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OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

REVIEW OF MEDICARE PAYMENTS TO RENAL PHYSICIANS UNDER THE ALTERNATIVE METHOD OF REIMBURSEMENT

MARCH 1, 1977

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LETTER OF TRANSMITTAL

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., January, 14, 1977.

CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT,
Committee on Ways and Means, House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: I am enclosing the report you requested on certain aspects of the End-Stage Renal Disease program. Members of my staff have discussed portions of the report with some of your subcommittee staff members, and will provide any additional assistance you may require.

We are sorry for the length of time it took to prepare the report, but, as you know, some of the information included therein was not readily available in our central office and had to be accumulated from other sources.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Enclosure.

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REVIEW OF MEDICARE PAYMENTS TO RENAL PHYSICIANS UNDER THE ALTERNATIVE METHOD OF REIMBURSEMENT

(Prepared by CRD Branch, DSpO, OCO, BHI)

I. Background

Soon after the implementation of Public Law 92–603, interim regulations and more detailed instructions were published which provided that physician reimbursement for supervising maintenance dialysis services furnished in a facility could be made only by the facility on the basis of contracts negotiated between the physician and the facility. Routine physician services, rendered on an outpatient basis and related to maintenance dialysis, were treated as facility costs, and medicare payments were made to the facility. The physician was reimbursed by the facility in the form of an annual salary, a per dialysis charge, or some variation of the two. Other physician services required by the dialysis patient (not considered routine) were billed to the medicare carrier on a fee-for-service basis, and reimbursement was made under existing medicare policy. (See appendix A for a detailed discussion of services covered under the initial method.)

Upon implementation of the initial method of reimbursement we found that many physicians were strongly opposed to this payment arrangement either on philosophical grounds or because they could not negotiate a contract for payment of their supervisory services with the facility where they practiced. After several months of program experience, many physicians still had not entered into such arrangements with their facilities. Therefore, in July 1974 the alternative method of reimbursement was developed. This method, which a physician could voluntarily elect, had the benefit of extensive consultation within the medical community. Under this method, physicians were to be reimbursed on a monthly basis for services (complicated or routine) furnished during a particular month to a renal patient on dialysis. Generally, the services covered by this method include:

1. Physician services during dialysis—including both supervisory services and direct personal physician services to the patient, rendered in connection with both complicated and uncomplicated sessions.

2. Office visits for the routine evaluation of patient progress or for treatment of renal disease complications, including the evaluation of diagnostic tests and procedures.

3. All physician services rendered by the attending physician in the course of office visits (i.e., which may reasonably be rendered in the course of such visits), the primary purpose of which is either the routine monitoring or the follow-up of complications of dialysis. This includes services involved in prescribing therapy for illnesses unrelated to renal disease, where the treatment occurs without increasing the number of physician-patient contacts beyond those normally required for monitoring routine dialysis sessions, or visits for treatment of renal complications.

Services not covered by the monthly payment are limited to:

1. Declotting shunts.

2. Physician services to inpatients—when patients for whom the physician has agreed to bill on a monthly basis are hospitalized, the monthly fee is to be reduced by 1/30th for each day of hospitalization; and the physician may bill on a fee-for-service basis for services rendered to inpatients. As an option, the physician may forego the fee-for-service billing and continue to accept the alternative method payment during the patient's inpatient stay.

3. Physician services—when needed—which are rendered either by the physician providing renal care or by another physician and which are beyond those which are related to the treatment of the patient's renal condition and which are not otherwise covered under 1, 2, and 3 above.

Physicians at a given facility are free to decide whether they will bill under the initial method or the alternative method of reimbursement for services rendered their renal patients; however, physicians attending patients within a given facility must all use the same method of reimbursement and must agree to bill for their services only under the one method selected. Where several physicians form a team to provide the monthly continuity of services to a group of patients, one monthly payment is made to the group for each patient in the group's care. (A complete discussion of the services covered and not covered by the alternative method, as well as the related provisions, is located in appendix B.)

Because the ESRD program is the first catastrophic care provision in the medicare program and the alternative method of reimbursement is a unique application of a number of medicare reimbursement procedures, the Subcommittee on Oversight, Committee on Ways and Means, requested the following information about the alternative method of reimbursement (copy of letter from the subcommittee is included as appendix C):

1. A random sample review of physicians on the alternative method, from several geographical areas, portraying (*a*) the number of renal patients treated by each physician, and (*b*) the amount of medicare reimbursement received by each physician for services furnished to renal patients.

