

REPORT NUMBER THIRTY-FIVE

to the

Secretary

U. S. Department of Health and Human

Services

(Re: Proposed Evaluation & Management Documentation  
Guidelines 2000, plus updates on Program Integrity,  
PRIT, HCFA/OIG Audits, and other matters)

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From the

Practicing Physicians Advisory Council

(PPAC)

For December 11, 2000

## Attendees at the December 11, 2000, Meeting

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### Members of the Council:

Derrick L. Latos, MD, *Chair*  
Nephrologist  
Wheeling, West Virginia

Jerold M. Aronson, MD  
Pediatrician  
Narberth, Pennsylvania

Richard A. Bronfman, DPM  
Podiatric Physician  
Little Rock, Arkansas

Joseph Heyman, MD  
Obstetrician/Gynecologist  
West Newbury, Massachusetts

Sandra L. Hullett, MD  
Family Practitioner  
Eutaw, Alabama

Stephen A. Imbeau, MD  
Internal Medicine/Allergist  
Florence, South Carolina

Jerilynn S. Kaibel, DC  
Chiropractor  
San Bernardino, CA

Dale Lervick, OD  
Optometrist  
Lakewood, Colorado

Angelyn L. Moultrie-Lizana, DO  
Family Practitioner  
Artesia, California

Sandra B. Reed, MD  
Obstetrician/Gynecologist  
Thomasville, Georgia

Amilu S. Rothhammer, MD\*  
General Surgery  
Colorado Springs, Colorado

Maisie Tam, MD  
Dermatologist  
Burlington, Massachusetts

Victor Vela, MD  
Family Practice  
San Antonio, Texas

Kenneth M. Viste, Jr., MD  
Neurologist  
Oshkosh, Wisconsin

Douglas L. Wood, MD\*  
Cardiologist  
Rochester, Minnesota

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\*Absent

DHHS and HCFA Staff Present at the December 11, 2000, Meeting

Robert A. Berenson, MD  
Acting Deputy Administrator  
Health Care Financing Administration

Mark Miller, PhD  
Deputy Director  
Center for Health Plans and Providers

Paul Rudolph, MD, JD  
Executive Director  
Practicing Physicians Advisory Council  
Office of Professional Relations  
Center for Health Plans and Providers

Barbara Paul, MD  
Senior Advisor  
Physicians Regulatory Issues Team (PRIT)  
Center for Health Plans and Providers

David C. Clark, RPH  
Director  
Office of Professional Relations  
Center for Health Plans and Providers

D. McCarty Thornton, JD  
Chief Counsel to the Inspector General  
Department of Health and Human Services

William Gould  
Senior Technical Advisor  
Office of Program Integrity  
Office of Financial Management

Helen Blumen, MD  
Associate Medical Director\*  
Aspen Systems

Hugh Hill, MD, JD  
Deputy Director  
Program Integrity Group  
Office of Financial Management

J. Leonard Lichtenfeld, MD  
Medical Director\*  
Aspen Systems

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Ted Cron, Consultant Writer-Editor

\* HCFA Contractor

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Public Witnesses:

None

## The December 11th Meeting: Morning Agenda

The 35th meeting of the Practicing Physicians Advisory Council was opened at 8:55 AM by the Council Chair, Derrick L. Latos, MD. The Chair indicated that this was the final public meeting for himself, Maisie Tam, MD, and Jerilynn S. Kaibel, DC, and that nominations are being accepted through the end of CY2000. Dr. Latos expressed his thanks to fellow Members and to the HCFA staff, adding that it had been a Areal honor and a pleasure to serve and to work during these tumultuous times.@ He also expressed his appreciation for DHHS Secretary Donna Shalala=s Aefforts to really engage the clinical community with the policy making bodies, such as HCFA.@

Next, Robert A. Berenson, MD, Acting Deputy Administrator, HCFA, told the Council that this might be his final meeting as well, adding that APPAC now is ... where the action is in terms of representing practicing physicians.@

### The Grid Review

The Chair then turned to the Recommendation and Follow-up Report (the Agrid@) prepared by Paul Rudolf, MD, JD, PPAC Executive Director. The Chair noted that PPAC had Arepeatedly@ and Astrongly@ asked that HCFA require managed care plans to disclose risk-adjusted profiles to their physicians so that those physicians Acan get a sense of what they need to do for the next contract cycle...@ But the Follow-up Report for December 11 indicates that the issues are Astill under discussion.@

**Waiting for the Anew leadership@:** Dr. Berenson responded that the incoming Anew leadership of HCFA needs to be involved and ultimately [make] judgments about some of these issues.@ He observed that risk-adjusted payments, encounter data, and related matters are key business issues for managed care plans and figure prominently in their decision-making for participation in Medicare+Choice. Therefore, said Dr. Berenson, these questions should be ripe for discussion at the March or possibly the June PPAC meetings, depending on Ahow quickly [the] new leadership gets their feet on the ground and is able to ... grapple with the issue.@ Council Members replied that they hoped HCFA would Anot focus solely on financial issues, but [rather] on the ways in which physicians can improve their performance in caring for Medicare beneficiaries,@ and data feedback is one sure way to help physicians do that, they said.

