the local medical community.

Funding issues. In 1996, Congress created a permanent mandatory source of funding from the Medicare trust fund for contractor fraud and abuse. This new funding allows us to improve our efforts in doing this. But the balance of the carrier/intermediaries are financed through the annual appropriations process. The administration's 1999 budget proposes $1.27 billion for our operations and this is a much-needed increase over 1998. This 1999 budget will pay for approximately 935 million claims, 44 million claims more than we paid for in 1998; help respond to over 31 million telephone and written inquiries from beneficiaries and providers; educate the beneficiaries and providers about the Medicare Program and help implement the more than 100 separate Medicare provisions included in the Balanced Budget Act of 1997.

We appreciate this opportunity to testify before your committee today and we commend you for holding these hearings to bring together all the stakeholders in the Medicare business to openly discuss the processes and problems, understand the goals and limits of each, and use this communication to build a health care delivery system that delivers the appropriate and necessary services while assuring the American taxpayers that their moneys are being spent correctly. I certainly welcome your questions.

Mr. SHAYS. Thank you very much.

Dr. Dickey, before recognizing you, I just want to congratulate you on your position as the president-elect of the AMA. I mean what an incredible opportunity and responsibility you have been given. I did point out to you though the one thing that you do not have on us is you cannot say that you are not a politician. [Laughter.]

Dr. DICKEY. You have taken my line.

Mr. SHAYS. Welcome.

[The prepared statement of Mr. Watson follows:]

I am Les Watson, Director of Medicare Payment Safeguards at Blue Cross and Blue Shield of Kansas, Inc. I want to thank you for the opportunity to testify before this subcommittee. Blue Cross and Blue Shield of Kansas has been a partner with the Health Care Financing Administration (HCFA) and its predecessors since the start of Medicare over thirty years ago. We expanded our role as a Carrier to include the State of Nebraska in 1988 and 1991 to include the Kansas City Metropolitan Area and other counties in Western Missouri. In 1992, we expanded our role as an Intermediary to include Johnson and Wyandotte counties in Kansas.

We take very seriously our role as Carrier/Intermediary in these jurisdictions. We are committed to administering the Medicare program accurately, efficiently, and provide a high degree of customer service to the Medicare beneficiaries, Medicare providers and suppliers and the Health Care Financing Administration.

Today, I will supply information on our Carrier/Intermediary activities relating to Medicare Review, Fraud and Abuse, and development of Local Medical Review Policy. Though I present these operation separately, please realize that all three operations overlap and effect the others. It takes a well trained staff dedicated to effective communication to achieve our goals as a Carrier/Intermediary.

My testimony today also calls attention to the need for adequate funding for all Medicare carrier and intermediary operations. Medicare contractor funding must be increased

significantly in 1999 to meet all of the new demands facing the program and to combat Medicare fraud and abuse effectively.

General Review

The Medicare statute is fairly general in describing what is covered under Medicare. The law requires coverage of broad categories of benefits (e.g., hospital, physician services, etc.) but does not generally specify which individual items and services are covered.

The law prohibits Medicare payment for services that are not "medically necessary" for diagnosing or treating a medical illness. Medicare contractors operate under specific guidelines from HCFA in determining appropriate payments for Medicare services.

In FY'97 we processed a total of 14,735,847 claims. Our Medical Review areas reviewed 2,162,744 claims prior to making payments to providers and reviewed 5,617 claims after making payment to providers. A total of 14.7% of claims processed were subject to a medical review.

In FY'97, our fraud department processed 2,811 referrals of potentially fraudulent activities. The majority of these referrals come from sources outside Blue Cross and Blue Shield of Kansas. This is an average of 191 referrals per 1,000,000 claims processed.

Allow me to briefly describe some of the activities performed in these areas of Medical Review, Fraud and Abuse, and Medical Review Policy.

MEDICAL REVIEW

HCFA's expectation for its Carrier/Intermediary Medical Review departments is to ensure all payments are appropriate, accurate, and consistent with medical policy.

Generally, the Medical Review Department is the primary resource used by a Carrier/Intermediary for an in depth review of the information submitted for reimbursement on a claim. The focused medical review process assists the Medical Review Department in determining what needs to have an in depth review.

Focus Medical Review

This is the process where the Carrier/Intermediary analyze utilization data for services/items to determine aberrant utilization practices. The data analyzed may be national data supplied by HCFA, data from Carrier/Intermediary's jurisdiction, or a combination of both.

The mere fact that an aberrant utilization of a service/item exists does not mean it is being improperly utilized. It only means that a closer examination of all the facts is needed to determine the appropriate corrective actions.

Appropriate Correction Actions

When a focus review identifies an aberrant utilization, there are appropriate correction actions available. These actions are:

- ❒ Establish Prepay edits/screens to review claims prior to payment.
- ❒ General Provider Education.
- ❒ Education of a specific provider or group of providers.
- ❒ Recommend a new or revised Local Medical Review Policy.
- ❒ Recommend a new or revised National Medical Policy.
- ❒ Perform postpay medical review.
- ❒ Refund of overpayments.
- ❒ Referral to Fraud Unit.

Prepayment Reviews

In certain situations, claims are targeted for review prior to payment. This will occur even though the information on the claim appears complete. There is something about the claim information that triggers the need for a more in depth review.

During a prepayment review, the Carrier/Intermediary will request medical records to support the information on the claim. When received, the information is reviewed by a trained staff including Registered Nurse Consultants. The Carriers/Intermediaries Medical Directors work closely with the reviewers to establish review protocols based on sound medical principles.

Though prepayment reviews serve to help reduce the incidents of improper payments, they do have some limitations. Those limitations include:

- Disruption of payments to provider/suppliers
- Extensive patterns of overutilization can not always be detected.
- Establishing edits in the claims payment systems.
- Changes in billing practices can not always be detected.

Postpay Reviews (Comprehensive Medical Reviews)

Postpay reviews are conducted on a specific provider/supplier claims for a specific period of time. The decision to select a provider/supplier for a CMR is based upon an analysis of its utilization patterns in comparison to similar providers/suppliers. The review is a comprehensive examination of the supporting medical documents for the claims paid to the provider.

The review can be done using a statistically valid random sample process that produces results at a 95% confidence level. This process can lead to an extrapolation of errors in the provider's universe of paid claims. From this extrapolation, an overpayment can be determined and a refund requested.

However, prior to the request for the refund of an overpayment, the provider/supplier is furnished an opportunity to respond to the preliminary findings of the Carrier/Intermediary. This response is considered prior to the issuance of the final overpayment demand letter.

Finally, in almost all incidents where a medical review decision is made against a provider, there is an opportunity for the provider to appeal the decision. Under all levels of appeals, the staff hearing the appeal are well trained and knowledgeable of Medicare rules, regulations, and policies. The hearing staffs are also organizationally independent of the Medical Review staff.

FRAUD AND ABUSE

HCFA Publication 14-3, Sections 14000 for Carriers and HCFA Publication 13-3, Sections 3950 detail the duties we perform in our Fraud Unit. A brief summary of our general duties are:

- ❒ Identify program vulnerabilities.
- ❒ Proactively identify fraud leads.
- ❒ Determine factual basis of fraud allegations.
- ❒ Explore all sources of fraud leads.
- ❒ Take appropriate actions to deny/suspend payments.
- ❒ Develop/refer cases to OIG.
- ❒ Establish networks to other fraud investigative agencies.
- ❒ Provider and contractor education.

I will now briefly describe some of the activities done in determining factual basis of fraud allegations and develop/refer cases to OIG.

Determine Factual Basis of Fraud Allegations

The fraud unit staff is trained to thoroughly and confidentially examine the allegation and ascertain the facts. Many times these examinations find simple, honest billing errors; misunderstanding of the services rendered; or misinterpretation of Medicare requirements. Allegations of this nature do not constitute fraud. These allegations are resolved quickly and with a minimum amount of provider involvement.

Examinations with outcomes other than those listed above may require additional review by the fraud unit. Given the nature of these additional reviews the fraud unit is sensitive to the providers/suppliers as these additional reviews are done.

The additional review work could include, but is not limited to, any of the following activities:

- ☐ Prior history of alleged fraudulent activities.
- ☐ Record reviews in-house or onsite.
- ☐ Interviews with beneficiaries.
- ☐ Survey of beneficiaries.
- ☐ Consensual interviews with provider staff.
- ☐ Interviews with licensing/disciplinary boards.
- ☐ Consultation with nurse consultants, physicians, and other specialists.
- ☐ Consultation with HCFA personnel.

The outcomes of these additional reviews would be to choose the appropriate corrective action listed below.

Appropriate Corrective Actions Include

The appropriate correct action available to the fraud unit include;

- ❒ Close out allegations with no finding against the provider/supplier.
- ❒ Recoup overpayments.
- ❒ Provider education.
- ❒ Refer to Medical Review for pre/postpay claims review.
- ❒ Referral to OIG.

Referral to OIG

The Fraud Unit maintains close coordination with HCFA and the OIG on cases developed for referral to the OIG.

The elements that need to be developed include:

- ❒ Providers previous encounters with the Carrier/Intermediaries Medical Review/Fraud and Audit Departments.
- ❒ History of Carriers/Intermediaries educational efforts with the Provider.
- ❒ Amount of overpayment involved.
- ❒ Frequency of inappropriate billings.
- ❒ Report of all contact with the Provider during the review.

The Fraud Units development of these elements on cases referred to the OIG is to assist the OIG in their criminal investigation of fraud. It is important to point out that only the OIG, not the Carrier/Intermediary can perform the criminal investigation of Medicare fraud.

Because of the resources we and the OIG must spend to investigate these referrals, we seek to refer only those cases we believe have strong elements of fraud.

The OIG reviews each case to determine what action should be taken. It is OIG's decision if a referred case is to be actively investigated for criminal/civil prosecution.

The Ben Carroll case can be used to illustrate the workings of a Medicare fraud case. Mr. Carroll was convicted of fraud in Kansas and Florida. He was sentenced to 10 years in prison and ordered to pay tens of millions of dollars back to Medicare.

Mr. Carroll billed Medicare for a "female urinary collection device" and was paid $8.45 for each item. Mr. Carroll in fact was delivering adult diapers costing him only $.30 each. The start of our investigation occurred when we did a data analysis on the codes used to bill certain supply items. Mr. Carroll's reimbursement for the code he billed was greater than all the rest of the users of that code combined.

Medical records were ordered and reviewed. Nursing home staffs from facilities that Mr. Carroll supplied were interviewed. Our case was summarized and sent to law enforcement. From there, the case was developed and prosecuted and Mr. Carroll found guilty.

As seen in Mr. Carroll's case, simple billing errors, misunderstandings, or misinterpretations do not make good fraud cases. Rather, good fraud cases are made of deliberate acts of deception that pay the perpetrator hundreds of thousands if not millions of dollars.

LOCAL MEDICAL REVIEW POLICY DEVELOPMENT

Medicare Contractors apply HCFA guidelines for the development of Medicare medical policy decisions, using a combination of national and local criteria. It should be noted that medical policy guides the determination of whether a given service or procedures will be covered. It does not replace the judgment of the practicing physician in deciding on an appropriate course of treatment. The goal of medical policy is to make sure that beneficiaries receive the care that will most effectively and efficiently meet their needs. Sometimes medical policy results in Medicare coverage of services that are newly accepted medical practices. At other times, medical policy results in the denial of coverage for inappropriate or unnecessary care.

Historically, it was accepted that standards for medical practice should be local. Over time, the Medicare program has developed national policies where there is a consensus on the medical appropriateness of a specific treatment or procedure.

Over the recent years, HCFA has made significant efforts to develop more consistent national medical policy standards. When HCFA has developed national medical policy standards, they are to be used by Medicare contractors. In the absence of any national medical policy standards, the local contractor is responsible for developing appropriate medical policies using a process specified by HCFA that requires considerable consultation with the local medical community.

Funding Issues

In 1996, Congress created a permanent mandatory source of funding from the Medicare trust fund for Medicare contractor anti-fraud and abuse efforts, including the activities which I have described today. These fraud and abuse detection efforts represent almost one-third of all funds that support Medicare carrier and intermediary operations. Over the past decade, funding for these activities had deteriorated and did not allow the kind of activities that are essential to detect fraud and abuse and prevent unnecessary Medicare payments. This new funding should reverse this trend and allow us to improve our efforts.

The balance of Medicare carrier and intermediary budgets are financed through the annual appropriations process. The Administration's FY 1999 budget proposes $1.27 billion for Medicare carrier and intermediary operations, a much needed $96 million increase over the FY 1998 appropriation level. This budget provides the funding necessary to:

- Pay an estimated 935 million claims in 1999.
- Respond to over 31 million telephone and written inquiries from beneficiaries and providers.
- Educate beneficiaries and providers about the Medicare program.
- Handle over 7 million annual hearings and appeals for reconsideration of initial determinations.
- Provide support to the Inspector General and other fraud fighting initiatives.

This increased funding is critically needed in 1999 to

- Implement the more than 100 separate Medicare provisions included in the Balanced Budget Act of 1997 (BBA). To achieve the $115 billion in Medicare savings under BBA, contractors will be required to make costly modifications to current computer systems, or in some cases, create entirely new systems.
- Detect and prevent fraud and abuse. While there is separate funding for specific fraud and abuse initiatives, the base account that is dedicated to paying claims is the first line of defense. An adequately funded claims payment program is critical and integrated into the fight against abuse and inappropriate spending. The largest impact is the connectivity of all components of contractor operations in "getting things right the first time".
- Process the 44 million additional claims expected to be received in 1999.

Conclusion

We appreciate the opportunity to testify before your Committee today to discuss the Medicare carrier and intermediary medical review process. We commend you for holding this hearing to bring together all the stakeholders in the business of Medicare to openly discuss the processes and problems, understand the goals and limits of each, and use this communication to build a health care delivery system that does deliver the appropriate and necessary services and items, while assuring the American taxpayers that their monies are spent correctly.

Dr. DICKEY. Good morning. My name is Nancy Dickey, I am a family physician from College Station. I do still see patients.

Mr. SHAYS. Move that microphone a little.

Dr. DICKEY. All right. Usually I do not have any trouble being heard—and I am the president-elect of the American Medical Association. I want to point out looking at my panel, I am not a regulator, I am a physician and I am representing physicians, but as you pointed out, I do spend a lot of my time as a politician.

On behalf of our 300,000 members, I would like to commend you for holding the hearing and thank you for the opportunity to testify about Medicare's billing codes, particularly the recent development of the E&M documentation guidelines.

Everywhere I go today, physicians are angry, downright mad about the latest demands of practicing medicine. Any extra time required for documentation can only come out of patient care, or as you heard so eloquently earlier, come at the end of what is already a very demanding day. But let me be clear that as a practicing physician, paperwork must not come before our duty to our patients.

That said, the AMA believes that good documentation is an essential part of quality of care. In addition, a well-documented medical record can reduce many of the hassles associated with claims processing and it verifies care provided should we be asked by one of these fine gentlemen to my right.

Our written statement details how and why the AMA became involved in these guidelines and the 1997 revisions that have ignited so much controversy. Recognizing that Medicare would review E&M coding as it did other services, we felt that physicians would be best served if carriers could use—in fact would be mandated to use—certain audit criteria reflecting input from CPT coding experts as well as practicing physicians. It was also critical that physicians have those criteria before any review started. We have long opposed any kind of secret audit criteria. This was a chance for them to be open and known ahead of time.

As detailed in our statement, the 1997 revisions follow this initial logic. They brought more detailed definitions of various single system and multisystem examinations and were found to be in response to concerns that had been expressed. Without those kinds of national definitions, carriers were developing their own and often rejecting higher level E&M codes for both specialties and family practice, either saying the codes did not cover specialties doing that intense an exam or family physicians surely never saw that complicated a patient.

These new guidelines took on added importance though with the 1996 HHS/OIG general financial audit which concluded, correctly or not, that a large portion of Medicare services did not contain adequate documentation and that as a result, suggested more than $23 billion had been spent inappropriately. I will call to your attention that of the examples given, only one was of a physician.

This audit led to the random prepayment reviews that have created a pervasive threat that honest physicians' medical records will be demanded by carriers for review without any reason ahead of time to think there is a problem, simply saying we have selected your record for today.

The heightened fraud and abuse environment has produced a chilling factor for physicians. Actually a siege mentality, if you will, increasing physician concerns about audits.

Now the AMA is very appreciative of the cooperative efforts of HCFA and especially their willingness to extend the deadline for implementing the guidelines. We continue to work with HCFA and organized medicine in a three-pronged approach to improve the E&M documentation guidelines. Our three goals: First, to protect physicians from unwarranted charges of fraud and abuse; second, to secure significant changes in the guidelines themselves so that any guidelines will enhance the quality of clinical care and maximize the interaction between physician and patient, not physician and payer; and then third, to provide physicians with an intense education program to help them with implementation of whatever the fixed, agreed upon guidelines are.

Working through their State, county, and specialty societies, physicians have been asked to comment on changes that they believe will be required to make these guidelines functional—to give us feedback. We have received hundreds already and expect that we will continue to receive more. These comments will be discussed by medicine's leaders as well as representatives of the AMA, CPT, and HCFA at a special fly-in meeting on April 27.

But corrections are only one step. We also need a field test of the revised guidelines because as you will hear, medicine signed off on these guidelines and then as physicians got them in their offices, they sometimes did not work—they almost never worked the way they were anticipated. So we need a field test to pilot study what happens. We expect that an extension of at least an additional 6 months will be needed to allow for the necessary changes, education, and field testing. While we regret the delay, it is more important the guidelines are done right, fair and equitably, than that we rush to get them completed and out on time.

We know that right now many physicians and possibly HCFA and others view these guidelines not as guidelines, but as iron-clad requirements that if they are not followed to the letter of the law, will lead to the real possibility of jail time and exorbitant fines. Documentation guidelines should assist physicians, they should be tools—tools, not rules—so that they can use them and make appropriate documentation, but not take inappropriate patient time in order to check off slots someone thinks need to be there.

Truth is, even in a detailed system like the one we have outlined for you, when evaluating and managing complex patients, there will be disagreements about the level of service that was given or the particular code that applies to a particular service. We want to be sure that where there are differences of opinion, they can be resolved short of accused criminal activity.

Claims reviewers need to be required to use judgment, they need to have the appropriate background, education, and training to make the judgments and HCFA needs to assure that its medical directors apply guidelines uniformly and implement review practices that are consistent with the agreed-upon guidelines rather than individually applied.

We have always taken a strong stance against fraud and abuse and we stand ready to help identify and stop anybody who is will-

fully, intentionally breaking the law or defrauding the Government. But medicine is an honorable profession, we believe most physicians out there are practicing straight-forward, honest medicine, and coding as best they can. Where there are problems, we need an educational approach.

We have already started off on what we believe are the right steps for correction, we look forward to working with all of you to find additional steps and to ultimately end up with a coding and documentation system that improves patient care rather than threatens the well-being of the profession.

Thank you. [Applause.]

[The prepared statement of Dr. Dickey follows:]

Statement

of the

American Medical Association

to the

Subcommittee on Human Resources

Committee on Government Reform and Oversight

U.S. House of Representatives

RE: Medicare: Cures for Billing Code Complexity

Presented by: Nancy W. Dickey, MD

April 9, 1998

Good morning. I am Nancy W. Dickey, MD a family physician from College Station, Texas. I am President-Elect of the American Medical Association (AMA). On behalf of our 300,000 members, I would like to thank you for this opportunity to testify before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight on development of new documentation guidelines for evaluation and management (E&M) services and other issues associated with billing code complexity.

Our statement will review the AMA's role in developing the Physicians' Current Procedural Terminology (CPT) codes for E&M and other services; review the background for the AMA's involvement in the E&M documentation guidelines; detail our response to identified physician concerns with these guidelines, including needed educational efforts by the

medical professional and the Health Care Financing Administration (HCFA); and outline our suggestions for improving implementation of the current billing and coding system.

The Role of the AMA in Developing CPT Codes for E&M Services

November 1997 marked the 30th anniversary of CPT, an organized listing of descriptive terms and identifying codes for reporting the services of health professionals. The purpose of the CPT is to provide a uniform language to accurately describe medical, surgical, and diagnostic services, providing an effective and unmatched means of communication among physicians, patients, and third parties. The AMA publishes an updated CPT book and associated database annually. As I discuss in more detail below, one of the most important revisions to CPT in the last twenty years was the introduction in 1992 of an entirely new series of codes and descriptors to report physicians' evaluation and management services.

In 1981, the federal government evaluated several procedure code sets to determine if any were suitable for adoption by Medicare as a national uniform standard. Based on this evaluation, CPT was adopted by HCFA for the Medicare program because it could be implemented nationally with a minimum of disruption to existing data processing and without fear of increasing health care costs; was acceptable to the medical profession; and had professional commitment for its maintenance. In 1983, the federal government and the AMA entered into a formal agreement whereby CPT was adopted by HCFA for reporting physician services under Medicare. Many private insurers and most other government programs subsequently began to convert their systems exclusively to CPT. By the late-1980s, CPT had become the uniform code set used for reporting physician services. Since

1983, the AMA has maintained CPT under its agreement with the federal government and has provided annual updates to HCFA and its agents at zero cost.

The AMA has developed a comprehensive structure and made a substantial commitment to maintain and update CPT. This has been a process designed and operated to meet the needs of the diverse parties that rely upon CPT–physicians and their organizations, other health care providers, public and private payers, and others who rely upon accurate data on the services that physicians provide.

CPT maintenance focuses on the CPT Editorial Panel, which includes sixteen physicians (including one non-MD health care professional), twelve nominated by the AMA and one each nominated by the Blue Cross and Blue Shield Association, the Health Insurance Association of America, HCFA, and the American Hospital Association. The Panel meets four times annually. In a typical year, it addresses 200 major topics, which normally involve more than 2,500 votes on individual items.

The Editorial Panel is supported by the CPT Advisory Committees, composed of physicians and other health professionals representing specialty societies in the AMA House of Delegates and several organizations representing non-MD/DO health care professionals. The Advisory Committees, now numbering over 100 individuals, meet annually. Typically, committee members also chair their own specialty society coding committees; CPT is thus supported by a network of nearly 1000 practicing physicians and other health professionals.

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One of the most important events for CPT in recent years was Medicare's transition to the resource-based relative value scale (RBRVS)-based physician payment system beginning January 1, 1992. The RBRVS brought a close focus on CPT, which had been developed and implemented before implementation of such payment systems. In some instances it was argued that then current codes were not sufficient to adequately, fairly, and uniformly reflect the "resource costs" of services, especially the physician "work" needed to provide a service.

This deficiency was believed to be particularly acute in the "visit and consultation" codes. Data indicated that these codes were used in very different ways by different physician specialties and across geographic areas. This disparity would be unacceptable with the new Medicare payment system, which largely prohibited differential Medicare payments for the same service across specialty or geographic area. In 1989, therefore, with passage of federal legislation mandating the Medicare RBRVS, the Editorial Panel began revising the CPT codes for visits and consultations. It developed new codes for office visits, hospital visits, and consultations, reflecting recommendations from a variety of sources of data and expertise. Issues considered included using time in coding, the number of levels of service, codes for different sites of service, and different codes for new and established patients.

As a result, the 1992 CPT codes for evaluation and management (E&M) services were fundamentally different from the previous visit and consultation codes. For 1992, familiar levels of service - such as brief, minimal, and intermediate - were replaced by more precise assignment of codes based primarily on the extent of history, examination, and on the complexity of medical decision-making. Other factors that could affect the level of service

were identified as well, including counseling, coordination of care, severity of presenting condition and face-to-face time taken to perform the service.

The Background of the E&M Documentation Guidelines

It is important to understand the rationale for and nature of the AMA's involvement in the E&M documentation guidelines. In 1992, as discussed, the AMA introduced new E&M codes to (1) reflect the fact that the RBRVS was based on physician work, (2) as an alternative to problematic proposals offered by other organizations; for example, that E&M code levels be based solely on time rather than reflecting the clinical content of the service, and (3) to respond effectively to the fact that, by 1992, HCFA was extensively downcoding physician claims for the previous visit and consultation codes.

The Executive Office of Management and Budget (OMB) then mandated that HCFA adopt documentation guidelines to be used for carrier review of the new E&M codes. In 1994, the AMA and HCFA developed an initial set of documentation guidelines; the initial reception was mixed but familiarity ultimately led to their acceptance. In 1997, the AMA, the national medical specialty societies, and HCFA together refined the criteria for single specialty and multi-system exams and further revised the 1994 documentation guidelines for E&M codes.

These revised guidelines were issued last July and education began shortly thereafter. They have been on the HCFA web page and were featured in the AMA's monthly *publication CPT Assistant*. At the same time, it is clear that our success in informing and educating physicians concerning these guidelines has been insufficient and must be improved.

Although the post-July period brought forward suggested changes from a few specialties, some of which were reflected in revisions to the skin and multi-system examinations, the initial dissemination did not involve enough focused information and assessment.

As we recognized that a problem was emerging last Fall, we asked for and HCFA quickly granted a six month extension of the grace period for the new guidelines. In December, at our House of Delegates meeting, it became clear that more and better education was not enough. Our members had profound concerns with the burden imposed by the guidelines, and problems with specific areas, most notably components of single system examinations.

I should underscore that the guiding principle of the CPT Editorial Panel was to allow the relevant specialty societies to determine the content of their own single system examinations. Thus, we worked extensively with and deferred to the over 90 specialty societies that are members of the CPT Advisory Committee. This process took place over a three-year period and we had agreement from the pertinent specialties on the single system examinations and the multi-system examination included in the 1997 guidelines. The AMA and HCFA also have acted quickly on requests for further refinements that emerged after July.