2. A review of physicians on the alternative method receiving the highest program payments, portraying (*a*) the number of patients treated by each physician, and (*b*) the amount of medicare reimbursement received by each physician for the services furnished these patients.

3. A random sample review of patients treated by physicians in "1" above, portraying (*a*) the types and frequency of occurrence of services received from other physicians, and (*b*) the amount of medicare reimbursement made for those services.

II. Purpose and Methodology of Study

A. Purpose

The purpose of this study was to determine the amount of the reimbursement made to physicians on the alternative method of reimbursement during 1975, the number of patients being treated by the physician, and other services provided to renal patients.

B. Methodology

To achieve the purpose of this study, a series of steps were taken to accumulate and organize data from various sources.

1. Identification of physicians on the alternative method of reimbursement.—We requested that all of the medicare part B carriers identify each of the physicians electing the alternative method. The carriers were also requested to provide the physician's identification number (for possible follow-up reference), date of physician's election to the alternative method, and the facility with which the physician was affiliated.

To limit our review to reimbursement for services rendered during calendar year 1975, we requested that only physicians having a date of election to the alternative method prior to December 31, 1975 be chosen.

2. Computation of payments and other statistical information for physicians on the alternative method of reimbursement.—We used two basic data sources to compile payment and statistical data on individual physicians on the alternative method:

(*a*) *The chronic renal disease beneficiary history file (CRDBHF).*—This file contains payment and statistical information by CRD beneficiary. One part of the file includes the SSA–1490 payment records. These payment records consist of a record of every medicare part B bill submitted to and paid by the carrier and then posted to the Health Insurance Master Record.

Since the SSA–1490 payment records contain payment information for all part B suppliers (laboratories, clinics, medical supply companies, physicians, etc.), we extracted from the file only those SSA–1490 payment records applicable to physicians' services. We further reduced the files so that only SSA–1490 payment records for services rendered to renal beneficiaries during calendar year 1975 (January 1–December 31) were included.

We reviewed the SSA–1490 payment record file for services rendered to renal beneficiaries by physicians during calendar year 1975 to determine whether the data in the file were compatible with the study objectives. As a result, we found that all physicians' specialties, such as surgery, ophthalmology, radiology, pathology, as well as nephrology, were included in the file. We felt that the data for physicians not normally directly associated with the dialysis treatment would distort the results of the study on physicians electing the alternative method of reimbursement. Therefore, we further adjusted the SSA–1490 file so that only physicians most likely to be rendering services directly as part of the dialysis treatment were included. To make this adjustment to the SSA–1490 payment record file, we assumed that physicians with the following specialties were most likely to be rendering services comparable with the study objectives: general practice, family practice, internal medicine, urology, pediatrics, and nephrology. We also assumed that if a physician had treated less than six renal patients or charged less than $1,000 during calendar year 1975, his involvement in the renal program was marginal. Therefore, this group of physicians was also excluded from the SSA–1490 payment record file used in this study.

In summary, the SSA–1490 payment record file used in this study included data on all of the physicians (both alternative and initial

methods) in the six specialties listed above who either were reimbursed more than $1,000 or had treated at least six renal beneficiaries between January 1, 1975, and December 31, 1975. The following data was compiled as a result of the analysis of this file: (1) physician identification number and carrier; (2) physician specialty; (3) number of individual renal beneficiaries to whom the physician provided a service; (4) the total amount charged for all services rendered to renal beneficiaries; and (5) the total medicare reimbursement made for services rendered to renal beneficiaries by the physicians during 1975.

(*b*) *Detailed carrier data.*—We requested that each medicare part B carrier, which had the computer capability, prepare and submit detailed payment and statistical data for its alternative method physicians for the fourth quarter 1975 (October 1, 1975–December 31, 1975). We also requested that the carriers submit complete patient histories for certain patients for the 4th quarter of 1975. These records showed: (1) the number of other suppliers furnishing services to the patients; (2) the types of services provided by those suppliers; and (3) charges and program payments made for these services.