### Clinical Examples Under Discussion

The next agenda item concerned the proposed Avignettes@ for the Evaluation and Documentation (E&M) Guidelines. It was noted that the term Avignettes@ had been changed to Aclinical examples.@ The Chair asked Sandra B. Reed, MD, to report to the Council on the results of the AMA meeting in Orlando, Florida, regarding the proposed E&M guidelines and clinical examples. Dr. Reed reported the following:

\$ The participants at the AMA meeting resolved that the process of developing the examples be Aopen to all specialty societies@ and not be limited to HCFA=s initial choice of 20.

\$ The participants strongly urged HCFA to work with the ... CPT Editorial Panel for simplifying the Documentation Guidelines in order to make this process less burdensome to practicing physicians.

\$ The participants also called for more education and information for physicians regarding the pilot studies and exactly what would happen if you participated in the pilot studies without a process of immunity or some type of protection against audits.

Dr. Berenson expressed the hope that we now can have more explicit participation with the CPT Editorial Panel because we've gotten over some of the difficulty between AMA and HCFA ... on this issue.

**Aspen staff outlines plans:** Drs. Helen Blumen and J. Leonard Lichtenfeld of Aspen Systems, HCFA's contractor for developing the proposed clinical examples, outlined their approach to the problem. These were some of their points:

\$ This is a work in progress and it will be an open, inclusive process.

\$ The guidelines will not be implemented until all medical specialties have participated in the development of clinical examples.

\$ While the process begins with 20 specialty societies, Aspen anticipates that those specialty societies will serve as conduits for information from any and all other medical societies and interests. Dr. Rudolf later explained that the first 20 specialties will have two rounds of comments, and then any other specialties ... will also have two rounds of comments later on.

\$ As for the issue of equivalency of work, Aspen wants to be sure that the formats are similar across all examples ... that the output is consistent across a broad range of activity.

\$ A significant concern is down coding, that is, that the medical records may have been down coded by physicians who wanted to avoid review. But Dr. Lichtenfeld added, Quite honestly, ... I don't believe that's going to be a major problem.

\$ For both Physical Examination and Medical Decision-Making, the contractors will obtain 2,000 representative pre-payment records from five or six Medicare carriers, tease out from that archive 5 clinical examples for each of 3 levels of complexity (brief, detailed, and complex), as reviewed and approved by 20 medical specialties, and produce a final total of 600 clinical examples.

Dr. Blumen said, We're looking to assist practitioners with coding, to illustrate examples of excellent coding. We're not trying to change clinical practice. Clinical practice is just fine as it stands.

**Concerns about work equivalency:** Members continued to question the use of comparisons across specialties, especially when reimbursement decisions based on such comparisons will be done by the carriers. They recalled that PPAC had specifically recommended (as reported in the Follow-up grid) that "Vignettes are not to be used as determinants of work equivalence or any standard of care or for cross-specialty comparisons." Yet, work equivalency was clearly a part of the Lichtenfeld-Blumen presentation. Members predicted that the use of work equivalency would lead medicine back into the situation where we had specialties fighting with each other because they don't feel that the comparisons are appropriate. Members noted, for example, certain work equivalency issues that arise between pediatrics and obstetrics-gynecology. Dr.

Rudolf replied, however, that cross-specialty comparisons are required by law; nevertheless, he said, HCFA is trying to reach a comfort level of work equivalency for itself and for the specialty societies, even though getting exact work equivalence is impossible. On the carrier question, Dr. Rudolf noted that five or six carriers would be multi-state carriers, in order to capture that greatest range of examples.

## MID-MORNING BREAK

### Review of PPAC Recommendations in The Grid

The remainder of the morning session was given over to reviewing the Council's recommendations for the E&M Guidelines, as presented in the Follow-up Report. While explaining the adjustments made to the current draft, Dr. Rudolf also left the door open for further PPAC recommendations. These were among the points made by the Council and published on the December 11 grid:

