125448

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

September 27, 1984

Richard L. Fogel
Mr. Fogel
Mr. Bernstein
Mr. Densmore
Mr. Farabaugh
Mr. May
Associate Director
Control Desk
28 SEP 1984

Carolyne K. Davis, Ph.D., Administrator
Health Care Financing Administration

Dear Dr. Davis:

Subject: Reimbursing Physicians Under Medicare on the Basis of Their Specialty (GAO/HRD-84-94)

Medicare regulations permit differences in prevailing rates for physician services if Medicare carriers determine there are differences in charging patterns among various physician specialties. For example, a carrier might establish $15 as the prevailing rate for a brief office visit to a general practitioner but establish this rate at $25 for a brief visit to a cardiologist.

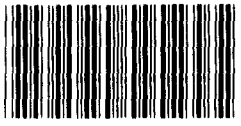
Medicare requires its carriers to compare charging patterns among physician specialities to determine if those patterns show a basis for establishing separate prevailing rates for the same procedure. The 11 carriers we reviewed, however, generally made little or no analysis in support of either multiple or single prevailing rates. Moreover, HCFA has provided no guidance to carriers on how to conduct these analyses. HCFA needs to take steps to provide assurance that carriers conduct charge pattern analyses as required and give carriers guidance on how to make such analyses.

Also, Medicare permits physicians to "self-designate" their specialties. That is, carriers are permitted to recognize a physician in the specialty of his or her choice, irrespective of education, training, experience, or other qualifications. HCFA should establish criteria as to what constitutes a specialist for Medicare reimbursement purposes.

OBJECTIVES, SCOPE,
AND METHODOLOGY

The objectives of this review were to examine (1) the basis for carrier prevailing rate structures, that is, the number of prevailing rates used for reimbursement purposes and (2) the

(106219)



125448

030447/125448

practice of self-designation for physician specialties. Our work covered HCFA headquarters in Baltimore and 11 Medicare carriers (see page 6). The carriers were selected for a number of reasons including proximity to GAO staff and the number of physician specialties recognized for reimbursement purposes.

In examining the basis for carrier prevailing rate structures, we held discussions with officials from 11 carriers and reviewed supporting studies where available. To examine the practice of self-designation, we held discussions with carriers on the criteria currently used and ways which could be used to strengthen program requirements. Also, at CIGNA in Connecticut, Blue Shield of Massachusetts, Inc. and Nationwide Mutual Insurance Company (Nationwide), we determined to what extent physicians in selected specialties were board certified. Board certification can be verified fairly easily and it provides some insight into the qualifications of physicians self designated as specialists. Our review was conducted in accordance with generally accepted government auditing standards.

MEDICARE PAYMENTS AND PHYSICIAN SPECIALTIES

Medicare carriers make payments for physician services on a "reasonable charge" basis. The reasonable charge for a specific service is the lowest of:

--the physician's customary charge (the physician's usual charge)

--the prevailing charge (the lowest customary charge for a service which is high enough to include 75 percent of all physicians' customary charges in a given geographical area); and

--the physician's actual charge (the amount billed for the service).

The authorizing legislation --title XVIII of the Social Security Act-- is silent on the recognition of physician specialties. Implementing regulations (42 CFR 405.504(b)), however, provide that

> "The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and

> other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns."

Where justified by differences in charging patterns, carriers can establish separate prevailing rates for specialists or groups of specialists. Consequently, where the customary charges of certain types of specialists are grouped together for the purpose of developing a prevailing rate, only those charges of the physicians in the group are used to develop the rate. Conversely, where only a single prevailing rate is developed, the customary charges of all physicians are used to develop the rate.

The use of more than one prevailing rate in some cases leads to widely different prevailing rates among physician specialties. To illustrate, the table below compares prevailing rates for common procedures and selected specialties for physicians located in Boston and other urban areas of Massachusetts.[2]

---

[2]Carriers establish prevailing rates by "locality" and Massachusetts has two--one urban and one rural. Usually, a locality is a political or economic subdivision of a State which includes a cross-section of the population with respect to economic and other characteristics.

PREVAILING RATES FOR SELECTED PROCEDURES
AND SPECIALTIES IN URBAN AREAS OF MASSACHUSETTS
FOR THE PERIOD JULY 1, 1981 TO JUNE 30, 1982

Procedure	General practice	General surgery	Cardiology	Gastroenterology	Internal medicine	Pulmonary disease
Office visit with comprehensive history	$35.80	$40.00	$44.75	$44.75	$44.75	$70.00
Office visit with limited examination	14.30	17.90	25.00	26.90	22.00	25.00
Initial hospital visit	26.90	44.75	62.70	53.70	44.75	62.70
Follow-up hospital visit	17.90	17.90	21.50	21.50	23.30	26.90
Nursing home visit with more than one patient seen	14.30	17.90	25.00	26.90	22.00	25.00
Consultation requiring comprehensive history	40.00	62.70	89.50	71.60	71.60	89.50

The rates for general practitioners are the lowest. In terms of dollars, the greatest difference in the prevailing charge levels shown in the table is for "consultation requiring comprehensive history"-- $40 for general practitioner and $89.50 for pulmonary disease specialist, a difference of $49.50. On a percent basis, the greatest difference is between initial hospital visits for general practitioners ($26.90) and for cardiology and pulmonary disease specialists ($62.70), the rates for the latter being 233 percent of the rate for general practitioners.