III. Results of Study

The following data summarizes the results of the study:

The median payment range for solo physicians on the alternative method for calendar year 1975 was about $8,600. The median payment to groups of physicians on the alternative method for calendar year 1975 was $25,000.

About 10 percent of the physicians (including both solo and group) electing the alternative method received more than $55,000 during calendar year 1975. About 50 percent of the physicians (including both solo and group) electing the alternative method treated less than 20 individual patients.

About 10 percent of the physicians (including both solo and group) on the alternative method treated more than 50 medicare renal patients.

None of the reimbursements in excess of $80,000 during calendar year 1975 was made for the services of solo physicians. All of these payments were for services rendered by groups of physicians.

About 10 percent of total payments to alternative method physicians (including both solo and group) was for services other than the monthly supervision of dialysis.

Beneficiaries receive medical services from an average of one supplier in addition to their attending alternative method physician.

The following sections show the detailed results of our analysis:

A. General

Our review of the data received from the carriers and from the SSA–1490 payment records provided substantial information about the physicians (both alternative method and initial method) who routinely provided services to renal dialysis beneficiaries. We determined that as of December 31, 1975, about 1,284 physicians in solo practice and about 400 groups of physicians, billed and received reimbursement from the medicare program for treating renal beneficiaries on dialysis.

Information from the carriers and the part B payment record file showed that 351 physicians in solo practice and 65 groups of physicians

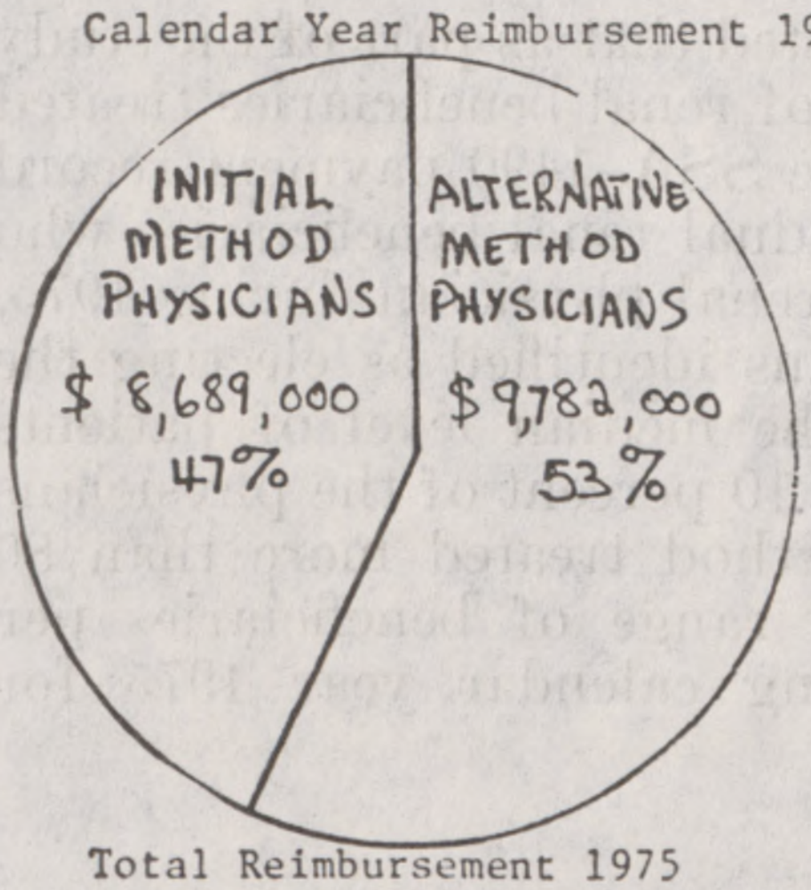
elected and received reimbursement under the alternative method of reimbursement for services performed during calendar year 1975.

B. Payments to physicians

Medicare payments made by part B carriers on behalf of renal beneficiaries during calendar year 1975 totaled about $45 million. This includes moneys paid to laboratories, and suppliers of home dialysis supplies and equipment, as well as physicians. Of the $45 million, about $29 million was paid exclusively to physicians for services rendered to renal beneficiaries during calendar year 1975. An analysis of the payment record file showed that about $18.4 million of the $29 million paid to all physicians was reimbursed to those physicians most closely involved with providing dialysis services to renal beneficiaries during 1975 (see page 6, Methodology of Study, No. 2). Payments to alternative method physicians during 1975 amounted to about $9.8 million.