- \$ Under History, PPAC accepted the revisions for the Review of Systems and, in general, felt that the whole thing under documenting positive and negative findings for the review of systems is excellent.
- \$ Additional language was suggested for History of Present Illness to wit, "including but not limited to the patient's ability to communicate, if applicable" and "patient's ability to communicate independent of mental status."
- \$ Permission for Nurses and other ancillary to elicit the chief complaint is not needed, Members said, since a physician must ultimately sign off on the HPI anyway. Dr. Rudolf suggested that such a statement might be more appropriate under II at the beginning, [that any component of the history may be obtained by staff or ancillary personnel. [However, the] physician is responsible for reviewing it ... or something like that. Additional concern was raised that the physician might still not be aware of the scope of the report covered by his signature, and this, too, should be clarified.
- \$ Dr. Rudolf recognized that there may be continued concern over the fact that the draft guidelines show three levels of exams and three levels of decision-making, whereas ... the CPT [has] four levels, for Examination, ... Problem Focus and Expanded Problem Focus [have been collapsed] into Brief, and for Decision-Making, Straight-Forward and Low-Level [have been collapsed] into Low-Level decision-making.
- \$ All agreed that the method for counting body areas and organ systems needs to be revisited by the CPT panel.
- \$ With regard to the pilot test, Dr. Rudolf indicated that nothing had yet been decided concerning physician recruitment, immunity, and compensation nor has a decision been reached on a pilot study of the review process for outliers.
- \$ As for PPAC's concerns about the carriers, HCFA agrees completely that the agency should make whatever effort is necessary to require consistency among the carriers and should perform evaluations of their guideline review variability. A revised standardized review protocol to that effect will be presented to PPAC at its March meeting. Members

noted, however, that carrier education may be the most important part of the revision of the E&M Documentation Guidelines.

**Lingering concerns over the clinical examples:** Following the grid review, the Council returned to the issue of the carriers' use of the clinical examples. If you're going to have carriers looking at [the clinical examples] as guidelines on how to pay, then that's how they're going to be used. The Council said, History [shows] that carriers generally go to the lowest common denominator, and ... that's what's going to happen with these guidelines. If you don't have everything in the guideline, then [the carriers will] drop [to] the next level... to decide how much to pay...

LUNCH BREAK

## The Afternoon Agenda: Program Integrity

Dr. Rudolf promised that for the March meeting he would try to have something [like the grid] available so everyone in the audience knows what the recommendations were from the previous meeting and how we're treating them.

**The error rate concerns dollar value only:** The Chair then welcomed as the afternoon's first witness Hugh Hill, MD, JD, Deputy Director of the Program Integrity Group in the Office of Financial Management. After going back through a couple of basics about Program Integrity, Dr. Hill noted, We think in terms of fraud or error and try to distinguish as much as possible between the two. Dr. Hill also reported that his office was developing a fraud database that would finally show the actual fraud situation in Medicare and pinpoint the true nature of fraud by practicing physicians (suspected to be very low). He noted that the overpayment error rate (deduced from a 5 percent sample of all claims paid) has been reduced over the past 5 years from 14 percent to about 7 percent of the dollar value of all claims paid. The Council noted, however, that the general perception is that the error rate pertains to the filing of wrongful claims and not to the overpayment of dollars. Dr. Hill explained, When we've got limited resources, ... we're going to look where the big dollar losses are... Hence, his group reports overpaid dollars and cannot yet provide accurate wrongful claims data.

**The error rate is close to bottom:** The Council observed that Gaussian theory (Carl Friedrich Gauss, 1777-1855) states that each extremity of a normal, random curve is 2.5 percent, or a combined 5 percent of the total curve. Therefore, because ... you're getting right close to that number, ... you may not be able to go any lower. Dr. Hill replied that our target [is] to [reduce] the error rate to ... five percent by 2002, but he also agreed that the cost of achieving a lower rate may be beyond a diminishing returns point. Dr. Hill thereupon reported the following figures:

- \$ In FY1999 Medicare had 1,160,000 Part B providers (including, but not only, physicians);
- \$ 441, or .038 percent of all providers were suspended;
- \$ those 441 providers received \$321 million in overpayments, so you can see that some of these are big providers... (e.g., hospitals, large medical groups, clinics, etc.);

\$ in FY2000, Medicare had 1,198,000 providers, and 524 (or .044 percent) were suspended.

**Why not Aerror@ rather than Afraud@?:** Dr. Hill indicated that Aon the first cut, all of these [overpayment claims] are investigated as errors@, hence, Council Members suggested his office might be better off to A use the term >error detection= as opposed to >fraud detection.=@ Dr. Hill agreed that Aerror detection@ might sound better, but it would not be wholly correct, Asince we ... have a responsibility to combat fraud, and Congress and the OIG and the public and, frankly, some of our colleagues are looking to us to assure that we are not paying fraudulent providers...@ The Members countered, however, that Athe message@ physicians have been getting is that they are under suspicion of committing fraud Auntil proven otherwise, and we operate under that basis...@ Members also noted that Dr. Hill's office was divided into the Medical Review Unit and the Fraud Unit and suggested that the two might better be known as Athe Error Prevention Unit and the Fraud Unit.@ Dr. Hill conceded, AThose are good points. We should consider that.@

## Proposed Customer Service Survey

PPAC Members had received in advance of the December meeting the Aearly draft versions@ of a proposed Customer Service Survey. Dr. Hill explained that the purpose of the survey Ais to identify constructive changes that will lead to improvements in ... program integrity and medical review activities.@ He said it would be Athe first step in a comprehensive improvement program ... both for HCFA and the Medicare contractors...@ Dr. Hill anticipates that OMB clearance will be achieved by mid-2001, when the survey process can then go forward.