The AMA had opted to work with HCFA on these revisions because many physicians were subjected to downcoding and arbitrary Medicare carrier payment policies. In particular, many Medicare carriers were arbitrarily denying payments for specialists billing for Level 4 and 5 visits. For example, the Iowa carrier refused to pay ophthalmologists above a Level 3 because there was no established definition of a comprehensive eye exam. Primary care

physicians were also being downcoded. Some carriers adopted policies stating that family physicians could never code more than a Level 3 because "their patients were not that complicated." Other carriers moved to establish their own definitions for single system exams, with no input from the medical profession.

Since its beginning, our work with HCFA on this project reflected our commitment to several principles:

- The need to define with precision the terms used in CPT;
- The need to work cooperatively with HCFA on CPT implementation;
- The need to assist physicians, HCFA, and other interested parties with accurate and efficient implementation of the E&M codes;
- The need for physicians to document the clinical care that they provide their patients;
- The recognition that clinical documentation also has uses for payment and utilization review;
- The need for physicians to have advance access to review criteria used by Medicare and other payors, versus secret, "black box" review criteria;
- The importance of allowing specialties to define the content of their single system examinations;
- The need for cross-specialty comparability in the work of each level of E&M service; and
- The recognition that any documentation guidelines must evolve over time as comments are received and there is experience with their use.

The Need for Change in E&M Documentation Guidelines

As emphasized above, it became very clear to the AMA that substantial changes were required in the documentation guidelines before they could be implemented by the carrier

community. We were therefore pleased that HCFA had agreed to our urgent request last December to delay the implementation of the new guidelines for six months.

The AMA is now working closely with organized medicine and HCFA to implement a three-pronged action plan to respond to immediate concerns and longer term needs for the documentation guidelines. The first element is advocacy to ensure that physicians are protected from unwarranted fraud and abuse penalties when inadvertent coding or documentation errors occur. The second element is ensuring that refinements to the guidelines are comprehensive and result from a process involving organized medicine, the CPT Editorial Panel, and HCFA. The final element is a coordinated effort between the AMA and the other components of organized medicine to conduct an extensive educational effort to assist physicians during implementation of the final revised guidelines.

Advocacy - With respect to the first element, the AMA has emphasized repeatedly that clinical documentation guidelines and needs should not be confused with fraud and abuse enforcement efforts. I would like to underscore that point today. Physicians are expressing their very strong and vocal concerns that they could be accused of fraud and abuse for merely miscoding a claim. On behalf of our members, the AMA demands that physicians be treated as the ethical professionals that we overwhelmingly are.

Although physicians certainly need to properly document their services, they must not be treated as criminals over what are very often simply honest differences of opinion about how a claim should be coded or documented. Indeed, we must recognize that carrier reviewers

have demonstrated a fairly high rate of error in reviewing E&M coding levels and are often overturned on appeal. Similarly, when the AMA worked with HCFA to validate the 1992 E&M codes through application of these codes to clinical vignettes, Medicare medical directors consistently coded visit vignettes one level lower than practicing physician participants.

In the heightened fraud and abuse enforcement climate that has arisen in recent years, many physicians have come to see the E&M guidelines as rigid rules that must be followed to the letter in every instance if severe fraud and abuse penalties are to be averted. This was never the AMA's intention. The guidelines are intended to be a template for reviewers who must evaluate medical records to assess coding accuracy, and to serve as a guide for physicians and their staffs on how one should code and document E&M services.

Nor do we believe that such a rigid application of the guidelines for fraud and abuse is in any way supported by current Medicare statute. In a June 17, 1996 letter, the chairs of the three House Committees responsible for the current fraud and abuse statutes wrote:

> *Physicians and hospitals should not be penalized for inadvertent behavior and errors under these anti-fraud and abuse provisions. That is why the criminal statute contained in this bill requires that a provider have specific intent to violate the law. A provider must have actual knowledge that what he is doing is fraudulent.*

The fraud and abuse statutes contain a "knowing and willful" standard for imposition of criminal penalties for coding errors. This standard intentionally makes it more difficult for prosecutors to find a party guilty of fraud because they must prove the party has voluntarily and deliberately committed a fraudulent act. As indicated above, honest disagreements may

occur over proper coding between carriers and physicians; such disagreements, however, should never result in criminal sanctions or penalties being imposed against the physician as long as the physician makes a good faith effort to document the care they provide.

The overwhelming majority of physicians are highly ethical professionals who do a difficult job under extreme time pressures and must be treated as such. There has never been any serious suggestion, let alone evidence, that physicians are a significant source of health care fraud or abuse. Nor is there any evidence that physicians have been unable to code reliably or are upcoding since the E&M codes were put in place in 1992. Indeed, many of our members tell us that they are downcoding just to be safe. Moreover, we know there is no single standard for documentation in the medical record, nor should there be. The text of the current revised guidelines is clear that multiple approaches to documentation can be accommodated; this point must be emphasized more strongly and clearly in the next version.

If the next version of these guidelines is to work, documentation should be first and foremost a function and byproduct of clinical care. Physicians and their staffs should code, and be able to code, based on this documentation. The sequence should be: (1) document for clinical reasons; (2) code from documentation; and (3) be able to verify code selection from This documentation and associated guidelines based in CPT definitions.

Moreover, claims reviewers must be required to exercise judgment as they review complex clinical documentation and evaluate related coding -- and they must have the training to do so. We therefore urge that you seek to ensure that HCFA requires proper training in and use

of documentation guidelines by carrier review staff, monitors the quality of such review, and has sufficient funding to effect the needed staff training and development.

The current guidelines recognize that some elements of code documentation are, of necessity, subjective, especially those involving the complexity of care provided. In the inevitable gray areas, physicians must be afforded the benefit of the doubt, certainly for payment and most emphatically for any question of fraud and abuse. Physicians are members of a profession that has maintained a strong and functioning code of ethics for more than 2000 years, ethical professionals; they must not be viewed as guilty until proven innocent.

Finally, our advocacy efforts are focusing on the need for a pilot study before the next version of the guidelines is fully implemented. Such a study is likely to involve several different methods, geographic areas, and physician specialties. We intend to work vigorously with organized medicine and HCFA to see that such a study is completed and evaluated before any required use of new guidelines.

Changing the Guidelines - Our second priority is to change the guidelines. We know many physicians do not think that the current guidelines have a solid basis in what really happens in the treatment room each day. Last December, our House of Delegates expressed dismay at the excessive content of the revised E&M guidelines and the increased burden being placed on physicians to report information that may add little value to patient care. Our first step in developing new guidelines was securing agreement from HCFA that changes to the

guidelines must be identified systematically and then implemented. We have been very pleased at HCFA's rapid acceptance of this principle.

Our next step was to ask the national medical specialty societies, state medical associations, organizations representing non-MD health care professionals, and larger county medical societies, to submit to the AMA their specific comments and suggestions for improving the guidelines by March 15. We have received over 100 comments on a range of issues, including complexity of the guidelines, changes needed to particular guideline components and great concern with current fraud and abuse enforcement related to E&M documentation.

We have begun an intensive process to evaluate this information and will use it as the foundation for a special "fly-in" meeting to be held with these groups on April 27 in Chicago. At the April 27 meeting, members of the AMA Board of Trustees, the CPT Editorial Panel, and HCFA will be available to hear specific problems and to assist in developing workable solutions. We also, by that time, hope to have available for discussion, a new framework for E&M documentation as well as alternate formats that may ease considerably their usage in a variety of clinical situations. In addition, the CPT Editorial Panel has been and will be devoting a major portion of its May and August meetings to refining the documentation guidelines based on the input received in March and April.

In developing revisions, the AMA recognizes that HCFA will use these guidelines and definitions within the context of the Medicare payment schedule. It is our understanding that, if HCFA believes that the resulting modifications have lessened the value of the

examinations, there may be reductions made in the relative value units (i.e., payment) for those exams. This is particularly important in considering modifications to single organ system examinations, where considerable effort has already been made to ensure that the "physician work" encompassed by those examinations is comparable to the "physician work" represented by a general multi-system examination.

We will take a broad and comprehensive approach to the revision process. Not only must we address specific comments and revisions on discrete components of the guidelines, we must also ensure that the resulting guidelines are efficient, accurate, and non-burdensome. Although specific comments are more immediately helpful than a comment that "this is too complicated," the latter comment is equally important; it must and will be fully addressed.

Education - We have begun to work with our state, county, and specialty partners on teaching materials and tools to increase the accuracy and reduce coding and documentation burdens. Once the guidelines are revised, we will work with these partners, HCFA, and Medicare carriers to ensure that these materials are widely distributed to practicing physicians.

As part of this effort, the AMA will use its substantial resources dedicated to educating our members and others who use the CPT codes on proper use of these codes. These resources include the *CPT Information Service*, the monthly publication *CPT Assistant*, annual CPT publications, the AMA "Web Page," train the trainer and other education sessions, and cooperative efforts with our partners in organized medicine. As part of this latter effort, we are establishing a clearinghouse of educational materials on E&M documentation.

Ultimately, we will need a coordinated educational effort involving the states, specialties, the carriers and the AMA if we are to assure that physicians properly understand the revised guidelines. As I have mentioned, we also need assurances from HCFA that they will make a concerted effort to thoroughly educate all those carrier personnel involved in reviewing the adequacy of physician documentation.

The AMA also wants to ensure that physicians have enough time for pilot testing and education before new guidelines are mandatory. As a result, we have already begun serious discussions with HCFA about an extension of the current grace period by at least an additional six months and are optimistic that we will have a favorable decision. By the end of this month, we will have a better idea of the time needed to complete needed revisions.

Related Recommendations to Simplify the Coding and Billing Process

We welcome your interest in our suggestions to simplify the coding and billing process. Given the subject at hand, our comments will focus on E&M coding and documentation.

First, it is clear that physicians need better tools to code E&M services accurately and to document the basis for their coding decisions. We are committed to working with our partners in organized medicine, HCFA, and other interested parties, to develop and disseminate such tools. Already, we have made a major emphasis in the CPT book to provide coding guidance, clear definitions of terms, and vignettes of typical clinical cases for each level of E&M service.

Second, all parties – patients, physicians, and HCFA – are best served when the claims payment process is automated, without requests for further documentation from physicians to support coding decisions. For physicians and carriers, processing these paper records is a major administrative burden that detracts from patient care and efficient claims operations. For patients, each submission of confidential medical records to carriers is a potential violation of the sacred and private relationship that exists between patient and physician.

Third, we therefore urge HCFA to conclude as quickly as possible the current random prepayment reviews of E&M services and to move as quickly as possible to a focus on coding patterns, targeting education and review where there is reason to suspect a problem. Random reviews, especially with concerns about aggressive fraud and abuse enforcement, make all physicians feel vulnerable to arbitrary carrier decisions on code levels and documentation. This environment makes physicians feel they must treat the documentation guidelines as a sword of Damocles over their heads, regardless of the extent to which they are coding in an accurate manner, or perhaps even under-coding to be on the safe side.

Fourth, on a related point, we urge that use of the guidelines emphasize targeted education rather than punitive down-coding, payment reductions, or allegations of fraud and abuse.

Fifth, we believe that physicians are owed a very clear and unambiguous statement of the manner in which fraud and abuse statues will be applied to coding and documentation issues.

Sixth, we urge that carrier budgets allow sufficient staff and non-staff resources and time for effective training of physicians and carrier staff in accurate coding and documentation.

Finally, the Medicare carrier appeals process must be sensitive to the identified problems with the current E&M documentation guidelines. Physicians should be afforded an efficient process for appealing downcoded or denied claims.

Conclusions

Please be assured that the AMA recognizes that clinical documentation is essential to good patient care and has a carefully circumscribed role to play in payment validation. We hope new guidelines will ultimately encourage and assist physicians and other health care professionals in providing proper documentation. We are also mindful that the time required for documentation, beyond what is clinically necessary, can only come out of patient care. Patient-doctor relationships already feel the crush of time.

Moreover, physicians must be able to provide high quality, well-documented patient care without laboring under the fear of unwarranted fraud and abuse penalties and prosecution. This outcome is only possible through accurate provision of accurate information to physicians by enforcement bodies and through needed changes in enforcement approaches. We welcome your support for these propositions.

Thank you for the opportunity to share our thoughts with you. We look forward to working with you to address these critical issues.

Mr. SHAYS. Thank you very much.

Before calling on Mr. Snowbarger, I am now going to repeat the question I had. I would like, so we know how many are on our third panel, to help me gauge time on this panel. How many would like to address—you will not be sworn in, you will just be invited to give testimony. We will probably not be asking questions, just allowing you an opportunity in the audience to make statements. How many would like to make statements? If you would keep your hands up nice and high—all the way up please; 11. Well, that is going to give us about 3 to 4 minutes per person, at least 3, we will leave it at that.

What I am going to do is to ask, if you do not mind, Larry Halloran will give these forms out. The reason we are giving the forms out is that we need the recorder to be able to record your statement as you make it and we need your name and address for that purpose and then we will take the number and we will divide you into groups. We are going to divide you into groups of four and we will call one group up and then the next group and so on.

Let me also make an observation before giving the chair to Vince Snowbarger, that I get the sense right now that we are kind of like ships passing in the night because the cases that I am seeing, I do not think any physician who has testified, an administrator would not applaud you for. So it is a question of how in the process of getting those individuals who truly have done very crooked things, we deal with the fact that I know even in my own district, 1 of 435 districts, that I have had physicians come to me and say they are being basically shaken down in a sense, coded lower. "Do not do what you think is right, you made a mistake here, by the way, your name may be in the newspaper." I think they care less about the fine than they care about the fact that for 20 to 30 years they have been practicing physicians and their names will be in the newspaper as someone who potentially has committed fraud. So I am going to want to make sure that those of you who were here, and I think most of you were, can kind of address the concerns to see if there is not a way to solve the problem that we were hearing this morning without making your jobs more difficult, yours as prosecutors and yours in HCFA as to how we do the coding.

So with that comment, I am just going to now recognize Vince Snowbarger.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Kind of along the same lines, I do not know where to start because again, the testimony is just kind of going in two different directions here. But let me try to focus just on the efforts that you each have been making.

Fairly simple question I think, Mr. Williams, have your investigative efforts increased recently in the area of Medicare fraud and abuse?

Mr. WILLIAMS. Yes, they have, in the last 2 to 3 years, sir.

Mr. SNOWBARGER. And at whose behest has that happened? We just all of a sudden figured out we have got fraud and abuse out there and decided to run out and investigate or has there been a more concerted effort to deal with the issue?

Mr. WILLIAMS. Well, I think complaints have just been building over the years and it is sort of like other waves that come through,

it gets to a point, and of course with Medicare, the tremendous amount of money out there, and complaints come in because of that.

Mr. SNOWBARGER. What kind of training does your investigative staff have, in terms of investigating these matters?

Mr. WILLIAMS. Our investigators are HHS and the Federal Bureau of Investigation and all of the training courses that are given to those agencies.

Mr. SNOWBARGER. Do you have practicing physicians as investigators?

Mr. WILLIAMS. I do not have any investigators in my office, we rely upon the FBI, the HHS and the professionals.

Mr. SNOWBARGER. Maybe I will move the question over to Mr. Kopf and ask the types of investigators that Mr. Williams relies upon. What kind of training do they have?

Mr. KOPF. Our investigators are trained in doing criminal and civil investigations, white collar crime investigations. What we look for when determining whether there has been knowledge and intent is the advice of the contractors through their professional review organizations, through their nurses on staff, to indicate whether the diagnosis was improper, whether there was upcoding involved or things of this nature.

Now most of our cases, all of our cases in fact deal with flagrant violations of the Medicare regulations. We do not, to my knowledge, for the length of time I have been with the OIG, and I was with the FBI before, have we ever investigated or prosecuted anybody because of an error.

Mr. SNOWBARGER. I really do not think you have given a comfort level to the folks sitting out in the audience that they do not need to worry about things if they are good.

Let me, Mr. Kopf, follow on with a different line of questioning here. We have talked about the audits that you are doing with health care providers in terms of their billing. Obviously the Office of Inspector General would also have some obligation and some duty to investigate within the system, within the administration of the system. And I had a question, have you ever audited either the intermediaries or HCFA, in terms of the advice that they give out. When someone calls in, they are given some interpretation of a rule. Have you ever followed up to find out whether or not if the doctor codes in that particular way that it is ultimately paid, the quality of the advice?

Mr. KOPF. We have had a few instances in which it looked like there may be a fraudulent activity occurring, and when we checked further during the course of the investigation found out that either the local contractor or HCFA central had given conflicting advice and in fact that was not the case, and the case was dropped. There was one in particular that had to do with some 110 hospitals with installing heart defibrillators that were experimental. According to the Medicare guidelines, this was, quote-unquote, illegal. When we looked further into the situation, we found that all the hospitals were doing it because it was a quality of care issue in the patient's best interest. That regulation was changed and there was no criminal or civil action pursued in that matter.

Mr. SNOWBARGER. But the only time you have looked at this internal advice system is focusing an investigation on a health care provider, finding out through that investigative process that there may have been something internally wrong. You have not gone directly after the internal——

Mr. KOPF. We do conduct internal audits on the contractors and we do have several ongoing investigations against the contractors for their participation in what we think is fraudulent activity.

Mr. SNOWBARGER. And are we assuming that the contractors are defrauding or have they called into HCFA and asked for advice on how something ought to be billed and gotten bad advice?

Mr. KOPF. In the investigations that we are doing, the contractors are actually committing the fraud.

Mr. SNOWBARGER. OK.

Mr. KOPF. In the other instances, our auditors go in and we work with HCFA to look at the regulations.

Mr. SNOWBARGER. Mr. Tilghman, if I can shift over to a different line of questioning, you have done a very good job of reporting, from a Government standpoint, to the extent that I have got so many figures floating around in my head from your comments, that I am not sure I followed everything.

You were talking about the report that came out last summer and if I heard you right, you said that that basically was from a sample of 5,000.

Mr. TILGHMAN. Correct.

Mr. SNOWBARGER. 5,000 out of what universe?

Mr. TILGHMAN. It would have been a total of 800 million that would have been processed in fiscal year 1996.

Mr. SNOWBARGER. I am sorry, eight——

Mr. TILGHMAN. 800 million claims that would have been processed in fiscal year 1996.

Mr. SNOWBARGER. OK. I thought I heard you say that in that sample of 5,000, that there was a fairly high rate, 90 plus percent—and I have got it written down as compliance rate, but I am not sure I know what I am talking about. Do you remember the 90-percent number?

Mr. TILGHMAN. What I said initially was in the 5,000 claims that were picked at random, and it was a scientifically based sample that they used to project to the overall universe, that they did the review in two phases. The first phase was they looked specifically at what the contractors would have seen, the claims form that came in, the edits that would have been run, and based on that, there was only a 1-percent error rate in the way we paid claims. But you have to keep in mind that we do not request documentation from the providers when we process the claims. We do it all electronically. The second phase is where they went out to the providers that submitted those 5,000 sample claims and said, "Send me the documentation that you should have in your records to show that this bill is in fact supported." That went out three times. It went out first with a written request, then they went out with a second written request for those that did not respond and then they made a telephone call on those that still had not responded, and then based on the documentation they got from that, they did the second review and that is where they identified the 14-percent

error rate and the $23 billion error rate was on the documentation provided for those 5,000 sample claims.

Mr. SNOWBARGER. OK.

Mr. SHAYS. You could do an auction.

Mr. TILGHMAN. I know.

Mr. SHAYS. You do not even take a breath. [Laughter.]

You are awesome.

Mr. TILGHMAN. I know, you are right, I talk too fast and I stutter and I swear sometimes. I have tried not to swear today.

Mr. SHAYS. Let me just say something to you and I do not mean to be facetious, but you have got to slow down a little bit. I feel what you say is important for us to hear.

Mr. TILGHMAN. Good.

Mr. SNOWBARGER. Let us go to the 14-percent error rate that you talked about. I think you said most of that was deficient documentation?

Mr. TILGHMAN. Correct.

Mr. SNOWBARGER. Three of five cases was deficient documentation. I guess I have a couple of questions, maybe we can start with this one first. When you looked at that sample of 5,000 and you boil it all down and you come out with a 14-percent error rate, is that error rate based on, for lack of a better term, a snapshot at one point in time? In other words, do you follow those claims through after new documentation is provided to find out how many of them were legitimate claims just poorly documented?

Mr. TILGHMAN. The auditors did not do that. After the audit report was issued, we at HCFA then are following through on those 5,000 sample claims to see—if we cannot get documentation, we are denying the claim, we are asking for the money to be repaid where it was overpaid, and so on like that. We do not have the information yet to exactly break down what were the results of the 5,000 claims. We are probably 3 or 4 months away from being able to do that, but it is something we are tracking.

Mr. SNOWBARGER. Well, how is that going to affect the $23 billion that someone has estimated has been wasted, if we do not follow through and find out that ultimately down the road it actually got paid, maybe at a lower level, maybe—or maybe not at all?

Mr. TILGHMAN. For now, we are accepting the $23 billion projected overpayment as in fact correct based on the information that was available to the auditors at the time that they did it. And we are not trying to dispute that there was a 14-percent error rate or a $23 billion projected overpayment.

Mr. SNOWBARGER. My concern about that is that we have made some pretty specific budget recommendations and assumptions on that $23 billion and what you are telling me is that once you follow these 5,000 cases through, there may be reason to find that there was not the $23 billion there, and we have already——

Mr. TILGHMAN. We do not know yet, we do not know yet whether that is the case.

Mr. SNOWBARGER. I understand that, but $23 billion was—you know, it was etched in stone last summer as the amount of money and my concern is as I looked at the study, it looked like it was taking one case and saying how did you do this, it was done wrong, OK it goes in the bad category, when if you follow that case

through and more documentation were provided, then ultimately it was a claim that was paid.

I guess that leads us to a different question which is who makes the decision about when documentation is insufficient?

Mr. TILGHMAN. First off, keep in mind that we do not request documentation on the great bulk of claims that we process. We started a prepayment review of claims in September 1997, as a result of the CFO audit that was issued, as a way to maybe improve the documentation levels by physicians, and that is one of the reasons that you heard a lot of physicians who are concerned about that right now.

On those, we asked the contractors to pull a random sample of claims with a specific focus on E&M services, on a prepayment basis and then contact the physicians that are involved in that sample and ask them to send in documentation to show that there is adequate documentation before we pay the claim. We give them 30 days to submit the documentation. If they do not submit it within 30 days, we deny the claim. If they do submit the documentation, basically one of three outcomes could happen. First off, the documentation will support the bill, in which case the carrier would go ahead and pay it. The documentation might show that the bill is coded wrong, in which case they would change the code and pay it based on what the code should have been based on the documentation provided.

Mr. SNOWBARGER. Let me go to a more specific question. Who is making the decision that they do not have enough documentation?

Mr. TILGHMAN. The carriers are doing that. The specific type of people they have on board that do that would be primarily nurse reviewers, unless they have a specialty claim that would come in say from an ophthalmologist, in which case they would then consult with a specialty ophthalmologist to review that particular claim prior to making a decision, although I would defer to Mr. Watson——

Mr. SNOWBARGER. So you are saying people at each local intermediary are making decisions about the level of documentation.

Mr. TILGHMAN. Yes.

Mr. SNOWBARGER. How many intermediaries do you have across the United States?

Mr. TILGHMAN. I am sorry, I could not hear the last part of your question.

Mr. SNOWBARGER. How many intermediaries do you have?

Mr. TILGHMAN. We have got a total of 60 contractors in the country that we deal with.

Mr. SNOWBARGER. So you have got 60 contractors perhaps applying different definitions because they make these decisions locally.

Mr. TILGHMAN. Here we would be talking about the carriers which would be our part B contractors, we are looking at 30–35 or so carriers that would be involved in this particular type of review.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman.

Dr. Dickey, congratulations again to you on your election, or whatever exactly may be the case.

Maybe you were in the room earlier in the day when I was talking about the AMA's role in this. Can you give me a little more history on the AMA's role in developing this?

Dr. DICKEY. Sure. I think it is important to know that the AMA got involved in coding back in 1928. In 1963, we published our first predecessor to this book, it was then called CMT, and in 1983, after spending what, 60 years I guess of developing a nomenclature to help collect data, talk better to one another, understand the nuances of communicating, HCFA decided that they wanted to use a single coding system in terms of billing. And so in 1983, AMA and HCFA signed an agreement to use the CPT codes in Federal payment systems. We have, since that time, had an annual update of the CPT codes that indicate new things that come into medicine and changes that require some modification to the codes.

Then in 1991, I think I have got my dates right, with the new RBRVS, there was going to be substantially more money going into office visits, it was felt that the coding for those needed to be looked at. So using our existing system, which is an advisory panel—an editorial panel and an advisory committee representing virtually all of the specialties in the country, they looked at the levels of service, those are the five levels multiplied by different sites and so forth, and defined what those levels were. And it is done by this advisory panel which is an AMA project but has input from specialty organizations and then as a result of AMA's contract with HCFA becomes the mechanism HCFA uses to bill.

Mr. BARRETT. We have heard the controversy today obviously. Is the AMA now taking an approach to collapse some of these or to simplify this?

Dr. DICKEY. Well, actually there were fewer usual office visits until we looked at the E&M codes as a result of RBRVS and I heard the panel this morning and shared with a couple of them individually that there is a great deal of difference of opinion among physicians about whether they want to simplify it, that is, collapse it together or whether they want to spread it apart.