Exhibit 1 shows the actual and percentage relationships between reimbursement to and the number of physicians on the alternative method and the initial method.

It should be noted that while only 25 percent of the physicians were on the alternative method, they received over 50 percent of the renal physician reimbursement. At first blush this might suggest that physicians under the alternative method are reimbursed excessively. It should be borne in mind that under the alternative method, physicians are reimbursed for practically all of the services rendered to renal dialysis patients. By way of contrast, physicians reimbursed under the initial method are only reimbursed for those services rendered directly to patients that are reimbursable on a fee-for-service basis. The remaining services, including supervisory services during maintenance dialysis, are paid to the physicians on the initial method directly by the dialysis facility, which in turn is reimbursed by the part A medicare intermediary. These amounts are not reflected, of course, in the amounts shown in this study as reimbursement to physicians under the initial method. (For a discussion of the services provided by initial method physicians which are reimbursed by the facility, as well as the services they may bill for separately, see Appendix A.)



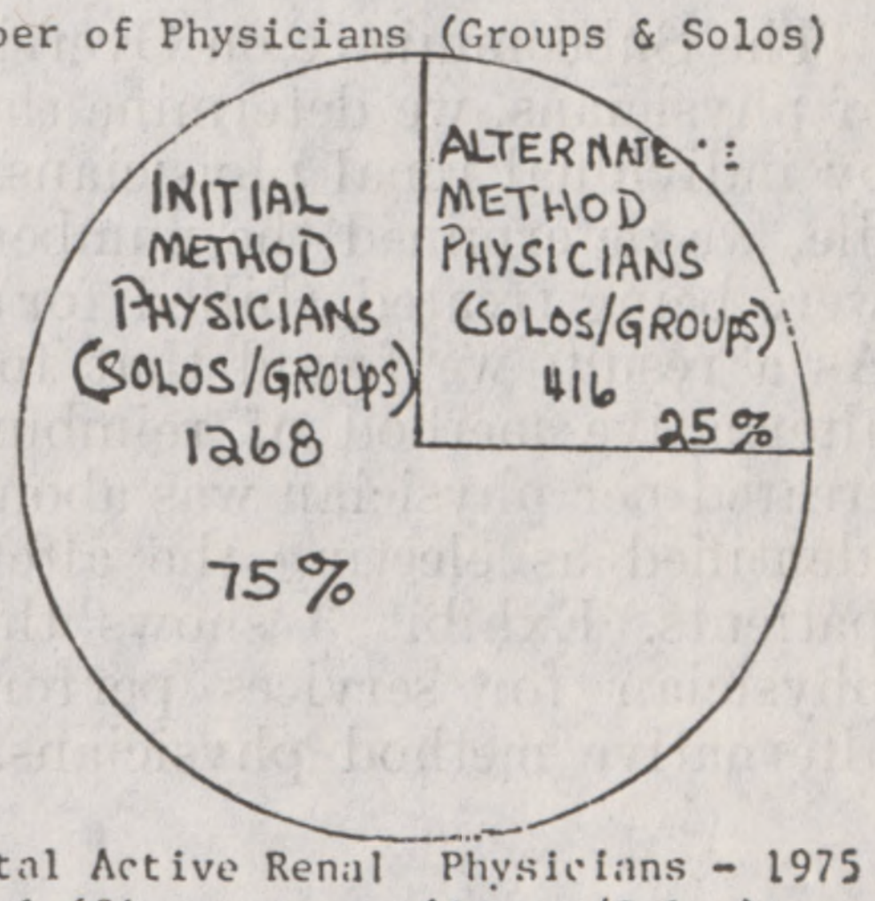


EXHIBIT 1

We made a complete analysis of the SSA–1490 payment record file to determine the magnitude of annual reimbursement to those physicians electing the alternative method of reimbursement. We determined that for physicians billing and receiving reimbursement from medicare as solo practitioners, the median (50th percentile) reimbursement for services provided during calendar year 1975 was about $8,600. For those alternative method physicians who billed as group practices and received medicare reimbursement for services rendered during calendar year 1975, the median level of reimbursement was about $25,000 for these groups.

A complete description of the distribution of the range of alternative method physician reimbursement is shown in exhibit 2.