The number of physician specialities (and subspecialities) is significant. In the 1982 census of physician professional activities conducted by the American Medical Association, 80 specific physician specialties and subspecialties were recognized. The Association's survey permitted physicians to designate as many as three different specialties and defined the physician's primary specialty as that discipline representing the largest number of professional hours reported by the physician. See enclosure I for the results of the survey.

LITTLE BASIS FOR PREVAILING RATE STRUCTURES

Wide differences exist in the way carriers recognize physician specialities in establishing prevailing rates. Some carriers do not recognize any specialties and have only one prevailing rate for a particular procedure; others develop prevailing rates for each specialty individually; and, finally, other carriers combine numerous physician specialties into several prevailing rate groups. The table below shows the number of prevailing rates used by each of the 11 carriers we reviewed.

Number of Prevailing Rates

Carrier/State(s)	Number
Nationwide (Ohio and West Virginia)	31
Blue Cross and Blue Shield of South Carolina	31
Blue Cross and Blue Shield of Colorado	30
New Hampshire-Vermont Health Services, Inc.	30
Massachusetts Blue Shield	25
The Prudential Insurance Company of America (Georgia)	23
CIGNA (Connecticut)	3
The Equitable Life Assurance Society of the United States (Wyoming)	2
Blue Cross and Blue Shield of Florida, Inc.	1
Blue Shield of North Dakota	1
Blue Cross and Blue Shield of Michigan	1

At Massachusetts Blue Shield, recognition of different prevailing rates for physician services depends on the type of service provided, which makes it different from other carriers we reviewed. Massachusetts Blue Shield recognizes 25 specialties for visit and consultative procedures, but classifies physicians into two groups for all other procedures. Family practitioners are combined with general practitioners in one group and all other physicians are in the other group.

The number of prevailing rates used by carriers are supposed to be based on the charging patterns of physicians. HCFA, however, has not elaborated on how physician charges should be analyzed, what specialties/subspecialties should be compared, the specific comparisons to be made, the procedure codes to be reviewed, or what constitutes a material difference in charging patterns. The 11 carriers we reviewed had done little or no analyses of charging patterns to support the prevailing rates used for reimbursement. Only three of the 11 carriers had done some type of analysis of physicians charging patterns.

Massachusetts Blue Shield did a study in 1969; however, neither we nor carrier officials could understand the study's methodology, scope, or results. The individuals that worked on the study were no longer employed by the carrier.

CIGNA performed a study in 1975 to justify separating the then used two physician groups into three. According to the study, the third group should contain the specialties of cardiology, gastroenterology, nephrology, and others. The rationale for establishing a third group--which was later done--was that these physicians charged more for office visits than other specialists. Because the bulk of their work was done in the office, these physicians' reasonable charges were lowered by being in a group with all other specialists, according to a CIGNA official.

In 1980, Blue Shield of North Dakota--which does not recognize physician specialties--analyzed the charges for eight physician specialties. The carrier concluded that recognizing individual specialties would not significantly alter the payment to any one of the physician specialties and, therefore, changes to its single prevailing rate policy were not warranted.

Five of the carriers reviewed based their prevailing rate structure on a listing of medical specialities contained in the Medicare Carrier Manual and had not performed supporting analysis. HCFA requires carriers to prepare a summary history of carrier payment transactions. As part of this history carriers are requested to code the specialty of the physician rendering the service using one of a total of 44 specialities ennumerated in the manual. The manual reference is a record keeping requirement and is not related to how carriers should establish their prevailing rate structures.

According to Florida Blue Shield officials, physician specialties are not recognized because the Florida Medical Association supports the use of a single prevailing rate. In addition, Florida Blue Shield officials said the State of Florida has not defined a specialist and this would allow non-board certified physicians to classify themselves as specialists. On November 7, 1980, the Society of Internists brought suit against Florida Blue Shield to force recognition of specialists. As of August 15, 1984, no decision has been reached.

Blue Cross and Blue Shield of Michigan currently does not recognize physician specialities. In the past the carrier had placed physicians into three groups; however, a U.S. district court ruled that the carrier improperly separated specialists and nonspecialist charges for essentially the same services. The U.S. Court of Appeals, Sixth Circuit, partially affirmed the district court's ruling on February 23, 1984, and remanded the case to the Secretary to establish an appropriate reimbursement mechanism for Michigan. On July 23, 1984, the decision was appealed to the U.S. Supreme Court.