Mr. BARRETT. I do not mean to interrupt you, but—so what we heard earlier, do you think that that is the majority view or the minority view? Again, just out of curiosity. And I hate to put you in that position.

Dr. DICKEY. I have not done a survey on it. I have to tell you that facing the current documentation requirements and our lack of trust that these gentlemen to my right really will not come after us for occasional errors, physicians are saying give me something easier.

Mr. BARRETT. OK.

Dr. DICKEY. But then when they try to use a set of numbers to describe what they do all day every day, they say wait a minute, that patient with a sore throat that came in took me a couple of minutes, I had to look at a lab test and do an exam, is not the same as the patient who is not a new patient but has diabetes, high blood pressure, a family history of heart disease. And if I have to collapse that together, it is not the same process at all. I spent 45 minutes with one person and I spent 4 minutes with another person. I worked very hard to determine what to do with this per-

son and this one was pretty straight forward, probably a third year medical student could have dealt with that particular person.

Mr. BARRETT. Which would argue against single——

Dr. DICKEY. And that is what led to the expansion of the codes.

Mr. BARRETT. Let me ask you this, if I may. As I assume you are aware, the Balanced Budget Act of 1997 required that changes to the Medicare billing be made in a budget neutral fashion. Now admittedly Congress just missed that goal a little bit on the transportation bill where we ran over by a mere $30 billion, which I think will embolden groups to say well, if Congress is not paying any attention to it, why should we. But having said that, my fear is that in the medical community there is this belief that we can fix this, it may cost a little more money, maybe we can have a code that is sort of in the midrange and maybe it will mean that Medicare spending will go from $211 billion to $220 billion, but that is OK. I do not know that that is going to work with Congress and I am wondering whether you feel that the medical community recognizes that whatever changes are made are supposed to be budget neutral.

Dr. DICKEY. I think they recognize that. The problem is that budget neutral is something we talk about when we come visit our Congressmen's offices. Seeing patients every day in our office, trying to honestly get paid for the services that we render, and then getting letters that threaten us with fraud and abuse or worse yet have three-inch letters on the bottom that say dear patient, here is your bill, here is what we paid your doctor. If you have some reason to think they are lying, cheating or stealing, please call us, make it a little difficult for us to practice medicine. [Applause.]

Mr. BARRETT. Let me stop you there, because this is a serious problem. We are going to get—it is going to be $211 billion and we can write you a check for $211 billion and you can divide it. You are still going to have physicians who are going to say I want a bigger piece of the pie. You are going to have hospitals say I want a bigger piece of the pie. And I do not know how you come up with the perfect system. So I think it is simplistic to say that we are just beating up on you.

Dr. DICKEY. Congressman, I do not think we are saying that. I think what we are saying is that our experience has been in the past that it has not been an equitable system. Let me give you the example I am much more familiar with because it has kind of played itself out.

Mr. SHAYS. Excuse me, I just want to make sure. You said it has not been that corrupt a system—I missed what you said.

Dr. DICKEY. No, I said we are not trying to suggest that you just give us more money and we will be happy with it. We want the system to work, but at the same time, our experience has been that it has not always been applied very fairly or equitably. So, for example, if the PRO system in the mid-1980's——

Mr. BARRETT. I am going to have to stop you there because I am running out of time, and maybe I will come back to it because I want to beat up on them a little bit too. I think I understand your point on this side.

Mr. Tilghman, I am going to shift gears a little bit to the PATH audits and give you the experience from my State. And now I am

sort of flipping on the other side here because with PATH audits, which I assume you are familiar with, we have a medical college in Wisconsin who is getting dinged big time for not complying as they should have. They, of course, come to me, ask me to defend them. I am concerned, I do not want to be in a position where I am defending someone if there has been fraud and abuse. So I look at it and I find that the argument that is being made to them is that the regulations are clear and your fiscal intermediary in Wisconsin, Blue Cross and Blue Shield, was very clear to you as to what the requirements are, so pay up—pretty open and shut case.

Then I read about other States where the directive was not given and I think well, geez, if I am an administrator at the Medical College of Wisconsin and I am talking to someone from the Medical College of Connecticut or Kansas and they are not being required to submit billing the same way I am, maybe they are not so clear after all. So rather than paying millions of dollars, I am going to just wait. So I think in the real world that is probably what happened.

What happens then with HCFA is HCFA comes to these other States and says well, your fiscal intermediary did not give you the clear instructions that the fiscal intermediary did in Wisconsin, so we are going to let you off the hook, we are going to let all these hospitals in New York off the hook, all these hospitals in Massachusetts off the hook. And I am thinking if these regulations are so clear, why is HCFA not going after the fiscal intermediary for not doing its job? [Applause.]

Can you answer that question?

Mr. TILGHMAN. That is a hard question to answer. [Laughter.]

The regulations and a lot of our policies are very difficult. I spend my career doing that and they are very hard to understand in many cases. As I said, we employ about 60 contractors nationally, we have 10 regional offices.

Mr. SHAYS. Turn the mic a little more in front of you.

Mr. TILGHMAN. And there are variations that come to our attention between carriers and intermediaries and between HCFA regional offices in the way we interpret various policies. When we become aware of those, we try to fix them and we try not to cast blame on those people that may have been in a situation where they got a slightly different interpretation, that once we got our heads together and figured out, no, we did not quite understand it this way, here is the way it should have been and reach some consensus on it, we try not to go back and cast blame on somebody who would be blameless because they were following instructions they were provided by our people.

Mr. BARRETT. Let me ask Mr. Kopf the same question. If these rules are so clear and the Government has been defrauded of money, should the responsible party not be paying and if it is not the medical school and the regulations are clear, then it would be the fiscal intermediary.

Mr. KOPF. Well, again, it is an interpretation of what they are being told. In instances—you are correct, in instances where the fiscal intermediary has given direct directions to the particular hospital on how things are going to be paid, they are now being pursued. So your question is what do we do with the fiscal inter-

mediary. There are a couple of things. HCFA has the right and the responsibility that if that contractor is not living up to that portion of the contract, throw them out of the program.

Mr. BARRETT. Is that being done?

Mr. KOPF. In the review of contractors—the contract has to be reviewed every year and it is based on the contractor performance evaluation plan I believe. Now if that contractor performance evaluation plan or CPEP has been in any way modified or documented to show errors in favor of the contractor, then the Office of Inspector General, the investigative branch, goes after that particular contractor criminally because that is a violation of law; and yes, we have thrown contractors out Blue Cross and Blue Shield of Michigan; Blue Cross and Blue Shield of California.

Mr. BARRETT. OK. Do you know whether in the PATH audit there are any current intentions of going after fiscal intermediaries?

Mr. KOPF. That I do not know, sir.

Mr. BARRETT. Could you find that out? And I would be curious if that is not the case, because I will tell you how I view it as a representative from Wisconsin, I view it as States frankly with more political power getting funding from the Federal Government that the State of Wisconsin is not receiving, if these States are being let off the hook. And again, I am working under the assumption that I hear from HCFA that these regulations are so clear. If these regulations are so clear, then everybody should pay and either the medical schools pay or the fiscal intermediaries pay. But in those States, I do not see how you can, from a justice standpoint, say justice is done by having hospitals pay but we are not going to go after the fiscal intermediaries.

Could I have another minute or two?

Mr. SHAYS. Keep going.

Mr. BARRETT. Mr. Williams, if I could ask you a question about the False Claims Act. Again, I assume that you heard the testimony earlier today from the hospitals who are not happy with the False Claims Act.

Mr. WILLIAMS. Yes, sir.

Mr. BARRETT. Do you feel that that statute—and the concern I have and I think you may have heard me raise it, I think that there has to be more than just back payment plus interest. I think at a minimum, if you are going after treble damages, you have a higher burden of proof than preponderance of the evidence. And my understanding is right now you can get treble damages with preponderance of the evidence as opposed to clear and convincing evidence. Do you think that that is fair or do you think there are changes that should be made here? If you could comment on that.

Mr. WILLIAMS. I think that maybe the test is reckless disregard or deliberate ignorance is what we have to show under the False Claims Act. And to do that—and they have to knowingly do those things. Knowingly means that a person has actual knowledge of the information, he acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth which means burying their head in the sand and saying well, I do not—I am not going to follow them, I am just going to——

Mr. BARRETT. But are they correct when they say that the burden of proof is a preponderance of the evidence as opposed to clear and convincing evidence? When you use the word reckless, I generally think that you need to have clear and convincing evidence.

Mr. WILLIAMS. The burden is not clear and convincing evidence, sir. I do not think that there needs to be a change because I think we need to have some kind of remedy in the civil area to recoup all of the losses.

Mr. BARRETT. And I agree with you. But can you think of another area of the law where we have treble damages but we do not have a higher burden of proof?

Mr. WILLIAMS. Well, we use the False Claims Act in other areas of the law.

Mr. BARRETT. But other than the False Claims Act. Again, am I wrong? Am I too far away from school to think that in cases where you have treble damages, that is not quite criminal but you are getting pretty close? And it is then appropriate, because it is somewhat akin to punitive damages, to have clear and convincing evidence.

Mr. WILLIAMS. You are correct, sir, but I think there is good reasons for that as I had earlier mentioned. And again, the False Claims Act has not been applied strictly to health care areas. In fact, I think the amendments in the early 1980's did that, and I think the reason for that is because otherwise, we do not have any way, any incentive for say in the cases I gave earlier to recoup. If there is no incentive for say a hospital—and I am sure there is nobody out here, people here are not in that category or they would not be here—if there is no incentive other than if I get caught, all I have to do is pay back what I took wrongfully, then the chances are whoever is engaged in that kind of mindset is not going to do that.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. WILLIAMS. I could give you—I think the 72-hour window is a very good example of that, that project.

Mr. SHAYS. This has been an interesting day for us. The first panel spoke and I followed what they were saying. I am following what you are saying to a degree, but I truly believe that we are looking on one hand at the practice of medicine and the subtleties of the healing arts and on the other we are looking at enforcement of law, the blunt exactitude of—and the bottom line for me is trying to have a sense of what the balance is. And I am really hearing two separate things. I truly think we are ships passing in the night. You all are going after significant waste, fraud and abuse and you are doing quite a good job at it, in my judgment. And yet we are hearing individual practitioners all around the country saying that the law that we passed to make health care fraud a Federal offense for both public and private billings is being used to intimidate individual physicians who frankly—maybe some game the system to make it work and we now have to deal with that—but candidly a lot of others are just filling out forms the way they think they need to.

I am just giving this observation because then I want to jump in. I think that the medical community, particularly your members, are going to have to come to grips with this—that if they allow for

so much variation in coding, it is going to be too subjective. And they are going to have to give up the fineries of being able to allocate what they think are legitimate billings to allow for more clear definition and they are maybe going to have to give up some billing—some revenue in one sense, but it would seem to me HCFA would come in the other way and say well, we do not have to see as much coding and documentation and so on, we will try to find out what that number should be and split the difference with you. I mean, that to me, in a perfect world, would be where we would want to head. I do not like the idea that we are—I mean I read through some of the cases, Mr. Kopf and Mr. Williams, that you cite and I am outraged by those cases. I am just not sure how that responds to what the doctors have said to us.

So what I want to ask you is I think all of you were here in the previous testimony and I appreciate the fact that you were here. Would you comment to what you heard this morning and tell me how that fits into what you do in terms of your work as a prosecutor, your work as inspector general, your work as HCFA and your work particularly as someone who is dealing with billings for a large organization and then, Dr. Dickey, I would like you to respond to the comments you heard before. So I want you to try to tie in what you do and what you heard in the earlier panel.

Mr. WILLIAMS. Chairman Shays, first I want to say that I appreciate Bill Robertson, the senior executive officer of the Shawnee Mission Medical Center's comment about the U.S. Attorney's Office, that we work——

Mr. SHAYS. He is a good man.

Mr. WILLIAMS. He is a good man. We try to work with the medical community and if I could, just one of my attorneys that I have in the area gave 23 speeches between May 1993 and October 1997, 11 to doctor, caregiver, hospital groups, 2 to Medicare beneficiaries, 7 to attorneys and paralegals, 3 to insurance companies and auditors and I have 2 other attorneys that gave at least 15 to 20 between them combined within the—at least within the last year.

Mr. SHAYS. And scared the hell out of them. [Laughter.]

Mr. WILLIAMS. No, I do not think any of them said your name is going to appear in the paper if we come to your door. And they have always given them——

Mr. SHAYS. With all due respect, we are here—we are not in San Francisco, we are here because Vince Snowbarger just heard too many comments and I said I am hearing the same thing in Connecticut, and Mr. Barrett is hearing comments like that in Wisconsin—all over the country we are hearing this.

I know you have tried to do outreach, but I am trying to say to you tell me—give me some examples of the fraud, without using names, of individual practitioners, give me an idea of the kind of thing you see individual physicians do that you think is so outrageous. Do you think we need to simplify the law, do you think we need to simplify the coding? That is what I am going to ask all of you.

Mr. WILLIAMS. What I see, listening to the testimony this morning, honestly is a misconception by the medical community of what we are looking at and it may be two ships passing in the night be-

cause we do not go after the honest mistakes, it just does not happen.

We have a number of investigations going on right now in the State of Kansas in the medical area and without naming numbers or types of professions, but in the medical care area, that is going on to determine whether or not there are violations of the law. I gave you the earlier examples of the psychiatrist. I have some other examples if you would like them.

Mr. SHAYS. Let me just ask you, are you sending physicians letters saying that we just want to do a routine audit, or is that the Inspector General? Are they getting—bottom line, we look at 1 or 2 percent of the billings, we look at 5 percent approximately of the billing charges. So a lot of people are not being looked at. But do you send out a notice to a physician and say, "we have reason to suspect that you are not properly billing Medicare?" I mean, what—how does the notice come? Describe to me the process.

Mr. WILLIAMS. No, we do not send out what is called demand letters. We have not done that and we do not do that in the District of Kansas. If we get evidence of possible violations of the law by the hospitals or doctors, we try to create a dialog, we send out what we call contact letters and invite them in and say this is——

Mr. SHAYS. What does a contact letter say?

Mr. WILLIAMS. Basically it says that we have these allegations of improper conduct and we invite you to the office to talk with our attorneys. [Laughter.]

Mr. SHAYS. And the bottom line to that is that if I were a physician—I am not saying that you—you have got to make contact, but if I were a physician, I would care less about what it would cost me, if I had practiced 30 years in the community, 20 years in the community, 15 years in the community, than about the thought that I would even have to walk into your office. That would frighten me, scare me, make me want to leave the practice, and the more honest I was, the more I would feel that way. And so I do not know what the alternative is but—so you invite them in——

Mr. WILLIAMS. Chairman Shays, but I do not have any cases where somebody has been practicing 15, 20, 30 years and been doing an honest job all those years—we do not have any cases. The type of cases that we prosecute are the type that I have earlier described, of just those few people in the State of Kansas, but it amounts to an awful lot of dollars. So I do not have an example and I did not hear the panel this morning describe any examples.

Mr. SHAYS. How many letters like that go out a year, do you think?

Mr. WILLIAMS. From our office?

Mr. SHAYS. Yes.

Mr. WILLIAMS. I do not have a number, but probably within a year's period maybe 100 or less.

Mr. SHAYS. To physicians?

Mr. WILLIAMS. No, not necessarily to physicians, to hospitals, to individual practitioners. I would say to physicians, very, very few. Now that does not mean that if we have an M.D. out there that is one of that small minority, we are not going to use the full resources of our office, because we are.

Mr. SHAYS. You are not going to get it both ways from me. I mean we have dumped enough on people that have not gone after waste, fraud and abuse, so I am just unsettled as to—unsettled is not the right word. I am trying to get a handle on this, I do not have a handle on it yet.

Mr. Kopf.

Mr. KOPF. I will try and put it——

Mr. SHAYS. I am sorry—and the point I want to make, Mr. Williams, I am not passing judgment on whether you are doing something right or wrong, I am just trying to understand it.

Mr. Kopf.

Mr. KOPF. I will try and put it in some perspective. First, let us look at the CFO audit for fiscal year 1996. One of the reasons that was done, of course, is to look at the program weaknesses and try and correct them. One of those program weaknesses is the coding system, that became clear. Now that is one aspect.

Now let us look at the fraud and abuse side.

Mr. SHAYS. Let me just ask you, do you believe the coding system is too complex?

Mr. KOPF. I think that in some instances it is—there are too many gray areas, and I only say that because of some of the cases that we have brought before the jury when the jury could not decide whether in fact the provider was at fault or not.

Mr. SHAYS. OK, that is an honest response.

Mr. KOPF. On the other hand, up until the passage of the Health Insurance Portability and Accountability Act, the Office of Inspector General only had, throughout the entire United States, 100 to 110 investigators. We now have about 160. By the year 2003, we hope to have close to 400.

Mr. SHAYS. That is for the entire country.

Mr. KOPF. For the entire country.

Mr. SHAYS. With a billing of over $200 billion. That does not seem unreasonable. I need to tell you that, that does not seem unreasonable to me at all.

Mr. KOPF. The point of it is in the areas that we look at, that we concentrate on, a health care investigation takes anywhere from 18 months to 3 years to complete. Our agents, for an average caseload, can probably carry no more than five to eight cases if they are successfully going to go through this. So we look and we go after the knowingly fraudulent carriers, we look at, for example, the DME carriers in south Florida that used to be cocaine runners and now it is more profitable to be in the health care business, so we go after them. We go after the large chain of corporations that from the top down has given memos to their senior staff down to the middle level managers that this is the way you get around the system and this is how you defraud it.

The individual provider investigations really have dwindled. We get, on an average, in our hot line approximately 3,000 to 6,000 calls per month from beneficiaries wanting to know about certain aspects of an explanation of medical benefits. Of that, most of the instances are just a simple misunderstanding on their part as far as what the services were. A very small percentage of that leads to overpayments, and even less of a percentage of that leads to actual investigations, whether criminal or civil.

So on the whole right now, in the Office of Inspector General, we have approximately 1,700 health care investigations ongoing, criminal and civil. This includes Qui Tam allegations as well as the other ones. So we are going after the big fish, we are going after the flagrant people.

Mr. SHAYS. Well, you just triggered a comment to Mr. Williams as well. Thank you for that.

Do you have a trigger point of $10,000 of fraud, $20,000, $50,000? Where does it——

Mr. WILLIAMS. We do not have a trigger point, Mr. Chairman. Normally we do not deal in the de minimis amounts at all, but if it is a health care issue, for example, a health care issue with a patient, then we do not have any actual dollar figure, but we go after the more flagrant ones.

Mr. SHAYS. If it is health care and they are not providing the service to someone and they put a patient at risk, that is one level.

Mr. WILLIAMS. That is right.

Mr. SHAYS. If they are miscoding and at the end of the year you add up $8,000, I realize there are a lot of dollars in the country but—I mean a lot of doctors in the country, but $8,000 adds up, it would seem to me you would want to be going after the big fish and helping those who have misbilled to say, "you have got to change your ways," without prosecuting. Can I make the assumption that that is pretty much the way you proceed?

Mr. WILLIAMS. That is entirely the way we proceed, sir.

Mr. SHAYS. Mr. Tilghman, I am going to go on—just give me another 5 minutes and then I will start the next round.

Mr. TILGHMAN. First, let me say it is a great question and I was jotting some notes down to give you as good an answer as I can, and I have got it in three parts.

The first one, I would have to say that I want to re-emphasize what was said——

Mr. SHAYS. Talk more into the mic, please.

Mr. TILGHMAN. Oh, and I will talk slow.

Mr. SHAYS. No, you will not, I have given up on that. [Laughter.]

Mr. TILGHMAN. I know. It is hard. I will try.

Mr. SHAYS. I know you have tried, but I have given up. I am not going to keep reminding you.

Mr. TILGHMAN. First off, we do not investigate fraud, but we do refer potential fraud cases to the two people on my right. And it is very clear from these guys that they do not want to see us referring fraud cases to them that involve coding errors or lack of documentation that we would identify on what we talked about on the morning panel today. And they would be grumpy at me if I referred a bunch of those type cases to them.

Mr. SHAYS. Let me just be clear though, HCFA would refer to the inspector general. Does the inspector general refer to the local prosecutor? Is that the stage it goes through?

Mr. KOPF. We develop the investigation and then when we have the evidence, we go to the U.S. attorney's office and say if we can prove A, B and C, what would you do.

Mr. SHAYS. Right.

Mr. TILGHMAN. But to re-emphasize the point, we do not even refer those type of cases to these guys because they would laugh

at us, get grumpy at us or whatever, they have enough work to do as it is.

That ties me to the concern, I do not know why there is this paranoia out there among the physician community, among the hospital community, among the home health community, except I know there is an army of consultants out there trying——

Mr. SHAYS. OK, let me just say, you say you do not know why there is paranoia.

Mr. TILGHMAN. Right.

Mr. SHAYS. But there is.

Mr. TILGHMAN. There is, there is absolutely.

Mr. SHAYS. So we are going to find out collectively. The subcommittee, you as well, and we are going to respond to it. It is just not in the country's best interest to have such paranoia.

Mr. TILGHMAN. Correct. [Applause.]

The second point has to do with simplifying coding, which was a question you raised earlier.

Mr. SHAYS. Right.

Mr. TILGHMAN. I heard a great term that came up in the meeting on Tuesday in Anchorage, AK, that we are trying to create billing records rather than medical records. And I thought that capsulized it very, very well. We at HCFA do not want to do that, believe me, we do not want to require additional documentation above and beyond what should be required for good quality medical practice. However, there are 7,500 codes out there. These are codes that were developed by physicians saying here is how we would like to be reimbursed. And we are talking about the CPT codes. We at HCFA want to use those codes, we encourage all other third party payers to use them, which simplifies the overall billing process.

Mr. SHAYS. Let me just interrupt you there. It is also by regions, the codes change by region. So you allow each region to establish their coding system, correct?

Mr. TILGHMAN. No, no, we use a national code, which is owned by the AMA, which is the CPT code.

The only way we have regional codes is if there is some very unique situation in a particular State maybe is not practiced elsewhere.

Mr. SHAYS. So we do not have the problem we had a few years ago where a doctor in some area actually is in two different districts—patients are in two different districts and he or she, the doctor, has to code the same procedure with a different number—that is not the case?

Mr. TILGHMAN. No, that should not be the case. If that is a case, someone should call it to my attention and we will try and fix it, especially for the Medicare Program. Now there may be some small third party payers that do have some variations, but most of them follow the CPT codes that Medicare kind of sets the flagship for. However, at the same time, to tie to the discussion we had this morning which I thought was a great discussion. If there are five levels of codes for an office visit, then as a third party payer, I have to be accountable to figure out why are we paying level three instead of level two or level four instead of level three, at least on the sample claims where we ask for documentation.

The third area on simplifying the law and the regulations of the overall Medicare Program, absolutely we would love to do that. It is a very complicated program, it is a huge program. We basically are the primary regulatory authority for the health care industry in this country which is a $1-trillion-a-year industry and represents about one-seventh of the gross domestic product, so it is a big, big job. But when you simplify it, what you need to look at is what happens to the 39 million Medicare beneficiaries. And a lot of the things that we have that are very complicated in our law and in our regulations and in our policy, is to make things easier for the beneficiaries, the elderly, the disabled, and the sick. And so what that means is the physicians submit the bills on behalf of the beneficiaries. Twenty years ago, the patients in the Medicare Program had to submit the doctor bills themselves. We also have protection for the beneficiaries in terms of balanced billing, in terms of doctors accepting assignment and on down this list. So when you simplify it, think in terms of simplifying it first for the Medicare beneficiaries out there and if that makes things more complicated for HCFA, for OIG, for the DOJ, and the providers——

Mr. SHAYS. I am not sure that they are mutually exclusive, I am really not. My time has run out, but I am going to pursue this.

Mr. Watson.

Mr. WATSON. You asked what we heard today and how it relates. We are taught at Blue Cross and Blue Shield of Kansas that perceptions are true to those people that have those perceptions. I heard this morning from this first——

Mr. SHAYS. Well, let me say something to you, it is more than just perceptions, because I have spoken to doctors who have had to go to Blue Cross and Blue Shield in my State, and justify their billing. In other words, they were told that basically they were being investigated for potential fraud. That just blew their mind. I mean it was like they were on two different levels. One doctor actually went to Blue Cross and Blue Shield to go over all his billings and was left in—came back afterwards, came back in the parking lot and just started to break down into tears, literally thinking of what the implications of this meant, just the fact that anyone would accuse him. So it is not perception, it is reality to that doctor.

Mr. WATSON. What I was trying to get at, sir, is that the words that we say as a contractor, whether we say we believe there is a fraudulent allegation, we believe that there is a medical review need or how you should be taking the information that the Health Care Financing Administration passes to us that we are expected to pass on down to the provider community, that we as a contractor must realize that our words now have a far greater impact upon this community, that we cannot just idly say well we think you are in fraud. If we say that, there is a perception now that this is a real trouble for these people. So we must be careful in the way we choose to go about this.

We also must increase—as we are increasing asking the physicians, or their perception that they are asked to be held to a higher and higher standard degree of compliance than what they have in the past, that we as a contractor must work harder and harder and harder to give them the information and the tools so that they

know that they are in fact meeting all the requirements, that they are in fact not really subjects to random threats of fraud or we are really going to publish your name in the paper just because we think there is something going wrong, that we truly focus on getting the bad guys, the $40 million people, those cases that you have heard, and help the provider community understand what it is that we are looking for and what we can do to help them understand and lower their—I do not know if lower is the word, but help them feel more comfortable with the system. And we have that responsibility now as a contractor.