EXHIBIT

DISTRIBUTION OF MEDICARE REIMBURSEMENT TO PHYSICIANS (SOLO AND GROUPS) IDENTIFIED AS ELECTING THE ALTERNATIVE METHOD OF REIMBURSEMENT FOR SERVICES RENDERED DURING CALENDAR YEAR 1975 [1]

Range of physician reimbursement	Number of groups [2]	Percent of total groups	Cumulative group percent	Number of solo physicians	Percent of total solos	Cumulative solo percents	Total groups/solos	Percent of total groups/solos	Cumulative total percent
0 to $999	1	2	2	20	6	6	21	5	5
$1,000 to $4,999	11	17	19	108	31	37	119	29	34
$5,000 to $9,999	9	13	32	65	19	56	74	18	52
$10,000 to $19,999	11	17	49	64	18	74	75	18	70
$20,000 to $29,999	1	2	51	39	11	85	40	10	80
$30,000 to $39,999	10	15	66	17	5	90	27	5	85
$40,000 to $49,999	1	2	68	9	2	92	10	2	87
$50,000 to $59,999	2	3	71	9	2	94	11	3	90
$60,000 to $69,999	5	8	79	3	1	95	8	2	92
$70,000 to $79,999	1	2	81	7	2	97	8	2	94
$80,000 to $89,999	2	3	84	2	1	98	4	1	95
$90,000 to $99,999	2	3	87	1	(3)	----------	3	1	96
Over $100,000	9	13	100	7	2	100	16	4	100
Total	65	100	----------	351	100	----------	416	100	----------

[1] From SSA–1490 payment records.
[2] Includes groups billing from hospitals (hospital-based physicians).
Less than 1 percent.

Note: The terms "solo" and "group" indicate the identification cf the specific entity's classification on the payment record file. In some cases, physician preference or State law requires a group to bill as "solo" practice. Thus, even though solo practice is indicated in the above chart, it is possible that entity may be a group. See sec. D, Physicians with the Highest Program Reimbursement for additional explanation.

C. Patients treated by physicians

The Subcommittee on Oversight requested that as part of the study of physicians, we determine the number of renal beneficiaries treated by individual renal physicians. Using the SSA–1490 payment record file, we determined the number of individual renal beneficiaries who were being treated (billed for) by each renal physician during 1975. As a result, we found that for physicians identified as electing the alternative method of reimbursement, the median level of patients treated per physician was about 17. Only 10 percent of the physicians identified as electing the alternative method treated more than 80 patients. Exhibit 3 shows the detailed range of beneficiaries per physician for services performed during calendar year 1975 for alternative method physicians.

EXHIBIT 3

DISTRIBUTION OF RANGE OF BENEFICIARIES TREATED PER PHYSICIANS (GROUPS AND SOLOS) IDENTIFIED AS ELECTING THE ALTERNATIVE METHOD OF REIMBURSEMENT FOR SERVICES RENDERED DURING CALENDAR YEAR 1975 [1]

Range of beneficiaries per physician	Number of groups [2]	Percentage of total groups	Cumulative group percent	Number of solo physicians	Percentage of total solos	Cumulative solo percents	Number of groups/solos	Percentage of total	Cumulative percentage
0 to 9	12	18	18	110	31	31	122	29	29
10 to 19	10	15	33	94	27	58	104	25	54
20 to 29	3	5	38	50	14	72	53	13	67
30 to 39	7	11	49	30	9	81	37	9	76
40 to 49	5	8	57	18	5	86	23	6	82
50 to 59	6	9	66	8	2	88	14	3	85
60 to 69	3	5	71	8	2	90	11	3	88
70 to 79	3	5	76	6	2	92	9	2	90
80 to 89	2	3	79	9	3	95	11	3	93
90 to 99	1	2	81	2	1	96	3	1	94
100 to 149	8	12	93	11	3	99	19	4	95
150 to 199	4	5	98	1	(3)	----------	5	1	99
Over 200	1	2	100	4	1	100	5	1	100
Total	65	100	----------	351	100	----------	416	100	----------

[1] From SSA–1490 Payment Record File.
[2] Includes Groups Billing From Hospitals (Hospital-Based Physicians).
[3] Less than 1 percent.