**An opportunity to measure carrier performance:** Members wondered why providers were asked to indicate their satisfaction with carrier performance, but no Aquantifiable@ carrier performance standards were included (e.g., maximum acceptable waiting times on the telephone, etc.). Dr. Hill said he thought that, by presenting such performance standards as guidance, the survey would be asking Aa different question,@ but he agreed to check back with the survey staff. The Chair urged Dr. Hill to give the matter some thought, because Aone of the questions we posed at our last meeting@ concerned Athe kinds of performance ratings carriers are given...,@ adding that the Aadditional data@ from the survey Awould be very interesting information to the Council.@ Dr. Hill said he was sure that Acontractor-by-contractor results will be available to us ... I'm glad you're interested, and we'll figure out a way to get that information back to you.@

**A Warm and fuzzy@ letter with a hint of Abounties@:** Dr. Hill then turned to the Medicare Integrity Program's Aplain language document@ called *Pay It Right*. While Members approved of the Awarm and fuzzy@ tone, they also detected Aa major disconnect between the sound of this document@ and, for example, the real-world pressure on physicians to sign consent agreements or, as another example, the presence of a bonus or Abounty@ system for carriers who detected alleged overpayment errors or fraud. Dr. Hill said there was no such Abounty@ system, but noted that the Payment Error Prevention Program (for detecting error, fraud, and abuse) is promoted through incentives in the contracts with Peer Review Organizations, which are not part of

Program Integrity. PPAC Members felt, however, that such an organizational distinction would be lost on most physicians.

**How many recoupment programs are there?:** Members also referred to the section of the Health Insurance Portability and Accountability Act (HIPAA) that provides a money incentive for beneficiaries to report to HCFA their suspicions of potential acts of fraud by a Medicare provider. The Chair then asked HCFA staff to recount for PPAC all the initiatives that HCFA's using currently to recoup paid monies, and, secondly, all the audits [of providers] that are currently being done..@

**When is a Dear Dr. letter published?:** Finally, Members objected to the fact that this warm and fuzzy letter, directed to physicians, was already on the Web and, in effect, published before PPAC had a chance to review its language, because we've already asked ... that we get a chance to look at [communications to physicians] before they're sent out, and this is ... one of those things. Dr. Hill said the letter was not yet published in hard copy and may not be for some time because of budget limitations, thus enabling PPAC and staff to make improvements.

## **Physician Regulatory Issues Team (PRIT)**

The Chair then welcomed to the witness table Barbara Paul, MD, Director, Physicians Regulatory Issues Team (PRIT) in the Center for Health Plans and Providers. Dr. Paul reviewed the history of PRIT, drawing on her October 24, 2000, report to former HCFA Administrator Nancy-Ann Min DeParle. Council Members congratulated Dr. Paul for her efforts thus far, making special mention of *Medicare and You 2001*, which Members indicated has been widely read by colleagues, staffs, and beneficiaries alike. Members also thought Dr. Paul's Interim Report was very easy to understand ... a good positive-type thing to read and ought to go out on the Web or somehow be made easily available to the physician community at large.

**Four major elements:** Dr. Paul described the broad PRIT effort, which includes, among other efforts, improvements to organized medicine communications, to PPAC communications, and to HCFA educational outreach. In addition, she described four specific developmental projects of the PRIT effort:

- \$ Medicare Basics, a book which will provide the medical profession with basic information about the Medicare program.
- \$ FAQs, a system taking the questions that come in to the agency and that get individually answered, and creating from them an ongoing compilation of Frequently Asked Questions about the Medicare program.
- \$ Sentinel Data, which is a system to measure quantifiable impacts of policy regulation changes on practicing physicians. This will be more quantifiable information than the data gleaned from the Sentinel Clinicians program.@
- \$ The Sentinel Clinicians system, which is envisioned as a process [for asking] ... a random sample of ... some 200 to 1,000 physicians across the country ... stratified in some way ... about aspects of their daily experience as physicians.@

These four programs, said Dr. Paul, are all very early in development, but she anticipates that one or all will be in place by some time this summer or next fall.@

**Interest in the proposed Sentinel Clinicians:** Members raised questions about the proposed Sentinel Clinicians program, even suggesting that its name be changed to something, such as the Community Physician Survey Program. Members also suggested that those of us who are practicing physicians and on PPAC to be included in the Sentinel Physician Program.

**Communications improvements:** Dr. Paul said the agency is doing a needs assessment of practicing physicians to determine their information needs with regard to [www.hcfa.gov](http://www.hcfa.gov). Members suggested that an initial area of need to be assessed is the degree to which physicians have access to B and routinely use B computer communication technologies, such as the Internet. In this regard, the Council also urged Dr. Paul to do whatever is necessary to update HCFA's many Web pages and linkages. Dr. Paul noted that this is indeed the intended end result of the needs assessment effort. She added that the agency was improving not only the internet but also telephone conference calls, exhibits at meetings, and regional physician meetings; she also asked members to send her any of their ideas on additional venues for communication.