Mr. SHAYS. I hear you. And one of the things that I am hearing that I have got to realize—and just a short yes or no on this—what I am hearing you say is since we have made it a Federal offense to defraud the system, it would almost be improper for you not to be upfront with them, if you suspect them of fraud and to say well we just want to come and have a nice little chat. And then they realize that the implications are quite serious.

So what I am hearing you say is while I might be uncomfortable with that, there is also a level of saying if you think there is fraud, you have got to be upfront and tell them.

Mr. WATSON. Right.

Mr. SHAYS. Dr. Dickey, and then I am going to go to——

Dr. DICKEY. If I heard your question, you asked me to respond to what these gentlemen have just said.

Mr. SHAYS. Yes.

Dr. DICKEY. And I will try to do it quickly. Mr. Williams said there is a misconception by the medical community of what we are looking at and yet, Congressman Snowbarger said Congress needs $23 billion. If they told you that is what it was, that is what you budgeted and I think what doctors are hearing is if you cannot find it easily in the big players, you will come after us in the small players, and we have real concerns. [Applause.]

I have concerns for you, Congressman Snowbarger, because I also just heard that it takes 18 to 36 months per case and if you are looking for $23 billion, you ain't going to get it for about 3 years. We have all got some serious problems now. There are only a few thousand investigations per month, but every one of us functions as though it were a small town. And so when it is us or our practice—if you have got some allegations, if you have got some information, then not only does the individual physician want to respond to that, but frankly, the organizations of medicine want to help you respond to that. We do not want criminals among our ranks either, but if you do not have the data—and I have been listening as carefully as you have today—if you have not got the data that doctors are defrauding the system, please quit telling the media and our patients that we are liars and cheats. [Applause.]

Mr. SHAYS. Let me say something. I just have to say to you—I am just going to respond to that. We are all in the real world, the system is getting ripped off, we all know it, we have enough proof of it, we are just trying to get the bad people.

In this business, I do not like the fact that everybody thinks politicians are crooks and I could stand up and applaud every time I hear the media say that. Do you want to stand up and applaud now? [Applause.]

So I just need to say to you that it is a reality that there are crooked doctors, there are crooked hospitals, there are a lot of people who are ripping off the system. We just do not want the honest ones—and we who are honest or feel we are honest just have to accept the fact that that criticism is out there and just not feel it applies to us if we think we are honest.

Dr. DICKEY. Let me get to the part that if there are tomatoes out there, we will probably get those instead of the applause. We do have some things on our half that we need to do. There are substantial educational things that need to happen. If there really is a physician out there that is billing a comprehensive visit with two lines of documentation in his or her chart, I do not think any of his or her colleagues would agree that that would adequately communicate the degree of complication of what we now call a level 5 kind of visit. We corrected hospital documentation 20 years ago, it was painful, there were a lot of unhappy doctors when it happened, but hospital charts today are a totally different animal than when I started practicing 20 years ago. Simplification may be an easy answer while we are looking at fear that we may get accusations, but it is not—medicine is not getting simpler, it is getting more complicated. And so what we would like is to put together a set of coding that appropriately, when asked, communicates to the payor and to the investigators for the payor what it is that we did, but not make it such a complicated set of coding that we become coders and documenters rather than physicians. And we believe that we can get there partly if we can get to a system—if in the next few months, we can develop a system where when there are problems, the first interaction is educational that says here is why what you are using for documentation is not acceptable. And that is what I was getting at earlier, Congressman Barrett, when I said our past experience has been, first we seem to have to shed blood, then we go back and say oh, there is a way we can work together to make this work for the benefit of my patients, their beneficiaries and your constituents. I would like us to start at that level rather than having to shed the blood first.

Mr. SHAYS. I think those are sensible recommendations. Mr. Snowbarger—what we are going to do, at the max, is five and five and then we are going to go right to the group and we will see how much time we have and divide it accordingly. We are going to get out of here at 3:40.

Mr. SNOWBARGER. OK, Mr. Watson, if I could direct my first question to you and I need a short answer because I will run out of time. Could you real quickly go through the process on how you handle a claim. The physician submits it, now what happens within Blue Cross and Blue Shield?

Mr. WATSON. Yes, I will be glad to. The physician or the provider submits a claim. Generally we receive these claims in an electronic file format. The file itself is edited for what is considered a consistency error, make sure if it is supposed to be in alphanumeric, it is in alphanumeric; if it is numeric, it is numeric; if it is alpha, it is alpha.

Once the claim comes in, it then goes against another series of audits—excuse me, of edits, edits such as is this the correct HIC number for this patient, are the services that are rendered appro-

priate so we are not doing prostate surgery on females and such as that. It then goes to other edits such as the secondary payer edits, it will also hit the medical review type edits to decide if it is meeting all those criteria.

Once it is established that the claim itself is a valid claim and has met all these edits, it is priced. It is sent to the common working file host site which verifies the eligibility and the deductible and copay status.

From there, it comes back to the carrier or the intermediary for payment. Usually this process takes about 10 days and we make our payments within the 14th to 20th day after receiving the claim.

Mr. SNOWBARGER. What happens when you find a claim that is not valid, after going through your screening processes?

Mr. WATSON. If we find a claim, if it is a prepay claim, a prepay edit on a medical review, generally these claims will suspend out to a staff, a person that has been trained to work them. Sometimes this person is able to look at this claim and decide in fact that the claim should be paid, that parameters have been set up by the medical review—by the medical directors, saying that this is OK, within this range and with these codes, it is OK to pay these claims. Most times we request the medical record to be sent to us so that we can examine what is on that claim against the medical record.

After we have decided that the medical record does support perhaps what is on there, the claim then goes through the rest of the process to pay. If we feel that there is a need to reduce the payments for certain reasons, that some of the services were not medically necessary, then that action is taken and that part of the claim is processed and paid and the other part is denied. If we feel that a total denial is necessary, we do that.

Other times, we will expand our review and bring in outside consultants, whether they are doctors or other specialists, to make sure that the decision we are making on denying or approving this claim is correct.

Mr. SNOWBARGER. Do you ever take an intermediate step of having your claims processor call the office to find out if there was some inadvertent error?

Mr. WATSON. We do that, yes, particularly in the instance where a beneficiary will call in and say I did not see this doctor, I did not get this service, I do not believe this is what I got. Many times, we call the provider's office and say we have an inquiry about this claim, what can you tell us, or can you supply us the records.

Mr. SNOWBARGER. Thank you. This is a question for all of you. As I understand it, the AMA has information, education, directed toward Medicare claims.

Dr. DICKEY. Right.

Mr. SNOWBARGER. Mr. Watson, I assume that as the intermediary and the one that really has direct contact with the health care providers, that you are providing some kind of educational opportunities from time to time.

Mr. WATSON. Yes.

Mr. SNOWBARGER. From the Health Care Financing Administration, I presume that you go beyond just printing regulations and expect everybody to understand it, I presume you have means by

which you, talking to various groups or whatever, try to educate them on proper billing practices, which gets me to Mr. Williams. And I understand that you are doing a wonderful job out there educating, but when the teacher standing in front of you is from the U.S. attorney's office, I think it may set a tone that lends to the perception that this is an adversarial relationship. We had the earlier panel, and we asked do you feel like this is an adversarial relationship, and to a person, they said yes.

So for each of you, I would like for you to respond to the same question, do you consider this an adversarial process.

Mr. WILLIAMS. Mr. Snowbarger, maybe I misunderstood. I tried to listen to the panel, but I was on one of the first two rows so there was an echo there. I did not think the panel was referring to the U.S. attorney's office, maybe they were, on an adversarial relationship.

Mr. SNOWBARGER. I do not think they differentiated. I will be surprised if you say it is not an adversarial process, I think that is what being the U.S. attorney is all about actually.

Mr. WILLIAMS. Well, the U.S. attorney's office, we look at cases involving civil and criminal fraud. Our investigations, our prosecutions are all fact driven and wherever the facts take us—you know, I was taught a long time ago, get the facts and that is what we do.

The talks that we give, and I have given a couple of them myself, have been more in the way of education, you know, asking questions, asking the audience to ask questions. We have had a lot of followup questions and maybe it is just the nature of the system that is adversarial, but we try to be informative, tell them what our office does and why and the system that we employ in looking into these things.

Mr. KOPF. I have talked to hospital groups about the new compliance plan, I have talked to the hospice groups about things there and I have been about eight different places trying to explain what the OIG does. I have yet to be asked to dinner by anybody that was in the audience, so yes, it is adversarial. [Laughter.]

Mr. TILGHMAN. Let me go back to a conference we had in Washington, DC, 3 weeks ago. We invited 300 of the top people in the country that are involved in fraud and abuse activities from the OIG, FBI, the provider community. We had—Secretary Shalala was there, Senator Graham, Senator Harkin and Congressman Barton, and we spent 2 days trying to figure out what we need to be doing to do better on combating fraud and abuse, not just in Medicare but in health care in general. We had Dr. Malcolm Sparrow there from Harvard, who wrote the book, "A License to Steal" which is kind of the bible now that a lot of people are following. And one of the key issues that came up out of that as we discussed kind of the results of what came out of the meeting, was there is this adversarial relationship between us at this table and the provider community, and it hurts us in combating fraud and abuse and we thought one of the action items we need to address and address quickly is how do we come to partnership to work with the hospital association, the medical society and the other people that ought to be our partners in combating fraud and abuse instead of

our adversaries. Some things we are trying to figure out how to do, but you are absolutely right that there is not that partnership now.

Mr. SNOWBARGER. My time is expired, so if we could get a real quick response, to keep us on track.

Mr. WATSON. It appears that the climate has started to get into a more adversarial climate than what I have experienced in the past, but I have been in the side of it that has always been kind of the side that is looking over the shoulder of the practitioners, but it has become a little more that way. And I think education and campaigns to help educate what is and is not appropriate is where we need to be headed.

Dr. DICKEY. I think the individual physicians no doubt consider this adversarial. I think that the organizations the physicians work with frequently partner with many of these people here. You have heard about the AMA/HCFA partnership. Most of us sit with our intermediaries at our State medical association meetings, but any time that there is a substantial change and a change that somehow seems to come in with a fury and then quiets down, that adversarial relationship at the individual level carries over to the organizational level as well.

Mr. SHAYS. OK, Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman.

A couple of weeks ago, I had a couple of constituents talking about my being a politician and they said how does it feel to have everybody think you are a scum. I thought, geez, I did not know everybody thought I was a scum. [Laughter.]

But when people ask me about politicians, I tell them it is the 90 percent who screw up that make all of us look bad. [Laughter.]

And that is not the case for physicians. For physicians, it is the 1 percent or the 2 percent or whatever. But Dr. Dickey, I have to admit I was offended with your statement. You know that we are not the ones feeding these stories to the media about physicians screwing up. We are not the ones going to "60 Minutes" with that kind of stuff. It is some physician who is screwing up that is doing that. And it is only going to take 1 percent or 2 percent of the physicians to give many physicians a bad name.

I came down here because I am interested in a constructive dialog on how to address this issue, not to play to the crowd. And I do not think that we advance our cause if we simply say big bad government, stop beating up on these little guys, because I want Mr. Williams to go after the people who have committed fraud. And I understand and I agree with Mr. Shays, I would not want to get that letter, I would be terrified to get that letter from his office and I hope that he uses them judiciously. But there is a problem here and I have to tell you a story.

A couple of years ago, I got a letter from a physician and he was complaining about Medicare payments, saying that the Medicare payments were too low, Congress should increase the Medicare payments to physicians. I thought fine, that is not an atypical letter. Two weeks ago, I got a letter, and I recognized the guy's name, it was from the same guy. And he was complaining because his taxes were too high—same guy—2 weeks later. And I thought, where does this guy think Medicare money comes from? What is going on here.

In Congress, we are cutting spending for foreign aid, we are cutting spending for welfare, defense spending is not going as high as people would like. Anybody who pays attention to these issues knows that the fastest growing part of our Federal spending is basically health care. And just as Willie Sutton robs banks because that is where the money is, that is what we are seeing. We are seeing people who are going after the health care system to get money.

I do not want to see the U.S. attorney, HCFA, the OIG going after physicians that are doing a good job, but I do think that we have a responsibility here to try to do what we can to make sure this system is fair. And just as politicians are unpopular, physicians can be unpopular here. And in here, there is a lot of anger, but I have never been to Kansas City, KS, before and as I was walking in, I noticed there was a Blockbuster Video across the street. I would bet I can walk in that Blockbuster Video across the street and say do you think physicians are underpaid, they would say no. So if I wanted to play to the crowd, I could go and do that.

But I want us to have a constructive dialog. And the AMA has played a much bigger role than Tom Barrett or Vince Snowbarger or Chris Shays in putting together this formula or whatever it is, these 7,500 codes. And I have gotten mixed messages today as to whether the AMA even wants it. I do not know after today's testimony whether you think we should simplify or you do not think we should simplify. And I think we could go a lot further in having a constructive dialog if I even knew which way you wanted to go.

Dr. DICKEY. I apologize for saying you quit calling me because that was kind of a global you, and unfortunately it is not the letters from the intermediary that says you lied and cheated. Those are letters that—those are messages that go out on the bottom of all kinds of communications to payments—to patients, I am sorry, that suggest that it is widespread, that you had better check everything your doctor does. And the doctor in the last panel that suggested that we need to help you, because you developed the Medicare Program, create ways that we partner with our patients will go a long way toward helping the fiscal issues as well as the relationship issues.

AMA does want to be a part of the coding system, as I said in my opening remarks. We believe that physicians need to be a part of and know ahead of time what the rules are. And in fact, when we went to the E&M codes—and we are not talking about 7,500 codes here, Congressman, we are talking generally about 15 or 20 codes, the office visit codes are most of what you are hearing about right now, and those are 10 or 15 different codes that are there.

When those codes went out originally with vignettes, it was this relationship that caused part of the problem because doctors said I am concerned that the vignette description you have given me will not be read the same way by the intermediary and they are going to tell me that I did not provide the level of service. We came back after hearing that, we being this advisory panel of physicians and HCFA, and wrote documentation guidelines and those answered some of the problems and doctors said again they do not answer all the problems and we went back and wrote the ones that were supposed to take effect in January of this year, the 1991 guidelines.

They are extraordinarily detailed guidelines, the physicians who sat on that panel believed they had represented what was needed, because intermediaries had said we will never pay more than a level three to family doctors, you do not see complicated patients. That is simply not true, but it was a judgment that was made.

So in an attempt to answer concerns like that, these very, very detailed documentation guidelines came out. They were signed off on by the AMA and the specialty societies—we thought we had done a good thing. But when they got out in the hands of the physicians, physicians said my gosh, I just cannot make this work in my office. And so we want to be a part of a new correction of these guidelines that meet our coding and documentation—our patient care problems first, but then will allow us to answer questions if one of the intermediaries calls and asks us about the documentation.

But we also want to make it very clear that it is important that the assumption is that we have got a learning curve. We are changing the rules on you. And so if you do not get it right, let us assume that we need to come out and educate and then re-measure rather than assuming that I was going out—and everything these gentlemen have said substantiates that. The individual physician is not where the biggest piece of fraud and abuse is, but unfortunately, if you get hauled into jail and fingerprinted before somebody asks the questions, it does not feel very good. And physicians are concerned and worried because perhaps it is partly our fault. Although we told people heads up these are coming January 1, nobody paid a lot of attention until it was almost time and then they went whoa, this is bad news.

We have committed to hearing physicians all over this country and we are going to hear the ones who want to split them apart even more and the ones who want to lump them together and simplify them, and try to come up with guidelines that work better for doctors. But they also have to work for HCFA because HCFA is going to use them for billing.

What we need is some commitment and understanding I think when our physicians, your constituents, come to you is that we need some time to roll these back out, we need to be able to educate them, that had not happened before they came out in January; we need some assurance that if we do this 1 percent of review, that it is not going to be the assumption that we are defrauding the Government, but the assumption will be that we can learn and educate.

I have now talked to half a dozen State medical associations who have said Mr. Watson, if you have a problem with an individual doc, refer him to us, we would be happy to help educate him or her. We would like to be in the loop, Mr. Barrett, we want to make this work for you and for us, but most importantly for our Medicare patients.

Mr. SHAYS. Thank you very much.

Let me say to all of you, all of you have represented, I think, yourselves well in this panel and I do think that part of the frustration is that we just have a lot more work to sort this out. I do not think it is realistic that we are going to resolve all these dif-

ferences and see the nuances in one hearing. We made that attempt, but I do not think it is all that realistic.

All of our panelists agreed just to stay seated and to hear the comments, so they are going to listen like we are. I believe we have 17 people who are going to speak. We are going to give each 2 minutes. I am going to be tough on this because I have some of my staff that are getting airplanes at 5 o'clock and they have to tear things down and get set.

So we are going to have groups of four and the first group, if you will just stand in line, we are going to do some good listening and we welcome you to make your comments and then you are going to bring your card over to Jesse Bushman, who is our clerk, and I want to take the time to thank Jesse for his work today and also the subcommittee staff, Marcia Sayer and Cherri Branson and also representative Snowbarger's staff, John Kerr and Lisa Browning. I thank all of you on the staff who have helped make this possible.

You have got 2 minutes.

STATEMENT OF WAYNE LETIZIA, M.D.

Dr. LETIZIA. Chairman Shays and Vice Chairman Snowbarger, Mr. Barrett, thank you for the opportunity to address the hearing today. I am a physician in private practice in Independence, MO.

I would like to flesh out some of the reasons for the perceptions that we have experienced today.

In October HCFA required us to have a number on our claim forms that was under the aegis of the CLIA. There was a grace period to December 31 and as of the first of January, the number absolutely had to be on the claim form. I started putting this number on my forms the beginning of December. Beginning December 29 of this year, my claims for lab work were denied by the fiscal intermediary because I did not have the CLIA number on my claim form. It turns out that the fiscal intermediary's computer strips this number from the claim forms and did for about 3 weeks.

I still have not received all of my claimed reimbursement for lab work done. My patients were told that I am not qualified to do these tests and to make matters worse, I received a letter that I have a large number of claim denials that were reversed on appeal and maybe I should use more care in filling out my claim forms.

I think this is one of the reasons why there is this distrust between providers and the other side of the table, sir.

The second comment I would like to make is that I am one of those defrauders of Medicare, I guess, I signed one of those letters. A number of years ago, I had some charts reviewed because of an outlier situation. The long and short of it is that when the situation was resolved, I was given three choices. Choice No. 1, you all are totally right, here is the money, I promise never to do it again. Situation No. 2, you are right, but I have a little more documentation for you, tell me how much money I owe you and I promise never to do it again. No. 3, I disagree with your findings, come and audit all of my charts. I understand that an IRS audit is a piece of cake compared to a Medicare audit.

I see my time is up, I have several other comments, but I will reserve those. Thank you, Mr. Chairman.

Mr. SHAYS. Let me ask. There were four people in this group? I just want to be sure, there are two others in group 1? OK, thank you, sir, I really appreciate your comments.

STATEMENT OF RICHARD WARNER, M.D.

Dr. WARNER. I am Dr. Richard Warner, I am a psychiatrist here in Overland Park, KS, and I am president of the Johnson County Medical Society. On behalf of the society, I want to thank the committee for coming out from Washington to hear our views on this.

I think the panel has done a wonderful job today of describing all the complexities in a general sense. I would like to tell just one simple story to kind of give an impression of how this may affect patient care.

Sometime not long ago, I got a call from a patient of mine, an 80 year old lady, who said, Dr. Warner, I know I am not scheduled to come in and see you for another couple of weeks, but I really need to come in much sooner if I can. I saw her shortly, she came into my office and sat down and kind of slumped and said I just feel like it is over for me, I know that my doctor thinks I have Alzheimer's disease, he has not told me that but I just know it is over. I said, Betty—that is not her name, but I have asked her permission to tell this story and I will just disguise the name—I said, Betty, how do you know that. And she said well, he has been my doctor for 20 years and through all that time, he has always been one to listen to me and talk with me about the things going on in my life and has always been very interested in me. But when I saw him the other day, it was totally different, he spent all of his time writing in the file and he spent—he asked me a lot of little questions and just kept writing and we never really did talk about what I was wanting to talk about, the pain in my leg. And so I figured he must just figure that I am over the hill, that my thinking is not what it ought to be and I am just not worth talking to.

Well, I told her, Betty, I do not think that is the situation at all, I do not think what happened in the office has anything to do with what your doctor thought about your mental abilities. And I said to her directly, I think it has to do with a change that is occurring in Medicare. Your doctor has to write down in progress notes a lot of very complicated details in order to justify the claim that he is going to send to Medicare. And if he does that wrong and if it adds up and there are a bunch of claims like that, he even faces $10,000 fines for that.

Well, she was relieved, I think, to know that it was not her mind that was a problem, but saddened by what was happening to the care.

Mr. SHAYS. Thank you, sir. Yes, sir.

[The prepared statement of Dr. Warner follows:]

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April 12, 1998

The Honorable Christopher Shays
c/o Lawrence J. Halloran
Staff Director and Counsel
Subcommittee on Human Resources
Committee on Government Reform and Oversight
B-372 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Shays:

On behalf of the members of the Johnson County Medical Society, I would like again to thank you, Congressman Snowbarger, and Congressman Barrett for holding the field hearing of the Subcommittee on Human Resources in Kansas City this past Thursday. I know from the various comments of my colleagues after the hearing that we all felt it was a productive exercise in democracy, and we look forward to the further attention that you and the Subcommittee will be giving to the difficult issues that have been opened.

I would like to take this occasion to add to the record some further thoughts that are stimulated by some of the questions and observations that the three of you raised in the hearing.

Congressman Snowbarger mentioned that when Medicare was started in 1965, it was budgeted for $3 billion and projected to cost $9 billion annually by this time. Instead this year's budget calls for $211 billion. Perhaps the most important question is "What did people not know in 1965, and have we learned anything in the interim?" I am sure that the rapid advance in the technology of medicine may not have been foreseen, and the changing demographics of aging may not have been projected accurately, but I do not believe that those factors fully account for the 2300 % error in projection that occurred.

I believe that the more basic problem is inherent in the structure that insulates patients from all but the least costs of their health care and deprives them of any personal incentive to shop wisely, demand accountability, and prevent whatever fraud or abuse there may be. For over three decades most people have had their health benefits provided by employers by way of defined benefit plans, and they have been able to remain ignorant of true medical costs. When they are enrolled in Medicare, they find a program with

very low deductibles and small copayments, most of which are covered by a Medigap insurance policy. Twenty years ago my father complained to me that, when he asked a doctor what a procedure would cost, he would be told, "Don't worry, Medicare will cover it." I am afraid that has been the norm throughout the history of the program, but the motive for the question has changed. My father's concern was for what it was costing all of us; I rarely hear the question asked in that spirit now.

If patients would pay some percentage of each charge incurred, they would be discriminating about the need and value of each item. It is hard to imagine a medical equipment supplier bilking the system of $80 million for "female urinary collection devices" if individual people had reason to look to see that they were being charged $9 per item, as Mr. Williams testified. More importantly, they would be in a position to demand quality and efficiency from their physicians. There are a number of proposals to encourage patients to assume first party responsibility for medical decisions, and these will no doubt get a good hearing by the new Medicare Commission. I am attaching a copy of the AMA's proposal, Rethinking Medicare, which has much to commend it.

The fact that patients are not in the position of primary responsibility has led to inevitable inflation, far beyond the inflation rate of the economy as a whole. If patients do not play their natural role in transactions, then it is left to accomplish cost containment by construction of a bureaucracy. Because that more complicated approach is never fully effective, it grows more complicated as the years pass, and we accumulate 45,000 pages of regulations. In that light the Evaluation and Management Guidelines make their newest appearance, and the complexity with which they burden medical record keeping becomes an outright intrusion on the practice of medicine.

You rightly noted the atmosphere of anger and fear among doctors. Doctors are angry because they are having to take much valuable time to write in the medical records details that are not pertinent to the patients' problems. Even their interviews of patients are being affected in such a way as to interfere with the clinical process of gathering information, explaining diagnoses, tests, and treatments, and helping the patients to cope with their problems. To think that lack of enough attention to irrelevancies may result in ruinous penalties is intolerable.

The gentlemen testifying to the enforcement measures seemed surprised that doctors would fear their activities. After all, their real interest was in the "big boys", the purveyors of multimillion dollar frauds. It is not their intent to make life difficult for doctors who are simply making inadvertent errors. Part of the problem is that doctors are having to rely too much on expressions of the auditors' and prosecutors' intentions. The wording of the laws and regulations do not contain much in the way of checks on prosecutorial zeal, and there are plenty of known instances of heavy-handedness on the part of federal agents not only from HCFA, but also the IRS, OSHA, and others. Doctors know that even to become the object of an audit is likely to be an extremely expensive affair. The President is even talking of wanting to remove the protection of bankruptcy in instances of Medicare fraud and abuse. How are physicians not to fear total ruin?

Interestingly, none of the dramatic examples of fraud cited by Mr. Williams or by other HCFA personnel in the press have anything to do with the minutiae of the E&M Guidelines.

Congressman Barrett asked about the lack of response to Medical Savings Accounts. I would suggest there are several reasons these have not yet caught on with the public. Because their allowed number is relatively small and restricted to only the smallest companies, it has not been worth the while of insurance companies or possible trust administrators to develop competitive plans and market them vigorously. I believe the public remains fairly uninformed about the idea. Also, having to fund the savings account with a lump sum of around $3000 would be difficult for anyone with tight cash flow. I hope Congress will look at opening up the approach to all companies, and perhaps allow self employed people to initially fund the account by transfers from KEOGH or IRA accounts.