Note: The terms "solo" and "group" indicate the identification of the specific entity's classification on the payment record file. In some cases, physician preference or State law requires a group to bill as "solo" practice. Thus, even though solo practice is indicated in the above chart, it is possible that entity may be a group. See sec. D, Physicians with the Highest Program Reimbursement, for additional explanation.

D. Physicians with the highest program reimbursement

As part of the alternative method physician study, we attempted to perform an indepth analysis of renal physicians identified on the SSA–1490 payment record file as having the highest program reimbursement. We used reimbursement in excess of $80,000 as the criteria for the highest reimbursement, which resulted in the identification of 33 physicians and/or groups. These 33 physicians and/or groups comprise about 2 percent of the renal physicians and/or groups shown on the payment record file.

Exhibit 4 provides some detail on the 33 entities (physicians and/or groups) selected as having the highest program reimbursement. The column labeled "Type of Billing" indicates the identification of the specific entity's classification on the payment record file. In some cases, physician preference or State law requires a group to bill as "solo" practice. In every case where the solo classification of billing was used by a physician receiving medicare reimbursement in excess of $80,000 during calendar year 1975, we found that, in fact, a group of physicians was providing these services. The "Remarks" column of exhibit 4 shows those situations, as well as, in the case of groups, the number of members identified as belonging to the group.

We could not identify the exact number of physicians in some of the groups identified as receiving the highest program reimbursement. We have asked the carriers involved to continue to attempt to identify these physicians.

EXHIBIT 4

PHYSICIANS WITH THE HIGHEST PROGRAM REIMBURSEMENT FOR SERVICES RENDERED DURING CALENDAR YEAR 1975 (REIMBURSEMENTS IN EXCESS OF $80,000)

Physician I.D. No.	Location: State	Specialty	Number of beneficiaries per physician's I.D. No.	Methods of reimbursement	Reimbursement per physician per I.D. No.	Type of billing	Remarks
1	Alabama	Nephrology	193	Alternative	$246,999	Group	Number of physicians unknown.
2	California	do	139	Initial	135,189	do	Do.
3	District of Columbia	General practice	12	do	88,287	do	Hospital-based physicians.
4	Indiana	Nephrology	118	Alternative	131,085	Solo	Group—3 physicians.
5	do	do	82	Initial	83,188	do	Do.
6	do	do	86	do	108,990	do	Group—2 physicians.
7	Maryland	do	87	Alternative	113,578	do	Group—3 physicians.
8	Massachusetts	Urology	380	do	461,914	do	Group—11 physicians.
9	do	Internal medicine	203	do	82,796	do	Group—8 physicians.
10	Kansas	do	104	do	113,509	Group	3 physicians.
11	New York	do	119	Initial	209,833	Solo	Group—Number of physicians unknown.
12	do	do	165	do	258,971	do	Do.
13	Pennsylvania	do	182	do	100,817	Group	Hospital-based physicians.
14	Texas	do	125	Alternative	88,460	do	Number of physicians unknown.
15	do	Nephrology	115	do	135,172	do	Do.
16	do	do	293	Initial	84,965	do	Do.
17	Washington	do	299	do	180,697	do	Do.
18	Hawaii	Internal medicine	194	Alternative	165,826	do	5 physicians.
19	Nevada	Nephrology	103	do	89,614	Solo	Group—Number of physicians unknown.
20	Tennessee	do	263	do	306,706	Group	Number of physicians unknown.
21	Louisiana	Internal medicine	146	do	91,498	do	Do.
22	Minnesota	do	105	do	96,594	do	Do.
23	Mississippi	Nephrology	132	do	118,524	Solo	Group—2 physicians.
24	Virginia	do	131	do	145,758	Group	Number of physicians unknown.
25	Montana	Internal medicine	180	do	184,241	do	Do.
26	Georgia	do	152	do	112,040	do	6 physicians.
27	New Jersey	Nephrology	112	do	109,391	do	2 physicians.
28	do	Internal medicine	112	do	123,871	do	3 physicians.
29	do	do	87	do	96,403	Solo	Group—2 physicians.
30	do	Nephrology	161	do	194,899	Group	2 physicians.
31	do	Internal medicine	79	do	81,790	do	Number of physicians unknown.
32	New York	do	242	do	210,881	Solo	Group—5 physicians.
33	Ohio	Nephrology	81	Initial	88,528	Group	Number of physicians unknown.