**The carrier issue rises again:** During the discussion on the working life of practicing physicians, Members emphasized to Dr. Paul the important day-to-day role the carriers play. Members even suggested that Dr. Paul might wish to explore ways to tap into routine physician-carrier information exchanges to get another perspective on the pressures under which physicians practice medicine. Dr. Paul was interested in the suggestion and noted that HCFA now funds 1-800 numbers for all carriers. But in case the outcome from a particular physician-carrier communication is still unsatisfactory, Dr. Paul noted that the [HCFA] regional office that oversees that carrier now has a very clear line of authority to resolve that problem.

**Keeping patient care in focus:** The Chair and other Council Members appreciated Dr. Paul's efforts to help improve and modernize HCFA's policies with respect to relations with the physician community, but they cautioned that, every time you put a [new] policy in place, the agency needs to ask, Does it have an impact, yes or no, on patient care? Members agreed that they were naturally concerned about the impact of HCFA policies on our lives, [but] it really ultimately comes down to whether [a policy] impacts our ability to provide good patient care. They concluded, If it's bad for the doctors, it's probably bad for the patients.

MID-AFTERNOON BREAK

## Presentation on HCFA/OIG Audits

Following the mid-afternoon break, The Chair welcomed to the witness table D. McCarty Thornton, JD, Chief Counsel to the Inspector General of the Department of Health and Human Services. Mr. Thornton expressed concern about mistaken statements in the press indicating that physicians may go to jail for honest billing errors. These types of mistatements are helping to generate a high degree of baseless fear among practicing physicians. In response, Mr. Thornton offered PPAC these five points:

\$ In our view, the great majority of [practicing physicians] are honest and working to render high-quality medical care to our Medicare beneficiaries... In addition, the annual sample

review of claims by the Office of the Inspector General (OIG) shows that physicians get it right at least 92 percent of the time...@

\$ Our primary enforcement tool is ... the Civil False Claims Act, [which] covers only offenses ... committed with actual knowledge that a claim is false@ or offenses by physicians who demonstrate a reckless disregard of the truth of the claim or [who indulge in] conscious ignorance, [which is] really sort of a form of recklessness.@ Mr. Thornton emphasized that, by law, physicians are not subject to civil or criminal penalties for honest mistakes, errors, or negligence.@ He added, Our other major [law], ... the Civil Money Penalty Law, has the exact same standard of proof.@ Mr. Thornton asserted his office [knows] the difference between negligent errors and mistakes on the one hand and reckless or intentional conduct on the other.@

\$ Even ethical physicians and their staffs make billing mistakes and errors through inadvertence or negligence, and partly that is due to the complexity of the Medicare Program.@ Repeating his belief that physicians get it right at least 92 percent of the time,@ Mr. Thornton said that there's very, very little evidence [of] recklessness or fraud@ in the questionable claims of the remaining 8 percent. Furthermore, in 99 percent or thereabouts@ of those disputed claims (i.e., the 8 percent), the physician eventually will return the amount that is improperly claimed but without penalties.@ This repayment procedure is handled for HCFA by the carriers; the OIG has no direct role [and] no interest in becoming involved in those kinds of disputes.@

\$ The inaccurate and excessive rhetoric@ in the media appears to be leading to some counterproductive behavior,@ Mr. Thornton said, citing physicians dropping out of Medicare for fear of being prosecuted for a trivial offense or ... fearful of returning an overpayment [and thus] engendering an investigation, or under coding on purpose, deliberately claiming less@ than what they're entitled to claim. We believe that physicians and other providers should get paid what they're entitled to under the rules.@

\$ Finally, ... we have not targeted the physician community in any sense, and there's been a gross exaggeration of the extent to which our investigations result in the imposition of civil or criminal penalties on physicians.@ Mr. Thornton noted that a little over 600,000 physicians ... participate in the [Medicare] program.@ However, of the 250 criminal convictions a year won by the government in the past three fiscal years, only 17 per year were physicians.@ And, as far as civil litigation goes, in the last three years, our investigations have led to monetary penalties being imposed about 600 times a year overall but on [fewer] than 25 physicians a year, and again none ... could be characterized as a [mere] billing error or a dispute over medical judgment.@ Hence, [fewer] than 50 physicians [a year] are either sent to jail or receive some sort of monetary penalty as a result of OIG actions.@ Of those 50 cases, Mr. Thornton later emphasized, most are actually settled before they get to trial.@ He also explained that, while the enforcement staff has been strengthened, really very little that they do pertains to physician Part B billings...@

**Positive results from effective enforcement:** Mr. Thornton reported that the heightened effectiveness of the government's enforcement program overall (not just among physicians) has produced a salutary change in behavior among people who present bills to Medicare. Overall,

providers are getting more careful with the bills that they send in. As a result, he said, the overall error rate ... [is] now down to about 7 percent, .. the rate of inflation which had been running 8 or 9 percent in Medicare in the early '90s came down in 1998 to 2.5 percent, and in 1999 ...the inflation rate was actually negative... Most significantly, in 1996 the Trustees of the Medicare Part A Trust Fund ... projected insolvency ... in 1999... They now project the fund to go to 2021 under the current financing.