To think about all of this legislatively, I realize that some of the things I am suggesting in terms of structural change are perhaps not strictly oversight matters. And I agree with Congressman Barrett, that we do not want Congress writing the rules for medical record documentation. Yet I believe the Subcommittee can play an important role in guiding HCFA to delay the implementation of the documentation guidelines pending not only their simplification and improvement, but also the outcome of the structural changes that will be recommended by the Medicare Commission.

I appreciate your statement of intention to hold further hearings in other locales, and I hope that your subcommittee will be the ears of Congress as Medicare restructuring is debated in the next year. I know that the doctors of the Kansas City area were grateful to be heard, and I hope you benefited from spending the day with those of us out here in the trenches. If I can be of any help to you in your work on these issues, please let me know.

Sincerely,

Richard B Warner MD

Richard B. Warner, M.D.
President
Johnson County Medical Society

cc: The Hon. Thomas Barrett
The Hon. Vince Snowbarger

American Medical Association
Physicians dedicated to the health of America

Rethinking Medicare:

A Proposal from the American Medical Association

Solutions for Medicare's Short-term and Long-term Problems

Executive Summary

In its first session, the 105th Congress took major steps toward reforming Medicare. It added the Medicare+Choice program to expand beneficiaries' choices among private health plans significantly beyond the limited choices available in Medicare's risk-contracting program. It provided for the appointment of a National Bipartisan Commission on the Future of Medicare to rethink the financial and benefit structure of the program and make recommendations to restore its financial solvency.

The AMA has long argued for expanding the choices given beneficiaries beyond the traditional fee-for-service program and applauds the Congress and the president for Medicare+Choice. However, the experts project that the traditional program will remain the choice of the majority of beneficiaries for the foreseeable future so that it will continue to be the major force driving the program's cost at unsustainable rates. Consequently, rethinking Medicare must also focus on improving the efficiency of the traditional program to reduce its cost growth.

This document presents the AMA's proposal for restructuring Medicare to assure its financial solvency for the baby boom and subsequent generations of Americans.

There is a better way to finance health care for aged Americans than increasing taxes to fund Medicare expenditures for future generations of retirees. With continued medical cost increases and increased demand on the program from the retiring baby boom generation, expenditures will rise dramatically and require significant, politically unpopular tax increases if pay-as-you-go financing is retained. Switching from the current tax-based pay-as-you-go system to a system of private savings invested in the private economy will drain less from American pay checks and pocket books, increase disposable income, and provide a secure source of funding for the retirement health care needs of future generations.

Meanwhile, the traditional Medicare program must be made more efficient and cost-effective.

The AMA recommends two structural reforms to the traditional program that will assure that Medicare costs no more than necessary to fulfill its promise the current and future generations.

First, the long-recognized inefficiency due to private supplemental "medigap" insurance should be corrected. Through medigap, beneficiaries convert Medicare into first-dollar coverage and defeat the intended constraints of cost sharing. The AMA's proposal to reduce Medicare's exorbitant cost-sharing requirements to levels that beneficiaries can tolerate without resorting to insurance against them can save the Medicare program and beneficiaries substantial sums.

Second, the systems of price controls that threaten the quality of services delivered to beneficiaries of the traditional program should be abandoned in favor of meaningful price competition. The ability of the government to administer prices adequately has met the barrier of the methodological impossibility of adequately measuring and allocating overhead on a per-service basis. The government must allow physicians the flexibility to set their own prices to reflect cost. Price competition, enhanced by proper incentives for beneficiaries to seek value in the market, would assure beneficiaries and the taxpayers that they do not pay more than necessary to keep Medicare's promise of adequate access to medical care for our elderly citizens.

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Introduction

The imperative to reform Medicare to meet the needs of those dependent on it and to keep the promise of health care for future generations of elderly Americans should be accepted now by all. For several years, notices of the impending Medicare crisis have been detailed to us by policy analysts, politicians, and the media. Medicare's current structure makes it highly unlikely that the promise of health care for the elderly can be sustained as the baby boom generation retires. The increasing tax burden on a relatively shrinking proportion of working Americans that would be required to support the program does not seem politically feasible.

Many of Medicare's problems are now understood to be inherent in its design. Medicare is–*as it should be*–a promise to help provide insurance for the most urgent, complex, and unpredictable services all of us will need in our lifetime–medical care in the stage of life when our needs and vulnerability are greatest, with freedom of choice and quality as hallmarks. No matter how the system is changed, keeping this promise will be expensive and spending will grow at a rate above inflation. Because technological progress will inexorably offer new ways to extend our longevity and improve our quality of life, our demand for medical services will increase. Therefore, pegging growth to increases in other sectors is ill advised. Does anyone really believe that the incidence of illness and the prevalence of disease that can benefit from medical treatment are related to changes in the gross domestic product? Expectation of savings must be realistic and it must be acknowledged that continued government help for these services is among the nation's highest priorities. Medicare will stay, and it will continue to grow. The way it is implemented must change if the program's financial integrity is to be maintained.

The real problem with Medicare is that it contains almost no incentives for providers of services, or for patients, to be efficient in providing or using medical care. There is no competition among providers in price, no efficient mechanism for the system to adopt marketplace innovations, no effective cost sharing among beneficiaries, and, in many respects, very little freedom of choice for beneficiaries. In short, Medicare is a program without the structural incentives that allow economic forces to foster efficiency

and restrain expenditure growth. The absence of incentives has caused the program's spending growth to spiral to unnecessarily high rates. Those who regulate Medicare have compounded the problem of rapid growth with price controls that endanger its promise of first class medical care for elderly Americans.

Because the sources of Medicare's problems are easy to see, a consensus is emerging on some elements of Medicare transformation and renewal. First, the Administration and Congress succeeded in 1997 in *increasing* the range of choice for beneficiaries by creating the Medicare+Choice program. The American Medical Association (AMA) supported this expansion of choice–as a voluntary option to traditional Medicare—and believes that it should be funded by a defined government contribution and administered similar to the successful health plan provided to federal employees. Moving Medicare from an open-ended entitlement toward a defined contribution is key to gaining budgetary control over outlays.

Second, many analysts believe that significant savings for both beneficiaries and government are available in making Medicare's intended beneficiary cost sharing provisions more effective. The AMA agrees and is proposing that the traditional Medicare health plan be modernized in a novel way that will *decrease* beneficiaries' out of pocket costs *and* obviate their need for additional health insurance beyond Medicare. Restoring the effectiveness of cost sharing can exert a substantial dampening effect on expenditures.

Third, there is growing recognition that Medicare's payment systems do not encourage efficiency and are endangering the quality of services provided to beneficiaries. They are also believed to facilitate fraud and abuse because beneficiaries have no interest in the prices or services that providers bill to the program. The AMA proposes meaningful price competition that rewards both beneficiaries and providers for efficient behavior but also guarantees beneficiaries substantial access to care at no out-of-pocket cost.

Fourth, the AMA agrees, along with the vast majority of Americans, with Medicare's promise that *the best of American medicine should be available to baby boomers in their retirement*. To guarantee this, we believe that incentives for personal savings must be built into the system to supplement the program. Moving away from the current pay-as-you-go financing is necessary to relieve the potentially onerous burden on taxpayers of financing Medicare.

Medicare will have to be changed in fundamental ways. The chapters that follow present an economically sound proposal to do so. We believe the rate of Medicare's expenditure growth can be slowed to within a few percentage points above inflation. But regardless of how the change in Medicare is accomplished, it will be our overriding goal to ensure that the change not damage the essential elements of the patient-physician relationship, i.e., that we bring the good innovations from the private sector but not its excesses. Above all, change cannot break the bond of trust between patient and doctor that makes medicine unique and makes it work best.

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Background

Medicare's structure and problems

Most think of Medicare as a government insurance program covering health care for Americans who are age 65 and older. However, because Medicare benefits are somewhat meager compared with the employer-sponsored benefits that many beneficiaries enjoyed during their working years, most beneficiaries are covered by various supplements to Medicare. These supplements are private insurance policies that they or their former employers purchase, or that are provided by other government programs such as Medicaid. Seventy-eight percent of Medicare beneficiaries are covered by private Medicare

supplemental policies (called "medigap") which essentially convert Medicare into first-dollar coverage by paying Medicare's cost sharing (i.e., deductibles and co-payments) requirements. Another 12% are eligible for Medicaid that also covers Medicare's cost sharing requirements.

In all, almost 90% of Medicare beneficiaries have coverage beyond basic Medicare benefits. Therefore, Medicare must be viewed as more than a public program. It is a combination of insurance coverages, both public and private. The combination of coverages expands the scope of Medicare's problems far beyond those that would prevail if Medicare were not supplemented by other coverage. It also magnifies the practical and political difficulty of dealing with Medicare's problems

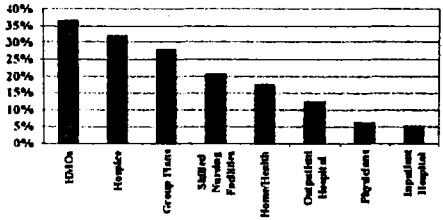
Because the term "trust fund" is officially used to describe the financing of Medicare, many people think that the payroll taxes they pay are saved and accumulate interest to pay for their medical needs in retirement. In fact, the Part A program is financed on a pay-as-you-go basis, with taxes paid into the program being used to pay for the benefits received by current retirees, and the excess used to purchase federal debt. Part B is financed mostly out of general revenues, with the premiums that retirees pay calculated to cover only about 25% of the outlays. Part B is modeled after private sector health plans, but whereas premiums in private plans cover 100% of outlays, beneficiaries fund only 25% of the cost of their services through premiums, leaving taxpayers to fund nearly all of the remaining 75% of the cost of providing Part B services.

Most retirees have received many more benefits than their contributions to the program could purchase. The pay-as-you-go financing of Part A of Medicare is often likened to a "chain letter". The similarity lies in the promise of future benefits to those who fund services for current beneficiaries, and the need for a growing number of new contributors to fund the growing number of beneficiaries. Chain letters must eventually collapse from an insufficient influx of new participants. The number of workers contributing payroll taxes to finance the hospital trust fund is declining. In 1965 when Medicare was enacted, there were 5.5 working-age Americans for every individual over 65. Today, there are only 3.9. In the coming decades, as the baby boom generation continues to age, the number will fall more rapidly. By the year 2030 there will be only 2.2 working-age Americans for each individual over age 65. By that time, Medicare will enroll 20% of the population, compared with 12.8% now.

Theoretically, Medicare need not collapse if Congress is willing to use its power to tax to make up for the falling ratio of Medicare contributors to beneficiaries. Medicare actuaries estimate that the payroll tax would have to be increased immediately from its current level of 2.9% to 7.4%. This would bring the combined tax rates of Social Security and Medicare to 19.8%. However, a tax increase would also be necessary to bring the Social Security trust fund into future actuarial balance. The Social Security trustees have estimated that the payroll tax would have to be raised from the current 12.4% to 18.8%. Thus, the payroll tax rate for a tax-based bailout of Social Security and Medicare is 26.2%. Increasing taxes this much is not politically feasible. Congress has looked for other ways to save Medicare.

Medicare's expenditure growth must be constrained. Figure 1 illustrates the rates at which Medicare outlays increased in fiscal year 1996 for the various types of services it purchases for beneficiaries. The high growth rates for many of the services are due to a combination of factors, including increased beneficiary demand for new services, slow program response to known flaws in payment rules that encourage high volume growth in some categories of service, insulation of most beneficiaries from cost considerations, and ineffective approaches to cost control. Over the long term, growth in the number of beneficiaries as well as increased life expectancy will add new financial burdens to those already pressuring the program.

Figure 1
Components of Medicare Growth - 1996



Medicare's actuaries, without stating how it will be accomplished, assume that the rate of health care cost inflation will be controlled over the next 25 years. This assumption allows them to project a significantly lower tax increase to fund the program than would be needed if the historical rate of cost inflation continued. Unless new incentives for efficiency are built into the system, however, it is clear that the same historical pressures on cost will continue.

The methods used by the federal government to control expenditure growth have not worked. Price controls have been one of the main approaches, they have been used since 1983 in Part A, and since 1975 in various forms in Part B. Despite the government's holding payment rates to providers below private sector levels and rates of inflation, Medicare expenditures grew from 3.7% of the federal budget in 1970 to 13% in 1995. If the rates of spending in both parts of Medicare are not slowed, Medicare actuaries have projected that spending will grow rapidly from 2.6% of gross domestic product in 1995 to 7.8% in 2035.

Medicare's problem involves its promises, its financing, and the way it is run. The new Medicare+Choice program will not relieve the pressure on the Part A trust fund or taxpayers' burden for funding the majority of Part B expenditures for some time to come. The traditional program will remain the choice of most beneficiaries for the foreseeable future, and will continue to drive up expenditures at an unnecessarily high rate if its flaws are not corrected. The program has severe structural problems dating from its original design. Medicare must be restructured so that it can continue to achieve its objectives in the 21st century without large tax increases or benefit reductions. The AMA's proposal to transform Medicare is a comprehensive approach to addressing all of Medicare's problems.

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Preparing For Future Generations

Most analysts recognize that the future program must be changed in ways that may make it

unrecognizable from today's program. Because repeated future tax increases to support the pay-as-you-go basis of Medicare finance are untenable, there is also wide agreement that a shift is required from pay-as-you-go finance (in which current taxes are used to fund benefits for current beneficiaries) to a method of finance that builds a secure fund for the use of those contributing to the fund over time. Continuing to fund Part A of the program through payroll taxes, and to fund the larger part of Part B though general revenue, will become increasingly difficult both economically and politically.

Some have proposed that saving Medicare for the future is a simple matter of raising taxes, increasing the age of eligibility for benefits, relating the amount of the federal subsidy to beneficiary income, and continuing to lower payment rates to providers. However, the political feasibility of raising taxes in an era of concern for the burden of entitlement financing on taxpayers is highly questionable. Increasing the age of eligibility and reducing the Medicare subsidy to the wealthy won't go far toward reducing projected spending. Continuing to cut provider payment rates, the major budgetary approach of the past, has not been successful in reducing expenditure growth and further cuts will jeopardize beneficiary access to high quality care. None of these approaches presents a viable long-term solution because they do not deal with basic structural incentive problems causing Medicare costs to increase too rapidly.

The AMA supports increasing the age of eligibility to match the one scheduled to occur for Social Security. AMA supports reducing the subsidy for high-income beneficiaries using income-related premiums. However, the AMA believes that private saving during working years for health care in retirement should be part of the solution to Medicare's financial health over the long-term.

Continuing the pay-as-you-go system of financing Medicare will impose an ever-increasing burden on working US taxpayers. While our obligations to those who are and will be dependent on Medicare in the future must clearly be honored, we do not need to retain the same system for those who are not now dependent on it, such as those currently entering the workforce.

How would we design Medicare if we had it to do over again, such as for the younger generations that will face ever-increasing taxes and prospects of eroding benefits if the current program were continued? To restore the viability of the program's promise to future generations, Medicare funding must be shifted from the pay-as-you-go system to a system in which beneficiaries have a larger responsibility to provide health insurance for their own retirement health care during their working years.

The AMA believes that shifting out of a tax-based pay-as-you-go system to a system of private savings is the preferred approach to assuring that all working Americans have access to health care in retirement.

This does not mean that government would not have a major role to play. The government would continue to make a substantial contribution toward the purchase of insurance for the elderly and it would enforce requirements for individual saving. The government should have a larger responsibility to socially insure against contingencies that society faces collectively, such as the general disruption of an economic depression or war, and for assuring that the economically disadvantaged are not neglected.

From a financial standpoint, greater individual funding of retirement health care has at least four advantages over a government-based system:

- A private system would allow individuals to freely choose the types of health care plans that meet their particular needs.

- Individual funding would remove federal budgetary considerations and the accompanying

extraneous budgetary issues from government policy toward the system.

- Much of the funding of a private system would be invested in economic activity in the private sector, rather than in unfunded federal debt that must be repaid by subsequent tax revenue.

- A higher rate of return is possible with investment of funds in private sector economic activity than in government debt instruments.

Economists who have studied the problem have proposed that the transition from the pay-as-you-go system to a fully funded system be phased-in over several decades. Martin Feldstein and Andrew Samwick of the National Bureau of Economic Research have proposed an approach in which every individual contributes to a Personal Retirement Health Account beginning at age 30. Retirees would use the proceeds to purchase conventional insurance like Medicare plus the long-term care insurance currently provided by Medicaid. They estimate that the individual contribution required to build such accounts and to fund existing obligations to those remaining in the pay-as-you-go system would rise from the current payroll tax rate of 2.9 percent to 3.4 percent, compared to a tax increase to 30 percent of covered earnings to continue funding the pay-as-you-go system.

Prof. Thomas R. Saving at Texas A&M University has proposed a similar approach in which entire age cohorts, rather than individuals, establish private savings plans to collectively fund their retirement health care needs. Like Feldstein and Samwick, Prof. Saving estimates that only a modest addition to the current rate of payroll tax will be needed to fund the transition to full self-funding over a period of years.

Even though employees during the proposed transitions must pay payroll taxes to support existing retirees as well as contribute savings for their own retirement, neither of the proposals require such employees to "pay twice" during the transition. This is because the combined contribution will be much less than that required to sustain the existing pay-as-you-go system, and because the contribution to honor existing pay-as-you-go obligations will decline as beneficiaries of the old system die and are replaced by new retirees with pre-funded private savings accounts.

Meanwhile, the current program of benefits, delivery of services, and government regulation requires immediate modernization and improvement to correct serious flaws, improve efficiency, slow cost growth, and enhance service to beneficiaries.

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Modernizing Traditional Medicare

To realize the actuaries' assumption that Medicare's cost growth will be constrained at a sustainable level, major structural modifications are needed in the traditional program to rectify the lack of incentives for provider and beneficiary efficiency. The AMA proposes two structural modifications to the program that would save both beneficiaries and the government money by providing the needed incentives for efficiency.

A. The Easy Path to Scoreable Savings: Eliminate the "Gap" Problem

The large cost imposed on the Medicare program by the "medigap problem" has long been recognized as a potential source of significant government budget savings. By covering Medicare's intended cost sharing with private supplemental insurance (medigap), beneficiaries use more services than they would

otherwise. Thus, Medicare's outlays are considerably higher than they would be if the cost sharing were not subverted by medigap insurance, which more than 75% of beneficiaries own.

Effectively solving this problem presents the best source of scoreable budget savings, because the savings produced are the result of efficiency improvements, not from imposing costs on taxpayers, beneficiaries or providers of medical care.

Why Do Beneficiaries Want Medigap?

Medicare's cost sharing requirements in 1998 impose a potential out-of-pocket liability on beneficiaries for:

- Part A deductible, $764
- Part A hospital coinsurance for days 61 to 90 in the hospital, $191 per day
- Part A hospital coinsurance for days 91 to 150 in the hospital, $382 per day
- All charges for extra 365 days in the hospital
- Part A blood deductible, 3 pints of blood
- Part B deductible, $100
- Part B coinsurance, 20% of expenses in excess of $100
- Skilled nursing facility coinsurance for days 21 to 100, $95.50 per day
- Emergency care in foreign countries

In sum, Medicare's potential cost sharing liability is more than $34,000 per year and, unlike most private insurance policies, Medicare does not limit the out-of-pocket cost that beneficiaries can be required to pay. This potential out-of-pocket cost is exorbitant. It creates the wrong incentives because it frightens most beneficiaries into insuring against high out-of-pocket costs with private supplemental insurance. Their former employers provide many beneficiaries supplemental insurance. Many of those, as well as most beneficiaries who are not covered by their previous employer's benefits, purchase their own insurance (at an average cost of about $1,100 to cover the potential liability in 1997) even though 20% of beneficiaries incur no cost sharing liability each year, 70% incur a cost sharing liability of less than $500, and 80% incur a cost sharing liability of less than $999.

If beneficiaries were not exposed to such potentially high out-of-pocket costs, they (and/or their former employers who provide insurance to supplement Medicare as a retirement benefit) would not have to waste so much money on supplemental coverage. The government does not need to expose beneficiaries to such high risk and precipitate a waste of money. Not only do most beneficiaries incur far less cost sharing liability than they pay for medigap, but medigap premiums have risen much faster than the rate of Medicare expenditure inflation in the last few years. The government can give beneficiaries and their former employers an economic break by eliminating their need for supplemental coverage.

In so doing, the government can also lessen the pressure that medigap puts on the budget. Beneficiaries with medigap insurance view their covered care as essentially free, and they utilize 28% more medical services than they would otherwise, according to the Physician Payment Review Commission. These extra costs are borne primarily by the Medicare program rather than medigap insurers because medigap pays only the deductible and coinsurance for covered services while the Medicare program pays the rest.

How Can Medigap Be Neutralized?

Congress should reduce Medicare's cost sharing requirement to a reasonable level. This means a level that

would not strongly encourage beneficiaries not to insure against the potential liability, but a level that would also provide an effective incentive for beneficiaries to reasonably moderate their demand for covered services.

The AMA proposes that Medicare restructure its cost sharing to reduce potential beneficiary liability in a manner that eliminates the need for private medigap insurance and, in exchange, beneficiaries would pay a higher premium than they do now. The premium charged by Medicare for the expanded coverage would be much less than that charged by private insurance companies because the government's premium would not include selling expense and profit. The effective cost sharing would reduce government outlays for medical services.

As an illustration of the approach, the average cost of the medigap "Plan C" that covers all of Medicare's potential cost sharing liability (about $1,100 in 1997) can be divided into two parts, consisting of a modest, single deductible for both Parts A and B of Medicare, and a premium for the extra Medicare coverage represented by eliminating all existing cost sharing liability except for the single deductible. Dividing the current cost of medigap Plan C into two parts, a deductible and a premium for extra coverage, would guarantee that beneficiaries would incur no greater out-of-pocket expense than they do now, and that many of them would save money.

For example, consider dividing the current medigap cost into a $500 deductible and a premium of $600. According to actuarial analysis by Price Waterhouse, the average beneficiary would spend only $360 of the $500 deductible, saving $140 per year compared with the current cost of $1,100 for medigap. By neutralizing the first-dollar-coverage incentive of medigap, the Medicare program would save an average of $275 per beneficiary, which could be returned to beneficiaries in the form of reduced Part B premiums or additional coverage. If the government savings were used to reduce the deficit, a total of $50 billion of savings would accrue over the period 1998-2002.

Medicare's current cost-sharing requirements are self-defeating because they frighten beneficiaries into insuring against them with expensive private coverage. By incorporating most of medigap's coverage into Medicare benefits, the government could save beneficiaries money by reducing the premium required for the coverage. In turn, the government can achieve the intended benefit of effective cost sharing to reduce program expenditures. Neutralizing medigap is a win-win for beneficiaries, the government, and taxpayers.

B. Decontrolling Prices Will Improve Medicare for Beneficiaries and the Government

Prices in Part A of Medicare are controlled through the prospective payment system for hospital payment and in Part B through the payment schedule system for physician payment. Price controls are responsible for many of Medicare's financial problems, and have not achieved the objective of controlling expenditure growth. They should be replaced by a better system before beneficiary access is seriously eroded. The AMA offers a sensible approach to replacing price controls with price competition in Medicare's fee-for-service sector.

The Failure of Price Controls

Price controls have failed to achieve Congress's objective of controlling Medicare's cost growth. This failure has caused Congress to consider imposing other cost-control measures that would erode Medicare benefits, such as higher deductibles and copayments. These other measures will not work, because most beneficiaries defeat Medicare cost sharing with supplemental insurance. Congress is also continuing to cut

payment rates to providers. Continuing to lower payment rates will only result in a growing reluctance of providers to dispense services to beneficiaries and will eventually reduce beneficiary access to care.

The impact of price controls on beneficiaries is not starkly apparent because is affects the quality of services rather than their ability to make appointments with physicians and other providers of care. Physicians have adjusted in a number of ways to the failure of Medicare payment rates to keep up with their cost of providing services. A recently completed AMA survey reveals how they are adapting to the Medicare cost squeeze:

Impact on patient interactions: time spent with Medicare patients on each visit is being reduced, and multiple visits for multiple problems are being required. Some physicians selectively refer the more difficult, costly cases to other physicians. Videos are being substituted for face-to-face patient counseling and education.

Cutting amenities: services for the convenience of patients are being dropped, such as arranging for community services, in-office phlebotomy and x-ray services, and incidentals such as post-procedure care kits. Screening and counseling are being curtailed. Satellite offices are being closed. Telephone consultations are being reduced, with office staff returning more telephone calls from patients. Commercially produced patient education pamphlets and brochures are being dropped.

Impact on access: Medicare patient loads are being reduced, limited or eliminated. Some physicians accept Medicare patients only by referral. Money-losing services, especially surgical procedures, are not being offered to Medicare patients. Simple procedures formerly performed in the office are done in outpatient facilities.

Technology lags: many physicians are not renewing or updating equipment used in their office, but shifting to hospitals to perform Medicare procedures. Purchases of equipment for promising new procedures and techniques are being postponed or canceled.

Access to specialists: specialists refer patients back to primary care physicians as soon as possible, and are less willing to become primary physicians for their chronically ill patients.

Physicians' reported adjustments to the Medicare cost squeeze indicate that Medicare's price controls are insidiously eroding the value of beneficiaries' entitlement to medical care. The perverse impact of price controls is further aggravated by difficulties in administering them. The rates of the relative value scale that Medicare uses to set payment rates, known as the RBRVS, are ideally based on the "resource cost" of providing each service. The government needs a better alternative for determining physician payment rates.