It should be noted that all of the 33 physicians and groups receiving more than $80,000 reimbursement under the renal program were also identified by the Bureau of Health Insurance's program integrity staff's high earnings physician list. This list contains utilization and other statistical and payment data on physicians receiving unusually large amounts of medicare payments. The physicians appearing on this list are subject to specific utilization and payment reviews by the program integrity staff of the Bureau of Health Insurance.

E. Other services performed by alternative method physicians

In addition to the monthly payment for services furnished to a renal patient on dialysis, alternative method physicians may perform other reimbursable services. We studied the detailed records for both groups and solo practitioners to determine the extent of these other services. For the purpose of this study we used detailed records from carriers for payments received during the fourth quarter 1975. We selected the largest alternative method group practice and largest alternative method solo practice in 8 of the 10 regions. In one of the regions (Denver) the carriers did not have the computer capability to supply the detailed data necessary. In another region (Kansas City) the data was received too late for inclusion in this study. Appendix D shows the 10 SSA regions.

As a result of our detailed review, we found that about 10 percent of the total reimbursement to the groups and about 9 percent of the total reimbursement to solo physicians were for services other than those covered by the monthly payment.

The types of other services performed were those that were generally expected since, at times, otherwise stable renal dialysis patients become acutely ill and require inpatient hospital services. Also, a renal physician is allowed to bill separately for services provided to renal patients which are beyond those which are related to the patients' renal condition and which are not otherwise covered under the alternative payment method of reimbursement; e.g., are not furnished incidental to a visit involving the renal condition.

F. Use of other physicians by renal beneficiaries

At the request of the subcommittee, we also studied patient records to determine the extent that patients of alternative method physicians used other medical services. As a preliminary step, we took a sample of five alternative method physicians and their patients. To determine the extent that these patients received other medical services, we used the detailed records submitted by the carriers. Since each patient record contains a line for every service from every physician or other medical supplier, extensive research was needed to analyze and then summarize the data.

We had planned to increase the number of patients reviewed in this part of the study by reviewing additional carrier records. However, as a result of our experience with the preliminary sample, we found that using carrier records was very time consuming and would unduly prolong the study. Therefore, we have asked our data processing people to develop a computer program to provide the data needed by analyzing the part B payment record file. We will amend this study with the data from the computer analysis when it is completed.

In the interim, the following are the results of our preliminary analysis of the carrier records. We selected, at random, five alternative method physicians representing a wide range of reimbursement levels. The five physicians we studied treated a total of 72 patients, and those patients had received services from 100 other suppliers of medical services. The types of services provided by these other suppliers included office visits, inpatient hospital services, diagnostic services, surgical services (nephrectomies), etc.

We expected other medical services to be provided to patients of alternative method physicians since the patient who was on dialysis at home would normally be receiving home dialysis supplies and equipment as a medical service. In addition, dialysis patients often receive bills from independent laboratories for laboratory tests performed during the year, and they also receive services from other physicians, such as radiologists, pathologists, cardiologists, opthalmologists, and physicians in other specialty fields. These physicians perform services such as office visits, diagnostic services, consultations, and surgery, which are beyond the scope of those services performed by the alternative method physician.

APPENDIX A

Description of Services for Physician on the Initial Method of Reimbursement

(Excerpted From Part A Intermediary Letter 73–25)

Physicians' Services

a. General.—Payment for physicians' services is subject to the guidelines in § 6102 of the Part B Intermediary Manual. The types of physicians' services rendered to chronic renal disease patients include: (a) inpatient services—for stabilization of renal failure and during hospitalization for a secondary condition, (b) necessary services performed during dialysis, and (c) follow-up office visits to review patient progress. Basically, physician services rendered a chronic renal disease patient are covered if determined to be reasonable and necessary.

b. Physicians' Services to an Inpatient.—Where a chronic renal disease patient is hospitalized for treatment of some other condition, it is often necessary for the attending physician to consult with a nephrologist on possible renal complications and to monitor the patient's progress. The carrier should, however, ascertain whether or when the concurrent services are duplicate.

c. Services During the Performance of Dialysis.—(1) The performance of maintenance dialysis is generally not considered to require a physician's personal service to a patient. However, complications can occur which may require a physician's personal service.