**Compliance is now a mission:** Mr. Thornton went on to suggest that health care providers [are] adopting compliance as a mission... He said, Five years ago [compliance] was a term that wasn't really even talked about, but today nearly all providers have compliance plans. Last September, after consulting with the physician community, the OIG published and placed on its Web site a model (and voluntary) compliance plan for physicians, said Mr. Thornton. It is simple and focuses on four areas [to which] we suggest physicians pay attention: ... Proper coding, ... adequate medical documentation, ... medical necessity, and ... avoiding kickbacks or other improper inducements. Mr. Thornton's remarks were well received by the Council, but Members repeated their wish that the OIG call its effort an error reduction program rather than a fraud program.

## Re-cap and Close of the Afternoon Session

Following Mr. Thornton's presentation, the Chair welcomed the return to the meeting of Dr. Berenson and Mark Miller, PhD, Deputy Director of the Center for Health Plans and Providers. For their benefit The Chair and Dr. Rudolf recalled the results of the PPAC meeting thus far:

- \$ Regarding the revision to the E&M Guidelines, The Chair said, In general, ... we're very pleased with the revised document and ... with the direction this is going. Dr. Rudolf noted that HCFA will be taking several issues ... to the CPT Editorial Panel in February or May ... He also recalled that some Members wondered if the clinical examples would be used as examples for coding or would they be primary in determining payment.
- \$ A corollary issue, he said, is ... work equivalence. Dr. Rudolf indicated that the staff would have more to say about that at the March meeting.
- \$ Council Members appreciated Dr. Barbara Paul's PRIT report and reiterated their interest in being involved in her several activities, including Sentinel Clinicians (or the suggested new name, Community Physicians Survey Program). They also asked her to find ways to make more visible an up-to-date HCFA organizational chart, complete with phone numbers.
- \$ Members suggested that Dr. Paul investigate the possibility of tapping into communications between physicians and carriers.
- \$ Members also submitted comments on the Program Integrity customer service survey that was still in the planning stage and which had been presented. The Chair said, That's exactly the kind of role [PPAC] wants to play: ... that is, when there is an important document, ... we would like to be able to see it, to ... advise if we think it's really off track. He noted, however, that the survey looks to be pretty solid so far.

- \$ The Members questioned whether or not carriers were given a monetary incentive to find physician billing errors and save money; this, too, may be clarified in March.
- \$ Also for March, said Dr. Rudolf, AThere's the potential for some encounter data issues to be ...addressed...@
- \$ Members also noted the Aon-going issue [of] all the audits ... that examine physician behavior and provider behavior...@and again requested a list.
- \$ Dr. Rudolf also pledged to bring to the March meeting a grid document that could be made available to the audience and to the public at large.

The Chair closed the meeting by voicing his belief that Athere's no question that [HCFA has shown] increased responsiveness to the concerns of practicing physicians, particularly this Council,@ which, he said, Ahas perhaps been more effective in its role of advising HCFA.@ As his last act as a Member of PPAC, the Chair again expressed his Apersonal thanks@to his fellow Members and to HCFA staff and wished everyone Agood luck.@ The Chair adjourned the meeting amid general applause at 4:36 PM.

Respectfully submitted,

Derrick L. Latos, MD  
Chair  
Practicing Physicians Advisory Council

## **Recommendation Highlights, CY2000**

Pursuant to the request of Council, these are the Recommendations presented to HCFA staff and reported to the Secretary of Health and Human Services by the Practicing Physicians Advisory Council in its four meetings held in Calendar Year 2000.

### **From the 32<sup>nd</sup> PPAC meeting, held on March 27, 2000:**

#### **Recommendations with regard to the revision of the ABN:**

- \$ That HCFA staff make every effort to shorten and simplify it, despite the addition of certain lines for clarification.
- \$ That the sequencing of the bullet paragraphs be reordered
- \$ That more space be given for the provider or physician to write down additional comments.
- \$ That the ordering physician be informed of the patient's decision, no matter what it is, in a timely manner.
- \$ That PPAC be kept informed of the status of the ABN revision and be able to provide comment at the appropriate time.

#### **Recommendation with regard to government-wide issues and paperwork:**

Council recommended that HCFA assume the leadership and collaborate with other agencies of government to address issues which impact on physician participation in publicly-funded health care programs. An example of such collaboration would be the provider enrollment form, which could be the same for physicians wishing to enroll in Medicare, Medicaid, CHAMPUS, or other federally funded health services programs.