Price controls also contribute the problem of fraud and abuse in the Medicare program. Because they do not participate in the process by which prices are typically set in a market environment, beneficiaries have little knowledge or concern about the prices and services that providers bill to Medicare on their behalf.

The solution to price control problems is, of course, price competition. Medicare prices should be decontrolled to stop the devaluation of the program's promises.

Competition is the mechanism that must be used to make sure that prices are not too high, and that services are provided with the maximum efficiency. This cannot be done through administrative mechanisms such as price controls or regulation of providers' economic behavior; rather, the market must

be allowed to function to provide incentives for producers to employ efficient methods of service production and delivery and to push prices toward the minimum necessary levels.

How is this supposed to work? Competition works because consumers care about prices and seek low-price producers for their services. This motivates producers to make their prices apparent to consumers, and to employ the most efficient means of production so that their prices can be as low as possible compared with their competitors. Competition rewards consumers for seeking lower prices, and punishes producers whose prices are too high, motivating them to find ways of lowering prices. Consumers must be rewarded for seeking lower prices, which is impossible under the current Medicare program because prices do not vary due to price controls. Thus, in order to foster competition it is necessary to let prices vary by decontrolling prices.

The second necessity is to give beneficiaries a motivation to seek lower prices. This means that they have to have to be able to get information readily about prices. Information is not currently available on prices; how is it to be provided? It also means that they have to be rewarded for choosing lower, rather than higher, priced services, if the quality and other attributes of the services are equal. How is this to be accomplished?

Allow Flexibility for Beneficiaries and Physicians

Some measure of the positive benefits of competition could be restored to this market by abolishing the "limiting charge" restrictions that limit Medicare's payment on unassigned claims. Unassigned claims are claims for payment submitted to Medicare by physicians who do not agree to accept Medicare's fee schedule amount as payment in full. Medicare's payment for unassigned claims is limited to 109.25% of the fee schedule allowance. Medicare's treatment of unassigned claims is punitive because claims are deliberately processed more slowly and non-participating physicians are assessed a 5% penalty. Thus, physicians assign most claims. However, as discussed above, a significant number of physicians remain outside the Medicare market because the Medicare price is too low. Further, some physicians who do continue to see Medicare patients are restricting their practices so as not to accept new Medicare patients or to limit the services provide to Medicare patients or to all the non-clinical aspects of the service to deteriorate.

Physicians who might want to offer better service or to make available otherwise relatively scarce skills cannot currently be compensated for those efforts through higher payment. Abolishing the limiting charge restrictions would allow beneficiaries to command better physician performance and service if they chose to do so. Permitting competition in this segment of the market will expand beneficiary choice. Medicare would not otherwise have to change its physician payment system. It could continue its Participation Program, which gives preferential treatment to physicians who agree to accept Medicare rates as full payment, including listing in a directory available to beneficiaries.

Given the healthy supply of participating physicians, non-participating physicians would not be able to price their services without limit. Evidence of this is provided by the fact that when there were no limits on physicians' charges (in 1966-1972, and 1974-1984), assigned charges for physician services provided to Medicare beneficiaries were never less than 53% of the total. Thus, abolishing the limiting charge ceiling should not place a hardship on beneficiaries; rather, it would allow those who want higher quality care or access to specialists who limit treatment of Medicare patients to freely seek it in the marketplace.

While abolishing limiting charge restrictions would improve beneficiary access to services, it would not produce fully competitive prices and the benefits of maximum economic efficiency and choice that would

accrue to beneficiaries and government from full competition. Furthermore, it would not divorce the price setting from budget considerations which override concerns about beneficiary access and service quality in the current price setting process.

The AMA has two distinct proposals for fostering competition in Medicare that enlist beneficiaries as agents of competition. Each proposal would reward beneficiaries tangibly for seeking value, and would make it easy for them to do so by making information about prices available to them. The proposals differ in that one builds on current pricing mechanisms of Part B, and the other builds on current pricing mechanisms of Part A.

Decontrolling Prices in Part B

The AMA has proposed a mechanism for decontrolling prices and allowing competition to determine them. The Part B mechanism would be based on the current RBRVS, but would allow physicians to determine their own conversion factors (CFs), which convert the relative values into dollar charges. Physicians would be required to post their CFs so that Medicare patients would know what their charges are, and would be able to compare the charges of different physicians. In turn, Medicare would determine a CF by which it would reimburse beneficiaries for services they received.

Medicare's CF would be based on physicians' CFs in each market, and would be determined to guarantee beneficiaries access to a certain proportion of the physicians in the market at no out-of-pocket cost beyond physicians' charges.

For example, suppose Medicare wanted to assure beneficiaries that they could see one-half of the physicians in their area at no out-of-pocket cost beyond what Medicare pays. Medicare would ask each physician to submit the CF by which they would price their services to beneficiaries, and choose the median CF for reimbursing beneficiaries. To assure competition, Medicare would collect information on physicians' prices and regularly provide a list of CFs to beneficiaries. Physicians would also be required to post their CFs in their offices for beneficiaries to see. In this way, beneficiaries would only need to know a single number in order to compare the prices that physicians and other Part B suppliers charge.

To maximize the incentive for beneficiaries to seek the best values from physicians, they could be reimbursed at the government level even though they obtained services from suppliers with CFs less than the government's. In this way, beneficiaries would be rewarded for seeking better values, and suppliers would be motivated to display the lowest possible CFs. Over time, the government would discover the minimum "bonus" payments to beneficiaries necessary to maintain competition and minimize the bonus payments to beneficiaries. Paying such a bonus would also prevent the government CF from becoming a floor (i.e., prevent suppliers with CFs below the government reimbursement level from raising their factors to equal the government's).

The bonus payments to beneficiaries who find better values than the government reimbursement rates would not be "give-aways" or wasteful expenditures. This is because such bonuses would compensate beneficiaries for performing a valuable function in the system--making competition work. Efficiency is not free, after all, and beneficiaries must be rewarded to expend the extra effort of searching for better value than they have to just to break even. The bonuses purchase assurance that provider CFs would be as low as possible, so that the government factor, in turn, could be as low as possible consistent with the access goal it wishes to achieve.

Competitive DRGs

Part A of Medicare currently pays for hospital services consumed by beneficiaries based on Diagnostic Related Groups (DRGs). There are several hundred DRGs, which determine how much a hospital is paid for a case of a certain type. Currently, DRG rates of payment are determined by the government on the basis of statistical analysis of hospital cost. Few would argue that statistical analysis of accounting data could determine efficient or economically correct prices; only competition can. Therefore, efficiency will be served by allowing DRGs to be competitively determined.

The DRG-based Part A system of hospital payment provides a ready-made platform for introducing competition. A system similar to the one described for Part B above could be implemented to allow competition to work in Medicare hospital payment. Beneficiaries should be reimbursed at government-set DRG rates and allowed to "keep the change" if they could find a hospital with a DRG less than the government's By monitoring the DRG rates that hospitals offer patients, the government would be able to set its reimbursement DRG rates at levels to optimize incentives for competition while minimizing program costs, as well as provide information to beneficiaries on the rates prevailing in their localities.

Responding to Distrust of the Market

Two general reservations have been expressed about the AMA proposal. First, the lifting of price controls has been characterized as giving physicians an opportunity to "price-gouge". However, competition among physicians for patients would limit their ability to charge significantly more than the average. To maximize the strength of competition, the AMA proposes that beneficiaries who are patients of physicians whose conversion factors are less than the HCFA reimbursement factor receive a rebate of the difference. This would strengthen the incentive for physicians to compete on the basis of price, because patients would be explicitly rewarded for the effort of searching for value in the market. With such incentives operating in the market, many economists are confident that the ability of physicians to "price-gouge" would be controlled. And patients would always be able to find physicians who do not charge more than Medicare's payment rate. Before Medicare limited physicians' ability to charge more than Medicare's payment amount, physicians accepted Medicare's payment (by "assigning" claims) for more than half of outlays on physician services.

The second major reservation expressed about the proposal is the ability of patients to "shop" for medical care in a competitive market. Of course, few patients are willing or able to shop for medical care when they are ill. But, this is not the manner in which consumers should arrange for medical care. Rather, patients should make long-term arrangements in anticipation of being in a medical situation where their ability to shop or make important decisions is compromised. The essence of the traditional patient-physician relationship with a regular personal physician is such a long-term arrangement that establishes guides for dealing with serious medical needs. Thus, one should not "shop around" when medical contingencies arise, but rely on pre-established relationships for dealing with problems. Medical needs, especially serious ones, are not highly predictable, and dealing with them requires advance planning and establishing relationships with providers who can be called on when they arise.

A Better Environment for Medicare Beneficiaries

Since Medicare payment is below many private sector rates for the same services, physicians must continually ask themselves whether they should stop seeing beneficiaries because Medicare's fixed prices are too low to cover costs. The AMA would rather have physicians competing for patients in a market where prices reflect actual economic conditions rather than resenting Medicare's misguided payment policies and having no alternatives except reducing their services to beneficiaries.

Beneficiaries would rather be welcomed by physicians and other health care providers as valued patients and customers than be resented as wards of a flawed and poorly conceived public program. Deregulation of prices and the competition that the AMA proposal would generate would put beneficiaries in the driver's seat, endowing them with considerably more clout and respect than they currently command in today's price-control environment.

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Conclusion

Putting Medicare on a sound financial footing requires a multi-faceted transformation of the program's funding, actuarial design, and incentive structure. Medicare's design reflects conditions prevailing in 1965 that have changed and evolved significantly since then. Unforeseen expansion of benefits, cost inflation, and demographic changes have made the original tax-based method of finance untenable. In hindsight, we can see that the cost-sharing requirements that were supposed to temper the rate of cost growth backfired. The alternative approach that the government chose to try to control cost–price controls–are eroding service quality and endangering beneficiary access to services. Furthermore, beneficiaries' disinterest in the prices and services billed to the program facilitates opportunistic fraud and abuse.

Rethinking Medicare has led the AMA to propose restructuring Medicare's cost sharing in a way that will save both beneficiaries and the government money; to propose adopting orthodox, market-based competitive approaches to pricing in place of price controls to give both beneficiaries and suppliers incentives to be efficient; and to propose switching from tax-based pay-as-you-go finance to a system of private savings-based funding that will cost less to sustain Medicare's promises in the long-run.

Despite the fact that beneficiaries' choices will be greatly expanded when the new Medicare+Choice options are implemented, the traditional program will continue to be the choice of a majority of beneficiaries for the foreseeable future. The traditional program will continue to drive Medicare's cost unless significant reforms are made in its incentive structure. Continuing the same approaches to cost control will also erode the quality of service significantly. Congress should approach reform of the traditional Medicare program with the same concern it devotes to rethinking Medicare's basic funding mechanisms.

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Decontrolling Prices Will Improve Medicare for Beneficiaries and the Government

Prices in Part A of Medicare are controlled through the DRG system for hospital payment and in Part B through the RBRVS system for physician payment. Price controls are responsible for many of Medicare's financial problems, and have not achieved the objective of controlling expenditure growth. They should be replaced by a better system before beneficiary access is irreparably damaged. The AMA offers a sensible approach to replacing price controls with price competition in Medicare's fee-for-service sector.

The Failure of Price Controls

Price controls have failed to achieve Congress's objective of controlling Medicare's cost growth. This failure has caused Congress to consider imposing cost-control measures that will erode Medicare benefits, such as higher deductibles and copayments. These measures will not work, because most beneficiaries obtain medigap insurance which defeats Medicare cost-sharing. Congress is also continuing to cut payment rates to providers. Continuing to lower payment rates will only result in a growing reluctance of providers to dispense services to beneficiaries and will eventually reduce beneficiary access to care.

The impact of price controls on beneficiaries is insidious and erodes the value of their entitlement to Medicare benefits. Meanwhile, providers will continue seeking ways to evade price controls. Evasion results in a general loss of efficiency and higher cost to the program. Providers' responses to price control cost squeezes affect beneficiaries by distorting services and treatment as well as reducing the quality of care to fit within cost constraints. Thus, beneficiaries are not generally treated optimally under price controls. Divergence from optimality is aggravated by the government's attempts to control cost through stricter criteria for coverage of new medical equipment, devices and treatments.

The perverse impact of price controls is further aggravated by difficulties in administering them. The rates of the RBRVS are ideally based on "resource cost" of providing each service. Attempts to measure overhead costs are presenting insurmountable problems to the government. Methodological problems in allocating fixed cost as well as difficulties in obtaining adequate data to measure components of overhead are compromising the validity of the RBRVS, and resulting in severe divergences between payment rates and the rates that physicians regard as equitable. These difficulties are threatening the acceptance of the RBRVS as a basis for physician payment and the viability of Medicare's physician payment system. The acceptance of the RBRVS has already been compromised by the threat of changing the current

are too low to cover costs. The AMA would rather have physicians competing for patients in a market where prices reflect actual economic conditions rather than resenting Medicare's misguided payment policies and having no alternatives except reducing their services to beneficiaries.

Beneficiaries would rather be welcomed by physicians and other health care providers as valued patients and customers than be resented as wards of a flawed and poorly conceived public program. Deregulation of prices and the competition that the AMA proposal would generate will put beneficiaries in the driver's seat, endowing them with considerably more clout and respect than they currently command in today's price-control environment.

The ability of the government to administer prices adequately has met the barrier of the methodological impossibility to adequately measure and allocate overhead on a per-service basis. The government must allow physicians the flexibility to set their own prices to reflect cost. Allowing physician-determined conversion factors also will end the contentiousness among physicians of multiple government-imposed conversion factors. Price competition, enhanced by proper incentives for beneficiaries to seek value in the market, will assure beneficiaries and the taxpayers that they do not pay more than necessary to keep Medicare's promise of adequate access to medical care for our elderly citizens.

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STATEMENT OF JAMES DIRENNA, M.D.

Dr. DIRENNA. Mr. Chairman, members of the panel, thank you for letting me speak. My name is Jim DiRenna, I am a family practitioner in the Kansas City area.

The point that I would like to talk to is about the education process that has been spoken of before today. In the Missouri area there are two carriers for Medicare, one is Blue Cross and the other is General America. And in 1997, General America denied 1.2 million claims that were not resubmitted, either due to physicians not responding or debate or the fact that they just simply denied the claims or they did not meet the time element of the claim process.

Now there is some discussion about charging physicians $1 on a resubmitted claim. This hurts the physicians, as you well know, because we are already locked into a situation. And this is not handwritten coding, this is computer electronic filing into these carriers. And it is not practical and it is generally known in the general medicine community, that the carriers are making the decision about medical necessity. So if HCFA comes out with their Federal rules, policies and regulations and we are trying to go by HCFA rules and regulations and then we are dealing with the individual carriers and the policies and the procedures are changed every 3, 4, 5 months, we are not all on the same page and it is very difficult to get a straight answer concerning that. And that is the point I would like to bring up.

Thank you very much.

Mr. SHAYS. Thank you very much. We have heard from the first group, so we will go to the second group. There should be four in the second group? I guess we have attrition.

STATEMENT OF RICHARD HELLMAN, M.D.

Dr. HELLMAN. My name is Richard Hellman, I am an endocrinologist and diabetologist in private practice. I chair the National Governmental Relations Committee of our Metropolitan Medical Society and I am privileged to be on an AMA committee that is working on the issues of quality in measuring physicians' performance and patient outcomes.

I wonder, by the way, how Alan Greenspan would feel if he realized that people were less interested in the correctness of his decision as to what to do with the interest rates than the quality of his documentation and writing, as measured by a particular committee.

But I am interested in two things here. The first is the issue of quality. One of the things that is happening here is there is so much focus that is distracting physicians from the difficult task of maintaining and improving quality. In fact, we hear that moneys are being moved from HCFA out of quality research and for PRO as well, and into the fraud and abuse. At the same time, the quality issues offer perhaps the best opportunity to really save money. You are going to have more old people and they are going to live longer and it is going to cost more. But if you can reduce the number of hospital days from diabetes because you prevent problems or the fractures from osteoporosis, you get somewhere. But this is distracting us from our task. And in fact, the outliers, some of the

outliers that you are going to have are physicians whose standing is high enough they get the sickest patients, they have adverse selection. And the people who I am afraid are most vulnerable if we do not correct these rules are those patients who are very ill, because it is those doctors who will be under the greatest deal of scrutiny and the most distracted because they are outliers, they have higher charges because they are spending more time.

I think to help the people in this Nation and to move forward, I think we have to let doctors do what they do best, take care of people. We have to restrict any diversion of that and we have to focus on quality and quality probably will mean revising these rules.

Thank you.

Mr. SHAYS. Thank you, sir. [Applause.]

[The prepared statement of Mr. Hellman follows:]

Written Testimony
of
Richard Hellman, M.D, F.A.C.P., F.A.C.E.
before the
Committee on Government Reform and Oversight
Subcommittee on Human Resources
of the
United States House of Representatives
on
"Medicare: Cures for Billing Code Complexity"
April 9, 1998
University of Kansas Medical School
Battenfield Auditorium

Chairman Shays, Vice Chairman Snowbarger and members of the Committee, my name is Dr. Richard Hellman. I am a practicing endocrinologist and diabetes specialist. I practice in both Kansas and Missouri, in the greater Kansas City area. I am the chairperson of the National Governmental Relations Committee of our Metropolitan Medical Society and a member of an AMA committee that has the responsibility to develop standards of quality for measuring patient care outcomes and physician performance.

I would like to comment on the new rules regarding the evaluation and management services as put forth by HCFA. These rules and the planned strategy of enforcement as outlined by HCFA, if left unchanged, may result in one of the greatest disasters in health care policy of this decade. I urge that the E & M (evaluation and management) codes not be implemented and, in fact, I urge that they be completely redone. I will explain why.

A Physician Assistant can be taught to take a patient's history and to perform a physical examination, but they lack the background to perform medical decision-making. This skill is the heart of what a physician does - a facet of the art of medicine and cannot easily be taught. The new E & M rules are so imprecise, particularly with respect to medical decision-making, that leading computer experts tell us that they cannot construct software designed so that a physician could put in their clinical data and then come out with a unique CPT code and be certain that that is the only reasonable choice. The subtlety and complexity of the clinical process cannot be reduced to the structured HCFA rules that have been proposed. Although the computer experts have now thrown up their hands, we physicians will still be forced to comply with a set of rules which are so vague that reasonable people would be expected to disagree often on their interpretation. Since both civil and criminal penalties are assigned based on the physician's non-compliance, it creates an impossible, unfair and very destructive system in which a physician is expected to operate.

The requirements of documentation are so complex as to be ludicrous and forces the doctor away from the patient just to comply with these rules. Let me give you an analogy to illustrate: we rely on the Director of the Federal Reserve, Alan Greenspan, for his expertise in deciding whether to change interest rates. But imagine how foolish we would be if we were much less interested in the correctness of his decision than how his documentation supporting his decision fit our predetermined (and arbitrary) criteria.

But there is a larger picture. Perhaps the most important challenge today in the practice of medicine is to improve the quality of care. Fraud and abuse needs to be controlled, but the amount of cost-savings derived from improving quality of care will probably dwarf any amount saved from fraud and abuse, and more importantly, benefit our citizens directly in improved health and longevity. The prevention of strokes, heart attacks and cancer is much cheaper (and humane) than the complex treatment of these illnesses. Moreover, reduction of errors in care will help to avoid unnecessary hospitalizations and subsequent disabilities. Many experts agree that it is in this arena that we should be putting more resources. Instead, we have recently learned that HCFA is taking money out of research on improving quality-of-care and putting it into fraud-and-abuse enforcement.

At the same time, these new regulations will almost certainly decrease the quality of care. As a result, physician's frustration with the government has reached a level of intensity not seen in the last 40 years. It is no surprise that physicians are talking openly about avoiding Medicare patients or even retiring early.

Since HCFA is focusing most on over-coding and it is the most complex care that will have the highest payment codes, the most complex and most needy patient will be the one that will be scrutinized most closely by HCFA. As a result, access to care for the most critically ill patients is likely to be placed at risk, since it is their doctors who will be most distracted by the threat of penalty.

We need to let doctors do what they do best, which is take care of patients. We should not allow anyone to decrease the access to care for the sickest. Our goal should be to focus on the difficult problem of improving quality, not destroying it. The country will be well served if the current set of HCFA evaluation and management codes were revoked now.

STATEMENT OF GERALD F. KERR, M.D.

Dr. KERR. Thank you. It is an honor to be able to stand and address you three gentlemen. It is a great country. I am a physician, third generation physician, practice in southeast Kansas, rural southeast Kansas. Thus far, I have one son and one son-in-law that are physicians as well.

My grandfather started his practice in 1905 in Perry, KS, horse and buggy days. Administrative costs for his practice at that time were 5 to 7 percent. My father was a hospital-based physician. In 1962, the hospital administrative management costs at St. Joseph's Hospital in Kansas City, were in the neighborhood of 10 to 15 percent.

In 1991, while I was contemplating rather large hospital bills of my own, recovering from a major illness, I did some research in the literature and found that in 1991, one of the largest, fastest growing cost centers in the hospital were administrative management costs and in 1991, they amounted to about 25 percent. Those were the direct management administrative costs. Indirect costs, however, were another 25 percent; that is, the time that nurses, physicians, technicians spent documenting the data trail, documenting kind of the evidentiary trail to support what they did to the tort system, to the Federal Government, to the third party payers.

That means that in hospitals alone, 50 cents in every dollar is consumed by management, administrative, data handling, data maintenance costs and that means that 50 cents of every dollar is not available to pay for physicians, nurses, drugs, x-ray tests, lab tests, to directly take care of patients.

This I think represents a system that is broken beyond repair. I think that all of these people are honorable people, I think that you are honorable people, but the system does not work. I do not think it can be fixed. My solution, I do not really know, but I think it involves patient choice of physicians and hospitals and it involves me as a physician looking my patient in the eye and presenting them a bill for the services that I render. It involves the hospital looking the patient in the eye and presenting them a bill. And any practice that has to spend 72 cents of every dollar that that physician maintained under oath today that he had to spend just to operate in this system, is way, way too much.

Thank you.

Mr. SHAYS. Thank you, sir. [Applause.]

STATEMENT OF HOLLY FRITCH KIRBY, M.D.

Dr. KIRBY. I am Holly Fritch Kirby, private practitioner, president-elect of the American Society of Dermatology. It is an honor and a privilege to be able to address you.

My first request is due to due process, that I do not feel that many of us know that we have, when we are under administrative law. I would like to ask you to consider the Administrative Civil Rights Act, a copy is present in my written statement.

The second thing I would like to do is to clarify how the system developed. We started traditionally over the millennium of a unique patient, a unique bill. We have an artificial experimental system that is not working, and my request would be to rethink it and consider starting over.

Medical savings accounts I think can be part of this, I think medical savings accounts over another 35 years may help solve the problem of Medicare funding, also give accountability and decrease the fraud.

I would also like to ask—it was not asked directly today—to strongly consider patient confidentiality. These records now are readily available to the Government if they are part of an audit.

I would also like to ask in this process that some of the committees that HCFA is using and maybe even in conjunction with the AMA, that they are indeed open to FACA and that they be re-examined whether or not they indeed fall under FACA.

There is a particular request that the American Academy of Dermatology would be interested in and that is just a request for the head administrator of HCFA to meet with the American Academy of Dermatology. The issue is over how pre-cancers are treated. Against all the directors of departments of dermatology, HCFA has basically at this point in time come up with a rule that is against our standard of care and the care that has been given through the recent ages and certainly through my training.

Again I thank you very, very much for this opportunity.

Mr. SHAYS. Thank you. I just mention to you that Mr. Barrett and I have put in a bill on patient confidentiality. I would love you to leave your name and address with Jesse, who is right over there, I know you gave him a form for that, but a separate one, and we will send you the bill. We would love your comment on the legislation we put in to see if we addressed the confidentiality in the way you think we should.

Dr. KIRBY. Thank you very much.

Mr. SHAYS. So if you would just leave your name and address or just check it and we will send it to you.

Jesse, that is our bill on patient confidentiality that we want to send her.

We are with the third group.

[The prepared statement of Dr. Kirby follows:]

Statement
to the House Government Reform and
Oversight Subcommittee on Human Resources

Field Hearing on Medicare Fraud
(Medicare: Curing Code Complexity)
April 9, 1998
Kansas University Medical Center

Submitted by;
Holly V Fritch Kirby, MD
Private practice physician in Shawnee Mission, Kansas
President-elect of the American Society of Dermatology
Executive Board Member of the Advisory Board, to the
American Academy of Dermatology

So why are physicians upset? What is the problem?

The bottom line is:

First, physicians were given an experimental, artificial, billing system. This occurred in 1994 based on the 1991 Resource Based Relative Value Scale legislation. This system was to be further updated in 1998. This billing system cannot (and never will be able to) create a workable method whereby all the complexities of human illness can be addressed simply and fairly. Traditionally each unique patient received a unique bill. The clear reason for the unique bill is that individuals are not simple, round, uniform pegs for little round holes, and never will be.

Second, and in my opinion a much greater peril in a free republic, the physicians are at greater risk for arbitrary ex post facto extrapolated draconian fines and imprisonment for failure to dot every "i". This highly complex coding system of 42,000 pages is ill devised.

To put the medicare rules into perspective, the IRS rules and regulations are a mere 17,000 pages. In other words, the everyday practice of physicians has become subject to criminal and civil penalties without procedural safeguards. Furthermore, the cost of defending oneself is immense.