Equitable (Wyoming) placed general practitioners in one group and all other physicians in another payment group. In discussing the basis for this arrangement, carrier officials said only two categories of physicians were established because of Wyoming's relatively small number of physicians.

SELF-DESIGNATION

At three carriers we determined whether physicians in five specialties were board certified because permitting specialty self-designation by physicians does not assure that they have the qualifications of specialists. We used board certification as our criterion because it can be validated with relatively little effort.

The physicians were checked for board certification with the 1981/1982 Directory of Medical Specialists, published for the American Board of Medical Specialties by Marquis' Who's Who. The Directory is the authorized publication of the Board which represents 22 medical specialty boards. The Directory incorporates biographical data provided by the physicians, but board certification is verified with the individual specialty boards.

For the subspecialties of internal medicine we analyzed (gastroenterology, pulmonary disease, etc.), we also checked to see if physicians were certified in internal medicine as well as the subspecialty, because certification in internal medicine is a prerequisite for certification in a subspecialty of internal medicine.

Overall, about half of the physicians who self-designated specialities were not board certified, and about one-fourth of those physicians who self-designated subspecialties in internal medicine were not board certified in internal medicine. The results of our analysis are shown in the table below.

PERCENT OF PHYSICIANS NOT BOARD CERTIFIED IN THEIR SELF-DESIGNATED SPECIALTIES

Carrier/State	Type of specialty	All physicians: Total physicians reviewed	All physicians: Not board certified No.	All physicians: Not board certified Percent a/	Subspecialties of internal medicine not board certified in subspecialty nor in internal medicine No.	Subspecialties of internal medicine not board certified in subspecialty nor in internal medicine Percent a/
Blue Shield of Massachusetts/ Massachusetts	Cardiovascular disease	368	194	53	87	24
	Gastroenterology	150	77	51	41	27
CIGNA/ Connecticut	General surgery	78	24	31	b/	b/
	Gastroenterology	40	23	58	13	33
Nationwide/ Ohio	Obstetrics/Gynecology	115	56	49	b/	b/
	Pulmonary disease	63	21	33	20	32
Total		814	395	49	161	26

a/For Massachusetts Blue Shield, we reviewed all of the cardiologists and gastroenterologists served by the carrier. For CIGNA and Nationwide, we reviewed a random sample of physicians and estimated the results at the 95 percent level of confidence; the precision estimates are ±9 percent for CIGNA and ±8 percent for Nationwide.

b/Not a subspecialty of internal medicine.

Self-designated specialists who were not board certified ranged from a high of 58 percent for Connecticut gastroenterologists to a low of 31 percent for Connecticut general surgeons. For physicians self-designating the subspecialties of internal medicine, those not certified in the subspecialty nor in internal medicine ranged from a low of 24 percent for Massachusetts cardiologists to a high of 33 percent for Connecticut gastroenterologists.

The carriers we reviewed believe that the only alternatives to physician self-designation are to require board certification or to not recognize specialty groups individually. Board certification is a good indication of a physician's qualifications and it can easily be verified by referring to the Directory of Medical Specialists. A problem with a requirement for board certification is that such a policy would exclude half of the physicians in the country who consider themselves specialists. Moreover, while the qualifications of the non-board certified

specialists as a whole are not known, no doubt there are those who are as competent as board certified specialists.

CONCLUSIONS

A physician's specialty can play a key role in determining payment under Medicare. Despite this, HCFA and its carriers generally give scant attention to this issue. While HCFA expects carriers to analyze charging patterns of physician specialties to determine if specialty recognition is warranted, little or no analysis was done by the 11 carriers we reviewed. Moreover, HCFA has not given carriers any guidance in this respect and we believe it should.

Beyond the lack of HCFA guidance to carriers, Medicare's practices of permitting self-designation raises a number of issues. For example: Who or what is a specialist? How many different types of specialists should be recognized? Because the type of specialty has a bearing on the amount of Medicare payment a physician receives, HCFA should establish criteria for speciality recognition for Medicare reimbursement purposes.

RECOMMENDATIONS

We recommend that you establish specific criteria on (1) what constitutes a specialist for Medicare reimbursement purposes and (2) how Medicare carriers are to analyze physician charging patterns. The latter should conclude guidance on (1) the physician specialties and subspecialties that should be compared, (2) the physician procedures that should be compared, (3) how comparisons should be made, and (4) what constitutes a material difference in charging patterns which would justify the establishment of separate prevailing rates.

We would appreciate hearing from you within 30 days on the actions taken or planned in response to our recommendations.

Sincerely yours,

Thomas G. Dowdal

Thomas G. Dowdal
Group Director

Enclosure