#### **Recommendations with regard to Encounter Data:**

- \$ That patient encounter data submitted to HCFA by managed care plans be blinded at the level of beneficiary and practitioner so that the source physician is not known.
- \$ That plans not be permitted to change any risk-adjustment data submitted to them by participating physicians, unless it is with the express understanding and permission of the subject physician; in particular, if the physician doesn't go to the fifth level and use the fifth digit in an ICD-9 code, then the plans should not be free to employ a fifth-digit default of their own choosing but must return the form to the physician for the desired fifth digit.
- \$ That HCFA work with those plans not utilizing standard HCP codes and help them make the transition to CPT and HCP codes in order to assure adequate and uniform data transmission; that HCFA work with the health plans to assure that the training of such personnel be really done aggressively; and that HCFA be aware that the CPT tracking codes for certain evaluation and management services will come into play while data collection is going on.
- \$ That HCFA re-consider the *four-only* rule for diagnoses. HCFA may wish to have the diagnoses presented in order of severity *or* by physician specialty *or* in some other way; as the instructions

now stand, the practicing physician has little guidance and the resulting aggregate data may be flawed.

- \$ That HCFA require the plans to publicly disclose and make available their risk-adjusted profiles, and that individual risk-adjustment payments be made to physicians through the plans.

**Recommendations with regard to the Physician Enrollment Form:**

- \$ That the request for gender and race be dropped or made optional.
- \$ That the revised form include place to indicate training status, including fellowships, in order to enroll new physicians into the system early.
- \$ That the specialty list be consistent with the list published by the American Board of Medical Specialties.
- \$ That HCFA contact other agencies to get them to help develop a universally useful form., but that, as a start, HCFA change the name of its own form to something like AFederal Health Care Practitioner Enrollment Form.@
- \$ That HCFA consider tracking physicians through their DEA numbers.
- \$ That HCFA offer longer time periods between re-validations (e.g., 5 or even 10 years) for physicians with no adverse information in their records.
- \$ That HCFA encourage physicians to re-validate and/or apply via the Internet.

**From the 33<sup>rd</sup> PPAC meeting held on June 5, 2000:**

Recommendations with regard to various issues:

- \$ That managed care plans be required to consult with the physician before making any modifications in that physician's diagnoses.
- \$ That the Council be allowed to review the wording of future letters to physicians before they are mailed so that the Council may identify words or phrases that might create problems for physicians and/or the agency.
- \$ That the revised ABN form list the services not covered by Medicare and that it be preceded by a sentence such as this, directed to the patient/beneficiary: **As you can see, these are the (six or seven) most common services that Medicare turns down. Even though the services suggested are covered under some circumstances, it's not going to be covered in your circumstances.@**
- \$ Council recommended the elimination of the first sentence under Option 1 (**If you want to submit any evidence [such as your own letter explaining why you think Medicare should pay], please send it to us, and we will send it to Medicare@**) and the visual separation of a box for Option 2 at the bottom of the second page.

**Recommendations with regard to OIG/HCFA audits:**

- \$ That HCFA provide the Council with a list of all the OIG and HCFA surveys and audits that can subject physicians to possible civil or criminal prosecutions.
- \$ That HCFA review all surveys to determine whether their objectives are to get data or to **catch scoundrels.@**

- \$ That physicians not be held liable for errors found in coding or in documentation during the conduct of the CFO audit.
- \$ That HCFA clarify who the actors are in the CFO audit, precisely what the audit system is supposed to accomplish, and what the law says should be the audit's actual outcomes.
- \$ That physicians, who had been audited and must make repayment, not be required to make repayments immediately in order to enable them to exercise their rights of appeal and due process.
- \$ That HCFA make clear to all physicians that they *always* retain their rights of appeal throughout the entire review process and that no HCFA or carrier policies or procedures circumvent those rights.

**Recommendations with regard to carriers:**

- \$ That carriers assume some liability for failing to identify physician underpayment
- \$ That HCFA clarify for the Council its system for managing contract carriers in order to curb and prevent carrier abuse of the Medicare system.

**From the 34<sup>th</sup> PPAC meeting, held on September 11-12, 2000:**

**Recommendations with regard to the revision of the E&M Guidelines for Documentation:**

- \$ That HCFA work within the CPT process;
- \$ That a grace period or some other mechanism be developed to give immunity to volunteer physicians in the pilot test;
- \$ That peer review be used with outliers, and that HCFA be sensitive to the fact that disadvantaged people may be disproportionately served by medical outliers.

**Recommendations regarding HISTORY in the E&M Guidelines:**

- \$ That the listing of each individual system not be required under Review of Systems.
- \$ That a certain level should be automatically reached, if it is not possible to obtain a history from the patient.
- \$ That growth, development, and functional capacity be included in the Review of Systems.
- \$ That the number of systems to be reviewed should be 1 for Brief, 2 to 9 systems for Extended, and 10 or more for Complete.
- \$ That it be possible to show four or more details about one or more presenting problems (e.g., a total of four details can be given for two presenting problems) under Extended History of Present Illness.
- \$ That one specific item from two history areas may be documented for a patient's complete family and social history.
- \$ That nurses and other ancillary personnel be permitted to elicit the chief complaint in the History of Present Illness (HPI)
- \$ That the status of at least three chronic or inactive conditions be acceptable as Extended HPI.