An attorney for the Kansas City firm of Shook, Hardy, and Bacon was quoted that the preliminary defense fees before the investigation is geared up or a grand jury impaneled, were a minimum of $10,000 to $15,000. To cover this cost would require 270 to 406 follow up 15 minute Medicare appointments without any consideration of overhead costs.

The potential risk is self-evident from the 1996 HIPPA, which funded the Inspector General of the HHS with $820 million, the Department of Justice with $330 million, the FBI with $548 million, and HCFA with $500 million to bring charges against errant providers.

No one is opposed to catching up with outright fraud. However, the HHS OIG Financial Statement Audit of 1996 clearly states that in 1996 the estimated 14% or $23.2 billion does not take into consideration outright fraud. This audit focused on the newly defined "correct" documentation and allegations regarding the lack of medical necessity.

Together, RBRVS and HIPAA have inadvertently or otherwise resulted in:

1)The perversion of the medical record from the patient's care record to a government record.

2)A wasteful, costly, inefficient, burdensome, if not impossible focus on doctoring the chart rather than directing the physician's attention to the diagnosis and treatment of the patient's problem.

3)Further interference in the practice of medicine both by limiting a patient's treatments options such as dropping coverage of the standard method of care to destroy pre-cancerous skin lesions and by limiting the work up of a patient's complaints due to incomplete lists of allowable diagnoses associated with a given test.

4)The loss of the confidential patient records with unfettered FBI access to the medical record.

The original Medicare promise (Title 18 of the Social Security Act, signed into law by President Lyndon Baines Johnson on July 30, 1965) reads:
"Section 1810. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."

There is something seriously wrong in this republic. Physicians cannot practice medicine in such a bizarre, dangerous labyrinth and patients are at grave risk. The government should not be practicing medicine nor should the government criminalize honest physicians who do.

SOLUTIONS

1. Insist on a moratorium relating to the prosecution of cases based on the CPT (billing) codes, especially the Evaluation and Management Codes.

2. Toss out the present 42,000 pages of Medicare rules and regulations and start over. Open the administrative codification and rule making process; investigate the current committees as to whether they are not indeed FACA committees and should already be open as was done with the Technology Advisory Committee.

3. Pass the ''Administrative Civil Rights Act''. (See Appendix)

4. Expand the MSAs (Medical Savings Accounts) along with high deductible policies to decrease fraud and create the resources for health care as citizens age. Use MSAs rather than wasteful costly bureaucratic nonsense combined with arbitrary excessive fines and imprisonment.

5. Protect patient confidentiality. Medical records should be the patient's care record, not the government's record.

6. Stop the interference in the practice of medicine; it is not in the patient's best interest, nor a constitutional provision for government.

APPENDIX

ADMINISTRATIVE CIVIL RIGHTS ACT

The constitutionally guaranteed civil rights of American citizens shall be protected in administrative proceedings.

Any agency acting under color of federal or state law shall have the right to impose only limited penalties through administrative proceedings, even when these penalties are called ''deterrents'' or ''means of protecting program integrity'' rather than ''punishments.'' Allowed forfeitures include only:

1. Withholding of future direct payments from the public treasury (except that Social Security benefits up to the amount funded by actual contributions by an individual, including amounts paid by employers in the individual's name, plus interest, may not be withheld);
2. Fines or civil monetary penalties not to exceed one week's after-tax income to an individual or one week's net profit to a corporation.

STATEMENT OF THE AMERICAN ACADEMY OF DERMATOLOGY BEFORE A HEARING OF THE SUBCOMMITTEE ON HUMAN RESOURCES OF THE COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT U.S. HOUSE OF REPRESENTATIVES REGARDING MEDICARE BILLING: CURING CODE COMPLEXITY APRIL 9, 1998

Chairman Shays and members of the Subcommittee, the American Academy of Dermatology appreciates this opportunity to submit its views for the record of the Subcommittee's hearing on the complexities of the Medicare billing system. We want to commend the Subcommittee for holding this hearing on this critical issue. We hope that this is the beginning of a thorough examination of the Medicare billing system that will ultimately produce major reform beneficial to both our physicians and our patients.

The American Academy of Dermatology is the professional medical specialty society for the more than 12,000 physicians who specialize in the diagnosis and treatment of diseases of the skin, hair, nails, and mucous membranes. Because many of these diseases afflict our senior population,

dermatologists treat a large number of Medicare beneficiaries. As a result, dermatologists are extensively involved with the Medicare system and have first-hand experience with its problems.

The complexities of the Medicare billing and coding system are issues of critical importance to dermatologists and our Medicare patients. Of all the issues confronting physicians today, these issues rank near the top. Physicians who treat Medicare patients feel that they are caught in the proverbial "Catch-22." They are doctors, not insurance claims examiners. They are interested in providing quality care and in curing disease, not in filling out forms. Nevertheless, they must comply with an extremely complicated maze of regulations, coverage policies, CPT codes, and documentation. As if this were not bad enough, looking over the physician's shoulder is the federal government complete with its auditors, investigators and its police power.

Our doctors simply want to do what is right, but determining what is right and correct is often not easy. Couple this with all the talk about health care fraud and abuse that has been emanating from the Health Care Financing Administration (HCFA), the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS), the Department of Justice (DOJ), and the Congress. In addition, there are all the new fraud and abuse laws, particularly the Health Insurance Portability and Accountability Act

(HIPAA) (Public Law 104-191) and the Balanced Budget Act of 1997 (BBA) (Public Law 105-33). Physicians are legitimately concerned that the least little mistake could result in a federal criminal charge. Physicians are also legitimately concerned that the federal government, which was once its partner in Medicare, has now become its adversary.

The Academy's statement will focus on some of the complexities of the Medicare coding and billing systems. However, the statement will also review some of the corollary problems associated with Medicare coverage policies and the computer programs employed by Medicare carriers to process claims. We believe that a system that is already unduly complicated is made more problematic by the actions of some Medicare carriers.

I. THE COMPLEXITY OF THE MEDICARE SYSTEM

The numbers alone are proof positive of the complexity of Medicare's coding and billing system. Everyday, dermatologists across the United States submit tens of thousands of claims to Medicare. These claims must comply with almost 2,000 pages of Medicare law, tens of thousands of pages of Medicare regulations, tens of thousands of pages more of Medicare instructions, and several thousand CPT codes. In addition, each state has a

Medicare carrier that processes Part B claims. These carriers may have their own individual procedures and a host of local coverage policies that often vary from state to state. Physicians with offices in more than one state are faced with multiple local policies and procedures.

The Academy is committed to the ethical practice of medicine vis-a-vis our patients and our third-party payors, including Medicare. Dermatology is committed to preventing and eliminating fraud and abuse in our health delivery system. The Academy has undertaken a major educational effort with our members through the use of coding workshops, articles in our monthly publication, *Dermatology World*, and the creation of a new publication, *Derm Coding Consult*. Additional compliance and quality assurance efforts are in the pipeline.

The problem for most physicians is that Medicare billing errors usually result from the multitude of confusing and conflicting regulations and instructions that make up the Medicare coding and billing system. Most physicians who make Medicare billing mistakes are attempting to comply with extremely complicated and frequently changing rules of Medicare reimbursement. They are not intentionally trying to abuse the system. Although they may be making mistakes, they are not committing fraud. However, the Administration, the Congress and the press seldom make a

distinction between inadvertent errors, legitimate issues of medical judgment, and true fraud.

HCFA's own numbers prove this point. Last year, the OIG released a report regarding HCFA's 1997 financial statement. This report received considerable press attention and media coverage because it alleged $23 billion in Medicare fraud. A close examination of the report, however, showed that most of the alleged "overpayments" were due to a lack of proper documentation and coding. In addition, the report included claims that had not been finally adjudicated in the standard appeals process. An analysis of HCFA's first quarter 1997 records indicates that physicians and other Part B providers received payments in 70% of the appeals where carriers had initially denied their claims.

The physician community's principal frustration is that one of HCFA's chief responses to combating fraud is to make the system more complicated. HCFA is adding new paperwork requirements for physicians, which are creating an administrative nightmare for doctors and their staffs. The new evaluation and management documentation guidelines have been published and are scheduled to become effective July 1. The Academy is concerned that these guidelines are onerous and will not improve patient care. They may, in fact, reduce the amount of time that the physician can spend with their patients. We

believe that further refinements in these guidelines are needed, and that HCFA should develop an approach that reduces true fraud without imposing unnecessary administrative burdens on physicians and their practices.

The Academy recognizes that health care fraud has become a political football. Yet, this "fraud and abuse" hysteria does serious damage to the patient-physician relationship by diminishing the patient's faith and trust in his or her physicians. In addition, this environment does not foster cooperation among the vast majority of physicians who want to assist in preventing and eliminating true fraud.

The Academy believes that much of what has been wrongly characterized as fraud and abuse can be effectively eliminated by shifting the emphasis from prosecution to prevention. We need a change in attitude, in direction, and in the rhetoric. The federal government and the physician community need to become partners once again.

We believe that HCFA should focus on administrative simplification and education. If the federal government is truly committed to addressing alleged health care fraud, it should simplify the requirements and commit significant resources to educating physicians and other providers about its current requirements.

II. MEDICARE COVERAGE PROBLEMS

A. Background

The problems associated with coding are further exacerbated by HCFA's method of establishing Medicare coverage policies. Currently, there are three methods that HCFA utilizes directly or indirectly to develop Medicare coverage policies.

1. National Coverage Policy. The Medicare statute is the primary authority for what is and what is not covered under Medicare. In addition, HCFA issues "national coverage policies," also known as "medical review policies." A national coverage policy indicates whether and under what circumstances a particular item or service is covered. A statement of national policy regarding Medicare coverage is: (1) published in HCFA regulations; (2) published in the *Federal Register* as a final notice; (3) contained in a HCFA ruling; or (4) issued as a program instruction in the *Coverage Issues Manual* or the *Medicare Carriers Manual*. Federal laws and regulations govern the issuance of national coverage policies.

2. Local Coverage Policy. Medicare carriers may also issue local coverage policies, known as "local medical review policies (LMRPs)." The *Medicare Carriers Manual* refers to a LMRP as a "program integrity tool." It is

developed to address "identified, or potential abuse (e.g., overutilization)," and it cannot conflict with any national coverage policy.

A LMRP specifies the criteria that are necessary for an item or service to be covered by Medicare. Carriers are allowed to identify the clinical circumstances that it considers to be "reasonable, necessary, and appropriate." The process for developing a LMRP includes: (1) the development of a draft policy based on a review of the medical literature and the local standard of practice; (2) soliciting comments from the medical community, including the Carrier Advisory Committee (CAC); (3) responding to and incorporating into the final policy comments received; and (4) notifying providers of the policy effective date.

3. Model Coverage Policy. While federal law and regulations govern the requirements and the process for developing national coverage policies and LMRPs, there are no legal requirements for the development of "model coverage policies."

In the past, working groups of Carrier Medical Directors (CMDs) have been formed under the auspices of HCFA. Their meetings are not open to the public, and there is no opportunity for comment by outside groups. These groups develop model coverage policies and promulgate them to the Medicare carriers, who are free to adopt, change or reject them. These model policies

carry the imprimatur of HCFA that they do not conflict with any national coverage policy.

B. The Problem

Increasingly, Medicare carriers are implementing LMRPs restricting Medicare coverage for a variety of medical services. This is being done even though the LMRP may violate the standard of care. Carriers are also restricting coverage for certain medical devices, even though those devices are approved by the Food and Drug Administration (FDA) for safety and effectiveness.

For example, in February of this year, Blue Cross and Blue Shield of Florida, the Medicare carrier in that state, issued a policy denying coverage for a FDA-approved, simple and relatively inexpensive breath test that can identify ulcer-causing bacteria. It would have spared many patients from having to undergo an endoscopy, a more expensive procedure in which the patient must be sedated and a tube inserted down the patient's throat into the stomach.

These policies are the product of one of the two processes highlighted above, the LMRP and the model policy processes. For different reasons, both of these processes pose problems and public policy concerns.

The model policy process is, at best, secretive, and at worse, illegal. There are no written operating policies or procedures. There is no opportunity for comment, and the meetings are held behind closed doors. In addition, the

model policies that are developed may conflict with the standard of care. Despite all of this, HCFA takes a "hands-off" approach to this process.

HCFA has also not exercised its oversight responsibility for Medicare carriers developing LMRPs. Even when it is pointed out that the carrier has violated the prescribed standards or procedures for developing a LMRP, HCFA has refused to intervene to stop the process.

This leaves the Medicare beneficiaries and providers with few remedies to challenge restrictive Medicare policies. It also produces a multitude of coverage policies for a host of items and services, coverage policies that will vary from state to state. This will inevitably result in an unequitable health care system. If Medicare is truly a national program into which citizens from every state pay a respective share, then every citizen, regardless of the state in which they reside, should receive the same care.

The problem is compounded by the new Medicare provisions of the Balanced Budget Act of 1997. The new Medicare + Choice program will make a variety of new health insurance plans available to Medicare beneficiaries in addition to the risk plans already available. In most states, the Medicare carrier also has a private insurance business with plans for Medicare recipients. There is little doubt that the carriers will increase the types and numbers of these plans under the new Medicare + Choice program.

Consequently, as the Medicare carrier, the company can implement LMRPs that will have the effect of driving beneficiaries into its private insurance plans. It can restrict Medicare coverage for items and services. At the same time, it can provide coverage for those same items and services in its private Medicare insurance plans. Medicare beneficiaries will be enticed to leave their current Medicare fee-for-service arrangement, where coverage is being restricted, and join the carrier's managed care plans where everything is covered. This is, at best, a clear conflict of interest.

In addition, the new Medicare amendments require HCFA to produce certain plan coverage information and comparative data. If LMRPs are allowed to exist, HCFA will be unable to adequately comply with the new requirements of the Medicare law.

As this Subcommittee focuses on the complexities of Medicare coding, the problems associated with Medicare coverage policies also warrant examination. At the very least, HCFA needs to rein in its carriers and use its oversight authority to enforce its policies and procedures for developing LMRPs. HCFA should also put a halt to this closed-door model policy process and devise a method for increasing the development of national coverage policies.

III. COMPUTER PROGRAMS AND SCREENS

In treating a Medicare patient, physicians must first determine what is and what is not covered by Medicare. He or she must then determine what is the appropriate CPT code to bill and what, if any, modifiers to use. The physician must also complete the necessary paperwork to ensure that the patient's chart is properly documented for Medicare billing purposes. All of this is in addition to direct patient care. In fact, all of these requirements take away from direct patient care. The more complicated and extensive we make the documentation and billing requirements, the more we add time and costs to the delivery of health care, and the more time we take away from patient care.

Yet, even if the patient is properly treated and the documentation and billing is correctly completed, the hassles for the physician are not necessarily finished. The fact is that Medicare carriers often employ computer edits or screens. These edits are employed as a utilization review tool to automatically flag claims that exceed a given amount, or otherwise do not meet some unpublished criteria set by the carrier.

These Medicare carrier edits operate in a similar fashion to the screens that the Internal Revenue Service's (IRS) computers use in analyzing tax

returns. If a deduction or other entry exceeds a preprogrammed amount, the computer "kicks out" or "flags" the tax return for a manual review.

With Medicare carrier edits, however, the computer not only flags the claim, but it also automatically denies it. There is no manual review by a claims examiner. The claim is returned to the physician. The physician must then file an appeal.

What is tragic is that the physician may have done everything correctly and be in total compliance with a given coverage policy. However, because of the unknown and invisible computer screens, the claim may still be rejected.

Take, for example, the following situation with Blue Cross and Blue Shield of Florida, the State's Medicare carrier. Over a year ago, Blue Cross implemented a new policy governing the removal or destruction of benign and premalignant skin lesions. This policy focuses on lesions that are medically referred to as "actinic keratoses" (AKs).

The Florida carrier's new policy represented a major change in Medicare coverage. Previously, Medicare covered the removal of AKs when it was considered medically necessary by the patient and the treating physician. This new policy circumvents the physician's judgment by describing specific circumstances and a course of treatment where the carrier will approve the removal of AKs. If none of these circumstances exist, or if the required

treatment is not followed, the carrier considers "the removal of an actinic keratosis as cosmetic and, therefore, noncovered." Patients would then have to either pay the charges themselves or remain untreated.

There is nothing in the Florida policy restricting the number of lesions that can be removed and reimbursed annually. Nevertheless, the computers for Blue Cross and Blue Shield of Florida are programmed with an edit to flag any claim for the removal of AKs after 15 AKs have been removed in any year. Even if the removal was appropriate under the restrictive Florida policy, the claim will be denied simply because the carrier's annual artificial threshold of 15 was exceeded. The physician is left with having to file an appeal because his or her claim was denied on grounds that were not even official Medicare coverage policy. This is not right. This is not fair. Physicians are being penalized for matters not within their control.

The Academy appreciates the need for utilization review. However, where artificial edits are used, flagged claims should receive a manual review automatically. An examiner can then determine if the claim meets established policy, and the need for a denial and subsequent appeal can be negated. As the Subcommittee reviews Medicare billing, special attention should be directed to the computer edits employed by Medicare carriers.

IV. CONCLUSION

The American Academy of Dermatology appreciates the opportunity to share its views and concerns with the Subcommittee. We hope that these comments on the Medicare system are helpful to the Subcommittee's deliberations. We stand ready to furnish additional information or assist the Subcommittee and its staff in any way that we can.

The Academy thanks Chairman Shays and the members of the Subcommittee for holding this important hearing. We hope that it will not be the last examination this Subcommittee makes of the complexities of the Medicare coding and billing processes.

STATEMENT OF CARL STRAUSS, M.D.

Dr. STRAUSS. My name is Carl Strauss, I am a primary care internist in the Kansas City area and along with the other physicians here, we are indeed pleased that you came down to listen to us. That is a start; we all need to listen and we all need to talk and I am somewhat relieved and soothed by that.

I am not soothed by the gentlemen at the table, although I understand that our legal system is an adversarial one. I appreciate what they do, and support their doing it. However, I do not think that is the issue.

As far as the coding is concerned, I do not think it really makes a lot of difference whether you expand it or contract it. The coding system is a very good system.

Mr. SHAYS. You say is a very good system?

Dr. STRAUSS. Is a very good system for learning how to do evaluation and management. I have learned from it: I want to be a better physician. But to take that very good academically oriented system and place it into the private practice of patient care is very difficult. That is where the hangup is.

Medicine is an art, it is not a science: it is an art based on a science. Let me give you an example. You probably have kids, you are out in the yard, the child falls down, runs to you crying, grabbing his knee. What do you do? You love him, kiss him, kiss the wound, make it better; or do you pick him up and take him to the emergency room? Now who is right, who is wrong? I do not know, I was not there, I do not know that child, I am trying to make a judgment now on what the action of that person, you, taking care of your child. Is it reasonable? Maybe it is, maybe it is not. But there is a range of acceptable activity and I want to take that activity and insert it into a real life situation. That is where I think our problem is that we need the interpretation, the adjudication, the inspection, the carrying out to be reasonable as to what we do as practicing physicians.

We will learn from CPT codes, I have learned a number of things that I think have helped me be a better practitioner, but I have a devil of a time making it work with the patients that I see in the office every day.

One final point, if you will allow me. I am soothed by the fact that you came here to listen to us, but I am not soothed by what the other gentlemen have said, and I cannot be soothed when I hear about bounty systems, when I hear about increased budgets for the OIG, when I hear about increased manpower and obtaining some of that manpower from the FBI, when I see harsh words in the paper: that makes me very nervous. When I go into an examining room to see a patient, I am supposed to be their advocate, but do I treat the patient or do I treat the chart? If I do not treat that chart, I may have a lot of trouble. Not only do I have to treat the chart, but my Government encourages the patient to complain about me. Not that they do not have their rights that they already have and should take——

Mr. SHAYS. Thank you, sir.

Dr. STRAUSS. Thank you. [Applause.]

STATEMENT OF ROBERT DURST, M.D.

Dr. DURST. Dr. Robert Durst, Topeka, KS.

Of the 7,500 codes we have talked about, 100 of them have to do with E&M, and there is a big problem there.

Mr. SHAYS. A hundred have to do with what?

Dr. DURST. Have to do with evaluation and management, and that is basically what we have talked about today. The other 74 have to do with surgical procedures and laboratory, and those 7,400, to the best of my knowledge, work exceptionally well. So you would really need to focus on 100 of them.

Of the 100 of them, a big part is physician compensation and other evaluation and management, a great deal of it is subjective, whereas the other is objective. And that is one of the big problems we have in determining what it is.

But the big reason I am up here is because of the fear, the fear of what might happen to me, because as I understand the way the law is written, it is very onerous, and you can basically come in and do whatever you want. There is a part of me that looks at the law and the letter of the law and I realize what can be done to me under the letter of the law. There is another part of me that I have always felt like America is a very fair place and that if they came in and looked at my office and said you made an honest mistake, there would be a reasonable penalty, you know.

But it is the fear part, the fear of what could happen to me that affects people like myself who are 55 years old and trying to decide whether we continue to practice medicine or not.

Thank you.

Mr. SHAYS. Thank you very much, sir.

STATEMENT OF TOM WILLIAMS, M.D.

Dr. WILLIAMS. I am Tom Williams, I am a family practitioner in Johnson County and I was asked to read a letter by a psychiatrist, Dr. L'Ecuyer, who could not stay. He is also a practitioner in Johnson County. And although I do not practice psychiatry, I can identify with this.

"Thank you for giving us physicians a chance to be heard regarding the complexities of Medicare regulations. The Medicare coding for psychiatry, which I practice, has been extremely confusing over the last several years. As an example, in January 1996, we were given revised policies for individual medical psychotherapy, a 90843 was to be 20 to 30 minutes and a 90844 was 31 to 50. In December 1996, the codes were replaced by a GOO72 and a GOO74 respectively, except that GOO74 was to be 45 to 50. That left it open for interpretation. In January 1998, these codes changed again, 90805 and 90807 respectively and again the times changed.

"Every month I receive a package anywhere from one and a half to an inch thick and I spend a couple of hours going through it a week. Other insurance companies also have complexities. This takes time away from patients" and he finally says "Thank you for your efforts to help make Medicare's operations more user-friendly to providers so that we can serve our patients better. With the current civil and criminal penalties applying heavy-handed toward errors in coding for billing and numerous changes made by Medicare in its accepted practice and billing, many of us practitioners feel we

may miss one of their changes and be punished severely for the mistake. We providers are willing to play by the rules but the rules need to quit changing month by month."

And I think that the devil is in the details and I would invite anybody here to spend about a weekend with me, go through everything with me, see how this feels and realize that while you are seeing patients, you should not be thinking about jail or if you win, you still lose because nobody will replace your money, your emotional loss or your good name.

Mr. SHAYS. Thank you, sir. We need that letter as well. [Applause.]

Is the name of that individual on that letter? The name of the letter, is there a name on that letter you read?

Dr. WILLIAMS. His name is on that letter.

Mr. SHAYS. Good, thank you.

I guess we are at the last group, which is four plus five because we only have one in group five. So if I could have group four and five come forward. And that is the conclusion, the individuals who will be speaking to us now.

[The prepared statement of Mr. L'Ecuyer follows:]

DRS. WURSTER AND L'ECUYER
A PROFESSIONAL ASSOCIATION

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649-0923

G.R. WURSTER, M.D.
JOHN F. L'ECUYER, M.D.
April 7, 1998

Congressman Vince Snowbarger
House Government Reform and Oversight Subcommittee on Human Resources

Dear Congressman Snowbarger:

Thank you for giving us physicians a chance to be heard regarding the complexities of Medicare regulations. The Medicare coding for psychiatry, which I practice, has been extremely confusing over the last several years. As an example, in January of 1996 we were given a "revised policy" for individual medical psychotherapy; a 90843 was to be 20 to 30 minutes of psychotherapy and a 90844 was to be for 31 to 50 minutes. In December of 1996 we were told that those two codes were replaced by G0072 and G0074, respectively, except that the G0074 was to be for 45 to 50 minutes of psychotherapy; this left the interpretation of 30 to 45 minutes of psychotherapy undetermined. In January of 1998 these codes changed again to 90805 and 90807, respectively; in March of 1998 we were told that the 90805 would include 20 to 44 minutes of psychotherapy and the 90807 would be for 45 to 50 minutes.

Every month I receive a package anywhere from 1/2 to one inch thick of Medicare changes and I have to read them through to find changes as occurred above. I spend approximately two hours per month reading through these Communiques and trying to make sure I am billing according to the most current Medicare guidelines. Since every other insurance company has it's complexities as well, this takes considerable time away that could have been devoted to patient care; patients now have to wait two to three weeks longer to get appointments with me than even six months ago, due to the burgeoning of paperwork and administrative hassles, such as outlined in the simple example above.

Thank you for your efforts to help make Medicare's operations more user-friendly to providers so that we can serve our patients better. With the current civil and criminal penalties applying heavy-handedly towards errors in coding for Medicare billings, and the numerous changes made by Medicare in its accepted practices in billing, many of us practitioners fear we may miss one of their changes and be punished severely for our mistake. We providers are willing to play by the rules, but the rules need to quit changing month to month as this makes for a very difficult way to practice a business.

Sincerely, John L'Ecuyer MD

STATEMENT OF ALLEEN VAN BEBBER

Ms. VAN BEBBER. My name is Alleen Van Bebber and I am a former Federal prosecutor, both for Mr. Williams' office and for the Western District of Missouri and I am now a private citizen. That particular group is not represented here today. As I understand, that was not the purpose of this group. But I do think I stand in a unique position.

These people were my colleagues, they were also my clients and I spent a good deal of my career defending doctors in medical malpractice cases. So I do not really have an axe to grind. I do think with 39 million people who are consumers of this product that those people should be as concerned as the two groups that are represented here.

I heard two things—I thought this was about complexity, but I heard two things. I heard one point of view that said too much documentation, too much complexity, and I heard another point of view that said too much fear because of the potential penalties. Those are two separate issues. I hope that you gentlemen do not get those two issues confused.

How did it get so complex? We heard a lot of things about that too. Results are too that there is also a tendency to add new regulations when the ones you have got do not seem to work or when the bad guys seem to find a way of getting around the regulations. There seems to be an innate tendency to not want to change and I wonder if that serves the purpose. Today, we heard that the doctors are willing to trust a simple system—well, maybe they are not willing to trust a simple system. As you say, there did not seem to be a consensus. Maybe that needs to be looked at a little closer.

With respect to the second topic; yeah, there is an adversarial relationship. We would be naive to say there is not an adversarial relationship at the prosecutor's level. But why should there be an adversarial relationship at the initial regulator level? That to me seems to be where the problem is. People—with all due respect, Doctor, people are not being fingerprinted and hauled into jail without cause. It is that kind of fear that concerns me and it is a fear of something that comes at the end, not at the beginning of the process. And to me that is where the emphasis ought to be, a process of dialog between the regulators, not the prosecutors, but the regulators, the public and the doctors.

We ought to be real clear about one thing, and that is that reckless disregard of the truth and willful ignorance are not the same thing as a simple mistake. We have to have regulators who understand that and we have to have doctors that understand that. Only the bad guys seem to understand that and they have no problem trying to claim that their willful ignorance was a secretary's error or somebody else's fault.

It reminds me of the story where they say are we using a shotgun to kill the skunk in the barn. Well, the farmer ends up killing the skunk but he scares the stuffing out of the cows. And that is what we seem to have with the doctors. Are they rightfully afraid? Perhaps they are. If so, then there may be a price to be paid. What is the right level of documentation? What is the right level of fear. I think you are right, you cannot answer that in one hearing, but I hope that you will do much, much more in trying to separate and

bring together the needs of all three groups—the public, the doctors and the regulators.

Mr. SHAYS. You have done a nice job of articulating the hearing, thank you ma'am.

STATEMENT OF LINDA M. JOHNSON, M.D.

Dr. JOHNSON. Hello. Thank you, I appreciate being here and your listening to us today. I am Linda Johnson, a neurologist from Johnson County.

My comments in some ways reflect what other people have said. The physicians with whom I work are all concerned, very concerned such that their fears have actually been transferred from the litigation attorneys to the Federal Government in recent years. That is partly because the Medicare system has become more complex each year, more burdensome. And I would say that from my point of view and ours, I think that billing errors should not be a fraudulent offense, I think that does bring the whole system into an adversarial role before it is needed.

I also am concerned that this ceiling you have to deal with, of the $211 billion, needs to be looked at from another point of view. I do not think that misbilling or actually even fraud is necessarily what is bankrupting Medicare. I think it is the choice and the prioritizing of how to spend the money and that maybe part of the problem is over-emphasizing the easy thing, which is picking at little details of errors and not looking at the very difficult decisions that have been faced in some countries and in a few States, which is do we prioritize care, how do we do it so that we really spend the money wisely, because in the end, that is your obligation and what we want.

Mr. SHAYS. Thank you.

STATEMENT OF REBECCA GAUGHAN, M.D.

Dr. GAUGHAN. I am Dr. Becky Gaughan, I am an ear, nose and throat physician in Olatha.

I am going to address two issues: One, why am I afraid? I used to be afraid of the IRS and I would worry about that. Then I was afraid, when I became a doctor, of malpractice attorneys. Now I fear the HCFA and I fear the FBI coming into my office. Why? A nurse in the recovery room handed me this today and said oh, Dr. Gaughan, you are going to this conference. This is from the American Journal of Nursing, the most read journal by nurses in this country, April, "Reward for Reporting Medicare/Medicaid Fraud." Did you know, Dr. Gaughan, that I can get 25 percent of the reward if I report a doctor for this? Can you believe this? This is in the American Journal of Nursing. I am concerned about being falsely reported and everyone in this room is concerned about being falsely reported.

Mr. SHAYS. Could we get a copy of that?

Dr. GAUGHAN. Sure.

My other point is I do not think that documentation equals quality of care. I think they are inversely proportional. When I was a medical student, I had a paper brain and I asked all these questions. When I saw the new guidelines, I said, this is what Creighton University gave me my third year to tell me how to do

a history and physical. If you came to me with hoarseness, as a third year medical student, I would meet all the guidelines for a comprehensive visit. I would have missed your throat cancer and you would have died. If you came to me now, I have gone to 4 years of med schools, 6 years of residency and 10 years of practice. I do not have to write out 10 pages, I can diagnose your cancer, I can treat you, I can cure you and you will live.

Now you are asking me to go back to being a third year medical student. I tried it on my patients, I hate seeing Medicare patients when I use these guidelines. I cannot listen to the patient and as a quality physician, I think listening to your patient is the most important thing. That is how you make most of your diagnosis is listening to the patient.

I have started asking them these questions and these poor old people, just like Dick Warner said, they get so confused and you are just pushing them to answer these questions. It is improper and it is opposite of quality care—documentation is not appropriate.

Thanks. [Applause.]

Mr. SHAYS. I think you are the last speaker. That puts a lot of pressure on you.

[The article referred to follows:]

that these nurses meet the patients and families as they did, yet each situation would have been even more unbearable if the nurses had not been there. In each situation the nurse–family relationship calls forth the nurse's best response.

I consider these stories to be resistance narratives in this era of business-oriented health care because they resist the depiction of nursing as a collection of tasks that might be delegated to others. The responses of these nurses are considered "intangibles" in accounting offices and organizational life. Usually such transcendent care does not receive public space and recognition in our organizations. Sometimes such stories are a source of silence and embarrassment because we cannot control these areas of our practice, or promise success. The work goes unnoticed, but opportunities for such meetings—and such possibilities—make our work meaningful, worthwhile, and even privileged.

You are also right that there are many more stories to tell of humor, triumph, and comfort. We keep participating in each others' storied lives daily.

UPDATE ON ARRHYTHMIAS

Thank you for "Identifying Nonischemic Causes of Life-Threatening Arrhythmias" (November). The article provided useful information and reminded readers of the many nonischemic causes of cardiac arrhythmias. However, there were several inaccuracies.

Listed as a cause of hypocalcemia is "malignant neoplasms—especially in bone." Such neoplasms are commonly responsible for hypercalcemia. Medullary carcinoma of the thyroid with calcitonin secretion may cause hypocalcemia. When treating hypocalcemia, the serum phosphorus level should be checked; if greater than 6 mg/dl, the hyperphosphatemia should be corrected before calcium repletion is begun in order to avoid metastatic calcifications.

Hyperthyroidism is listed as a cause of hypercalcemia; I suspect the authors intended this to read hyperparathyroidism. In addition to the treatments of hypercalcemia listed, dialysis may be indicated. Hypomagnesemia may be caused by diabetic ketoacidosis, but not simple hyperglycemia. Hyperparathyroidism may be a cause. Thus, assessment of reflexes should include not only deep tendon, but also Babinski's. Treat-

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STATEMENT OF KATHY CHARTRAND, M.D.

Dr. CHARTRAND. Thank you, I feel reassured. Kathy Chartrand, family practice, Olatha, KS. Vince, you are looking well, it is nice to see.

Mr. SHAYS. How did he look before? [Laughter.]

Dr. CHARTRAND. No comment.

Becky and I actually have known each other since high school days and once again, she has kind of stolen my thunder, but I would just like to echo her comments. Forty-five percent of my practice is Medicare, I am medical director of a nursing home. I see those patients every 60 days, as required and manage them in the interim and manage their families and answer all their concerns.

If I have to document on each of those Medicare patients every 60 days to the degree that I am proposed to do with the new E&M codes, I am not going to be able to continue to do that. I have been taking care of these patients for 14 years, the families trust me, my notes are comprehensive. The tool that Dr. Dickey referred to is what I do use, but I use it as a tool, and as Becky said, I am not going to go back and regress and document as a third year medical student because it has absolutely nothing to do with the care I am providing for that patient.

Thank you.

Mr. SHAYS. Thank you very much. We are coming to a conclusion. I want to thank the second panel who agreed to listen to the comments of constituents in the Kansas area. I thank you for your testimony and also your willingness to stay on the panel and listen. I also want to thank Mr. Barrett, who came and participated in this hearing from Wisconsin. We appreciate his participation and I just give you the floor for any comments.

Mr. BARRETT. Nothing, thanks.

Mr. SHAYS. And also to thank Vince Snowbarger. We are here because Vince asked us to be and I am very grateful he did. And Vince, I would be happy to just give you the floor a second.

Mr. SNOWBARGER. You mean I do not get to take all the time that was allotted to folks that did not show up?

I want to thank the chairman, Chris Shays, for being willing to do this. This is quite an event to move a committee hearing out into the field. You see the number of staff members that are involved, the fact that we have to get a court reporter and all kinds of things of that nature. So it is quite a bit of work logistically. I do appreciate those of you that have shown up and have spent most of your day when you really should have been back in the office trying to bill or something like that—or see patients, one of the two. [Laughter.]

But thank you again, Mr. Chairman, I appreciate your coming out. And to my colleague, Mr. Barrett, I appreciate your coming down from Wisconsin, good to have you here.

Mr. SHAYS. With that, let me just thank all of you who participated and those of you who attended. I think you have done Kansas City proud and Kansas proud and the midwest proud, and it just makes me have to tell you why I just love being an American, when I get around to other parts of the country, I just say this is a magnificent country, it is truly a magnificent country.

We are going to do our work, this is the beginning, not the end, and we will be working with people trying to find some common ground because I think there is common ground.

I thank all for participating and we will close the hearing out. [Applause.]

[Whereupon, at 3:35 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

KMS
KANSAS MEDICAL SOCIETY

To: Subcommittee on Human Resources of the
House Government Reform and Oversight Committee

From: Jerry Slaughter
Executive Director

Date: April 9, 1998

Subject: Proposed Medicare Evaluation and Management Documentation Guidelines

The Kansas Medical Society appreciates the opportunity to offer comments regarding the proposed evaluation and management (E/M) documentation guidelines that are scheduled to become effective for the purposes of Medicare on July 1, 1998. KMS represents over 4200 physicians in all specialties across the state of Kansas.

We are strongly opposed to the implementation of the documentation guidelines as they currently are constructed. They are unnecessarily complex, time-consuming and burdensome to the practicing physician. They will result in fewer patients being seen each day by physicians because of the additional time required for the documentation required, and they will add nothing but cost and hassle to the typical medical practice. An unintended result of these guidelines could be increased physician exposure to fraud and abuse prosecution for inadvertent errors in documenting the care delivered.

The original intent of the new E/M documentation guidelines was to provide more accurate coding that reflects the clinical content of services rendered within the context of the RBRVS. It was hoped by HCFA that the guidelines would give Medicare carriers a better tool to determine whether the services being billed for were actually provided. Physicians hoped the guidelines would improve the quality of patient care, while helping physicians avoid incorrect or inadvertent upcoding. Unfortunately, the guidelines do neither.

Physicians will most likely respond by routinely *undercoding* services rendered to avoid the possibility of prosecution for coding errors. This not only undervalues the true services provided by physicians, but it inaccurately reports the actual patient encounters. Again, neither outcome is desirable for any of the stakeholders in this debate.

Particularly troublesome is the impact these guidelines will have on the patient medical record. Contrary to conventional wisdom, the medical record is designed to be a clinical tool for physicians, not a billing or audit justification for the green-eyeshade folks. The guidelines will clutter up the record with needlessly repetitive and redundant boilerplate information that gets in the way of efficient patient care, instead of promoting it. Subsequent treating or referral physicians will have to wade laboriously through a much more complicated and lengthy chart to

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Western Kansas office • 108 E 12th St. • Hays KS 67601 • 913.625.8215 • 800.293.2363 • FAX 913.625.8234

get at the pertinent information they need to care for the patient. Forcing physicians to fill up their charts with unnecessary data may make all charts look the same, but it won't improve care. Homogenization of the medical record is probably not Medicare's goal, but it will likely be the result.

Finally, the documentation guidelines are counterproductive as it relates to improving access to physicians, particularly primary care physicians, for the Medicare population. The added time required to comply with these guidelines will reduce the number of patients that a physician is able to see by three to five patients a day, it is estimated. For the rural and other underserved areas of our state, this means longer waits and delays for elderly Kansans needing medical care. Additionally, the documentation guidelines will discourage physicians from seeing Medicare patients altogether, further exacerbating the access problem.

For the record, the KMS does not condone fraudulent behavior by physicians. If a physician is intentionally and knowingly violating the law, he or she should be prosecuted. Now, with the expanded use of the federal False Claims Act, regulators have a powerful tool to deter fraudulent behavior. The potential for severe criminal and civil penalties has created a palpable paranoia among physicians. The complexity of the guidelines will lead to inadvertent coding errors or omissions in billing documentation which leaves honest physicians unnecessarily vulnerable to unwarranted penalties and prosecution.

The documentation guidelines should be scrapped. There must be a better way to achieve HCFA's goals without demeaning the profession, substantially increasing costs, creating barriers to access, and subverting the primary focus of the clinical medical record. At a minimum, the guidelines should be delayed indefinitely until the profession and HCFA can work out an acceptable approach to the problem.

Thank you for the opportunity to offer these comments.

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William L. Matthew, M.D. — Kerry B. Jordan, M.D.
John M. Feehan, M.D. — Peter A. Bock, M.D.
Ted R. Cook, M.D. — John R. Bernard, M.D.
KU-OMC Family Practice Residency

April 9, 1998

The Honorable Congressman Snowbarger and Congressman Shays
House Government Reform and Oversight Subcommittee on Human Resources

Dear Congressmen Snowbarger and Shays:

First let me take the opportunity to express appreciation for your time and commitment in not only hosting this Field Hearing on **MEDICARE: CURING CODE COMPLEXITY**, but your ongoing efforts in addressing an extremely difficult and I'm sure frequently volatile issue.

My name is John Feehan, M.D. I am a family physician that practices and teaches in Olathe, Kansas. My professional time is shared between the opportunity to provide family medicine care and the teaching of family medicine as a specialty to 10 family medicine residents. The Kansas University Medical Center Department of Family Medicine sponsors our community track in conjunction with Olathe Medical Center. It is with this background that I would like to take the opportunity to share concerns with you related to the Medicare E & M documentation guidelines.

First an example of why I believe the proposed E & M documentation guidelines are too complex: One of our third year residents recently spent 4 weeks with me doing an elective rotation in practice management. As a special project he was assigned to do an internal audit on the encounters of 15 physician providers (five faculty and ten residents). The goals of this project were to expose him to the concepts of QAQI, reinforce the proposed E & M documentation criteria (through the repetition of chart auditing), and to review how effective we have been in both teaching and implementing the documentation guidelines. Of 66 encounters, 20% of these had questionable documentation to support the level of encounter. There was no variance between the percentage of fallout from faculty to residents. My point in this example is twofold. First, the complexity of the guidelines is such that even our educators are having difficulty implementing it. Second that a resident with nearly 7 years of combined medical school and residency training found the guidelines difficult to apply in auditing charts. *This experience reinforced to me that these guidelines are going to be incredibly difficult to implement, and to audit.*

Secondly, I would like to echo some comments that AAFP President Neil Brooks, M.D. is reported to have delivered recently to the Practicing Physicians Advisory Council:

- The guidelines are too seriously flawed to be fixed by minor alterations.
- Implementation of these guidelines is overly burdensome and hard to follow. A consequence of this will be to threaten high-quality, cost-effective patient care. This may also become a reason for physicians not to treat Medicare beneficiaries.
- If the guidelines are implemented after minor alterations, then the medical notation of a finding of "normal" should be sufficient.

- Focus on the documentation of "negatives," may make it more difficult for physicians and colleagues to locate pertinent clinical information in the patient's record.

- Finally, that the guidelines may achieve a goal of the Office of the Inspector General of the Department of HHS and HCFA with respect to payment auditing, but the guidelines detract from the goal of good patient care. Any E & M documentation guidelines should absolutely preserve the first goal of medical records as being the promotion and documentation of high-quality, cost-effective care to our patients.

Thanks again for hosting this Field Hearing, and for your ongoing time and commitment to this extremely complex issue.

Sincerely,

John Feehan M.D.

John Feehan, M.D.
Clinical Assistant Professor of Family Medicine
Residency Track Director, KU-OMC Family Medicine Residency Track

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INDIVIDUAL PROVIDER # :
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AMOUNT OF BENEFITS PAID :
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Topeka, Kansas 66629-0001

If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of 13.875 percent for each 30-day period. Periods of less than 30 days will be counted as 30-day periods. Medicare has the authority to charge interest on its outstanding Part B debts in accordance with Section 1833 (j) of the Social Security Act and 42 CFR 405.376.

On January 24,1998, we will automatically begin to offset the overpayment amount against any pending or future assigned claims. Offset payments will be applied to the accrued interest first and then to the principal. If you believe that offset should not be put into effect, submit a statement within 15 days from the date of this letter giving the reason(s) why you feel this action should not be taken, to:

Medicare Payment Safeguards
Cost Center 380L
PO Box 1558
Topeka, Kansas 66601-1558

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For copies of applicable laws and regulations, please contact us at the address shown in our letterhead.

As Carrier for the Medicare Program, it is our responsibility to advise you that if you continue to bill for services which are determined to be billed incorrectly and the billings are determined to be willful and intentional, this could result in you being excluded from the Medicare Program, as outlined in Section 1128 (b) (6) of the Social Security Act. Also, continuation of these incorrect billings could result in application of Civil Monetary penalties of $10,000.00 per line item as provided under the Civil Monetary Penalty Law of 1981 Section 1128A of the Social Security Act (42 USC 1320a-7a).

If you should have any questions regarding this matter, please contact me at (785) 291-8674.

Thank you in advance for your prompt attention to this matter.

Sincerely,

Sharon Smith

Sharon Smith, Analyst
Medicare Payment Safeguards
E973195A/E970000A

cc: beneficiary

March 18, 1998

Congressman Vince Snowbarger
8826 Santa Fe Drive, Suite 350
Overland Park, KS 66212

RE: Upcoming Field Hearing on Medicare: "Curing Code Complexity"

Dear Congressman:

I would commend you and your committee for bringing this Field Hearing to the Kansas City area. This is indeed a subject which is of great concern to me as a practicing interventional radiologist at Saint Luke's Hospital in Kansas City, MO. I find myself frequently in a position of performing new procedures on patients for which there is either no code or for which we do not know how to code. We experience a great deal of difficulty finding the proper answer even when we consult our national specialty organizations.

The vast majority of my problems with coding have to do with new procedures or variations of old procedures for which new codes have not been developed. As I understand it, the local Medicare carriers across the country do have some authority to negotiate locally regarding coding controversies. I understand, however, that this is usually done retrospectively for people who have probably charged too much or used too many codes.

I would like to suggest a proactive solution to the above mentioned situation. When it is necessary that I perform a procedure for which there is no code, I would like to have the ability to contact someone in the local carrier's office who could speak to me regarding the situation. Generally, I will have some notion as to what the coding might be and the local carrier's coding expert will probably have some suggestion as well. It would seem reasonable that the two of us, on a proactive basis working with the local carrier committee or a subcommittee thereof, would be able to come to an agreement on how to code for that procedure within a short period of time. The local carrier could then inform other individuals in our area of this agreed upon solution. They could also forward this information to HCFA for their comments. HCFA could in turn inform other carriers across the country and we could very rapidly solve, on a tentative basis at least, how to bill for this new procedure. In past years we have frequently used a code which is similar and would produce a similar fee to what we think is reasonable for the new procedure. However, under the new rules and excessive scrutiny by the Office of Inspector General this does not seem like a reasonable thing to continue to do.

It would seem reasonable that a part of this mechanism would include a rule that the local Medicare carrier must either approve or offer another suggestion for coding and that a workable solution between the differences suggested would be worked out within a reasonable period of time.

The above suggestion, if implemented, would really solve the vast majority of my coding problems.

I appreciate any attention that you or your office could give to this suggestion. If you have any questions, I would be happy to speak with yourself or any member of your committee.

I am sincerely yours,

G. David Dixon, M.D.

GDD:lls

cc
Ms. Jill Watson
Director of Public Affairs
Metropolitan Medical Society
3036 Gillham Road
Kansas City, MO 64108

Handout for Congressman Snowbarger's Field Hearing on Medicare: Curing Code Complexity

Stuart L. Shear, M.D.
Los Angeles, CA

It was the first week in March of this year on an unusually cold morning that I took from my pocket the key to the front door of my office which is located in a decaying, inner city neighborhood in Los Angeles. As I turned the key to enter, a young blonde woman in a blue dress called out to me from across Whitmer Street, "Dr. Shear! Dr.Shear! Can I talk to you for a minute? She ran across the street with her hand held out to shake mine.

"I'm Jennifer Fitzgerald.

She introduced herself as a recent journalism graduate of a small local catholic liberal arts college. She was on her first job assignment with a small inner city newspaper.

"I am doing a story on the gangs in this neighborhood. It will be a byline!"

She could have been my daughter. Her fresh youthful enthusiasm contrasting with the background of vandalized cars and turned over garbage cans, and the ethnic and minority young men out of work and hanging around on the sidewalk behind her. She asked if I could talk to her for a little while. I had a half an hour before my first patient and I invited her into the office. We came into my consultation room. As I microwaved a cup of instant coffee for each of us, she took out a pad and pen from a leather bag with the words CHANNEL written on it.

"Why do you practice here Dr. Shear?"

I looked into her clear blue eyes and paused for a few seconds and then with a soft cracking voice and with a slight welling up of tears in my eyes the words came out.

"Because I love it."

"If I may ask, how much money do you make here?"

"I make about half of what the average physician made last year in this Medical Economics Magazine Survey."

I picked the magazine up from the counter and handed it to her. "You can keep this by the way."

"Are you bothered by the gangs in the neighborhood?"

I took her over to the window which looks down on 6th Street."

"See that 1984 white station wagon?"

"Yes"

"I have parked it there for years and it has never once been vandalized. The gangs don't bother me. Its never been a problem. I don't really know why."

"Then what is your biggest problem?"

"My biggest problem is the new Medicare documentation regulations that take effect July 1st of this year"

Just then Theresa came in.

"Jennifer, this is Theresa. She is my medical assistant, office surgery nurse, receptionist, office manager, and social worker. Its the two of us here."

"Getting back to these new regulations, here is one of my patient's charts. I inherited this 5 inch by 8 inch charting system from the retired physician from whom I took over this practice. I have 8,000 active charts and another 16,000 inactive (not seen in the last 3 years). The vast majority of my patients are Medicare with Medi-Cal (California Medicaid). They require these new Documentation regulations.

"The requirements are for copious notes which will make it impossible for me to continue to afford to dictate my charts. I have been dictating charts ever since I left my residency training. Dictation costs 13 cents a line."

> "Come out here to the nurses station. All these file cabinets have to be replaced by 8 1/2 by 11 inch file cabinets. Refurbished file cabinets are running $440.00.

I lifted the refurbished office equipment catalogue from the top of the old file cabinet and pointed to the price.

"That makes a total of $1760."

"We need this new size file cabinet to fit this boiler plate 3 page 8 1/2" by 11" form into every Medicare chart. This form was sent to us by our specialty society. You see here...we have to get a certain number of bullet points to be reimbursed fairly. This means a series of medical assistant duties such as weighing patients, taking their blood pressure, pulse, temperature, and respirations. Even when it is not necessary or relevant. Each patient is to fill out a review of systems sheet here. Most of my patients don't speek English. Many are too old and arthritic to write clearly or even see the printed word. When I see a patient, I am, many times, calling a relative or friend on the phone to communicate with them through translation...Vietnamese, Russian, Korean, Chinese, Tagalic, you name it."

"Here are applications for a medical assistant we have to hire to help Theresa out with this volume of excess, irrelevant medical assisting duties. We need someone on board by July 1, preferably before. That is salary plus worker's compensation insurance and health insurance. It may cross the line between overhead and income here and finally this federal regulation will actually put me out of business. We are very worried. She will also be helping the patients fill out the the frequently unnecessary review of systems even when there is no medical reason for it for good patient care. We are treating the chart not the patient. Our charts will be providing beans for a federal a agency's bean counters. They will no longer be our tool for proper patient care."

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"I have only touched the iceberg of how this new federal regulation will affect my practice. My hands will be on the chart instead of the patient. The Weed System of medical records (also known as the SOAP system) created and taught by some of the greatest American medical educators of our time will be abandoned. J. Willis Hurst, M.D., a champion of the Weed system who helped introduce it and wrote about it in textbooks and medical journals 30 years ago stated the beauty is in the relavence, pertinence, efficiency, and opportunity for good prose. These new federal regulations create the DOPE system: Document obsessively, pointlessly, excessively."

"Already I receive mail like this brochure, lifting a shiney blue pamplet with the words 'Software for the New Documentation Regulations.' For $2,500.00 you can press a button on the computer and beat the system. The irony is that these new regulations were created to combat fraud. Thus the wealthy frauduient physicians who can afford sophisticated software will be upcoding even higher, it will again be the honest physicians who will pay the price of unnecessary governmental regulations."

I received a call from Jennifer today. She said she wrote about my most important problem for her first assignment. Her editor said it was a good piece of work but decided not to print it and instead sent her back out here to get a story about the gangs. I told her to make sure and stop by and I would walk her through the neighborhood.

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