- \$ That an examination or a history not be required when the only service to be provided is counseling/coordinated care (including medication management), and that only a reasonable or general HPI description be required for the counseling service.

**Recommendations regarding EXAMINATION in the E&M Guidelines:**

- \$ That a limited examination of the affected body area(s) or organ system(s) be permitted under Extended Problem Focus.
- \$ That functional status be included in a physical examination and in a Review of Systems for HPI.
  
- \$ That the terminology in the 2000 revision be consistent with the CPT terminologies and the 1995 E&M Guidelines.

**Recommendations regarding MEDICAL DECISION-MAKING in the E&M Guidelines:**

- \$ That the 2000 revision include the tables from the 1999 Guidelines, which describe Low, Moderate, and High complexity.
- \$ That **ALow** be used for low-risk diagnosis or treatment, **AModerate** for moderate risk, and **AHigh** for high risk.
- \$ That 1 condition be needed for Low-level medical decision-making, 2 to 3 conditions for Moderate, and 4 or more for High Low-level medical decision-making.

**Recommendations regarding CLINICAL EXAMPLES (formerly Vignettes) in the E&M Guidelines:**

- \$ That the Clinical Examples be considered as guides and not mandatory and that their intent is to make it possible to understand the content of the examination and/or the content of medical decision-making.
- \$ That the Clinical Examples not be used as determinants of work equivalents or of any standard of care or for cross-specialty comparisons.

**Recommendations regarding PILOT STUDIES in the E&M Guidelines:**

- \$ That volunteer physicians be able to participate in these studies without penalty.
- \$ That physicians or providers involved in the pilot study be paid on a capitation basis for the number of claims submitted or in some other manner that avoids the issue of paying pilot-study claims from the trust fund.
- \$ That the volunteers who are recruited, including possible outliers, be a diverse and representative group of providers.
- \$ That at least one pilot study involving peer review be conducted to examine outliers and that the reviewing physicians practice the same medical specialties as the outlier physicians whose records are being reviewed.
- \$ That the criteria for success of the pilot study be roughly defined *before* the it is begun and that all parties remain open-minded about the system being tested.

- \$ That HCFA require consistency among carriers and perform evaluations of carrier guideline reviews to assure that variability among carriers will be minimal.
- \$ That the pilot test be a collaborative effort between coders and providers so that both coders and reviewers will be accountable.
- \$ That an educational component for both carriers and providers be built into the beginning stage of the pilot study.
- \$ That HCFA consider a test period longer than the planned six months in order to assure success.

**From the 35<sup>th</sup> PPAC meeting, held on December 11, 2000:**

**Recommendations with regard to the E&M Guidelines:**

- \$ That language be added to HPI to indicate the following: "including but not limited to the patient's ability to communicate, if applicable" and "patient's ability to communicate independent of mental status."
- \$ That a statement be placed at the beginning of the Guidelines to the effect that any component of the history may be obtained by medical staff or ancillary personnel but that the attending or reviewing physician is responsible and signs off for the whole document; in addition, that the Guidelines make clear that the physician's signature indicates his or her responsibility for all information in that document.
- \$ That the method for counting body areas and organ systems be re-visited by the CPT Editorial panel.
- \$ That HCFA do whatever is necessary to require consistency among carriers and periodically evaluate their guideline reviews.
- \$ That HCFA keep close watch on whether the carriers view the Clinical Examples as guides to patient care or as the lowest common denominators for payment.

**Recommendations with regard to error detection and fraud:**

- \$ That the OIG consider using the term error detection as opposed to fraud detection.
- \$ That the OIG audit be divided into an Error Prevention Unit and a Fraud Unit.
- \$ That HCFA do an inventory of all programs to recoup overpayments, in addition to the long-sought inventory of all audits that affect practicing physicians.

**Recommendations with regard to the Physician Regulatory Issues Team (PRIT):**

- \$ That PPAC Members be included in the Sentinel Physician Program, and that PRIT consider re-naming this (something like) the Community Physicians Survey Program.
- \$ That PRIT assess the degree to which physicians have access to **B** and routinely use **B** computer communication technologies, such as the Internet.
- \$ That HCFA update its Web pages to include current mailing addresses, and telephone numbers of key HCFA staff and make such information more visible and accessible.
- \$ That PRIT explore ways to **A**tap into@routine physician-carrier information exchanges.
- \$ That PPAC see in advance any important communication directed to physicians in order to make constructive, positive suggestions for effective changes.
- \$ That HCFA make clear whether or not carriers are given monetary incentives to find physician billing errors.
- \$ That a version of **A**the grid@be prepared and made available to public observers at PPAC meetings.