Only a very small percentage * * * of dialysis patients require physician personal services during dialysis on a routine basis. When bills are submitted for such physician personal services, the carrier should require medical documentation of their necessity. Bills for physician personal services in connection with maintenance dialysis should not be allowed without clear evidence of medical necessity.

(2) Interim conditions of coverage require that every dialysis facility must be under the general supervision of a physician. However, such services are not considered to constitute a patient-care service, and reasonable-charge reimbursement will not be made for such services. Unit supervision is considered a facility service and should be included as a component of the cost or charge for the dialysis.

d. Follow-up Office Visits.—Chronic renal disease patients require regular periodic evaluation and laboratory tests. When physician services do not exceed the following interim guidelines, the services may be reimbursed without requiring medical documentation: (a) office visits for followup of stabilized patient—one per month; (b) in-depth evaluation of progress for stabilized patients—twice annually. When these guidelines are exceeded, payment should be made on the basis of medical documentation that establishes an abnormality requiring the added services.

e. Physician Service During Self-Dialysis Training—Training of patients for self-dialysis requires a larger personnel input than ordinary chronic dialysis. The staff utilized in self-dialysis training also requires greater physician supervision; additionally, there is some patient care by a physician that is needed. The necessary physician supervision which is covered should be treated as a facility cost—similar to general supervision of a dialysis unit—and not as patient service.

APPENDIX B

Department of Health, Education, and Welfare,
Social Security Administration,
Baltimore, Md., June 1974.

Refer to: IHI–311.
Subject: Alternative reimbursement method of monthly payments to physicians for services rendered to patients on maintenance dialysis.

INTRODUCTION

This intermediary letter contains the coverage conditions and billing procedures for a method of reimbursing physicians—which may be voluntarily selected as an alternative to the current method described in Part A and Part B Intermediary Letter No. 73–25, 73–22—for services rendered to maintenance dialysis patients. In addition, it modifies the instructions in those intermediary letters to provide that a comprehensive training payment will be the type of reimbursement made to a physician for services rendered in connection with training for self-dialysis under both the alternative and current methods.

The alternative method may be selected with respect to maintenance dialysis services furnished on or after the first day of the month following the month in which the physician elects this method or the month following the month of issue of this instruction, whichever is later; since billings will be on a monthly basis, carriers will have at least 30 days to make the necessary arrangements (Separate instructions will be issued shortly on payments not yet made for the period prior to the effective date of the alternative method.) Payment of fees for dialysis training described in Section III will apply with respect to services furnished on and after the first day of the month following the month of issue of this instruction.

The method presented recognizes the need of patients on maintenance dialysis for continuing medical management over relatively long periods of time and is intended to be responsive to physicians' charging patterns in their localities. The essential elements of this alternative method are:

1. The physician will bill monthly the medicare program (where he accepts assignment) or the beneficiary (where he does not accept assignment) for payment for services related to renal disease (as described further below) which are rendered to beneficiaries on maintenance dialysis for that period;
2. Medicare reimbursement of the monthly payment may be made either to the physician who accepts an assignment for the services billed or to the beneficiary where the physician does not accept an assignment (this payment is subject to the usual medicare deductible and coinsurance);
3. The physician may voluntarily elect the alternative method or continue to be reimbursed under the current method;
4. The physician who elects the alternative method will be reimbursed, or the beneficiary in non-assignment cases will be reimbursed, a monthly payment which would reflect physician variations in charges, i.e., using a conversion factor (which reflects not only the frequency of services which are customarily provided to maintenance dialysis patients but also the complexity of the specialized care rendered by nephrologists) relating the physician's monthly charge to basic unit charges which would vary (followup office visit prevailing charges for internal medicine);
5. The physician who elects the alternative method agrees in so doing to accept certain other conditions described further below; and
6. The physician may elect the alternative only where all of the physicians in the facility who render services to patients on maintenance dialysis in the facility setting elect to do so.

(For consistent reference to a provider or free-standing facility the word "facility" will be used in these instructions for both types of facilities unless a particular instruction pertains to only one specific type.)

This is an option: the facility, carrier, and intermediary must have on record, for each physician using it in maintenance dialysis cases, a statement that the physician(s) elects this method and agrees to the condition for application of this method. These instructions set out general descriptions of services covered by the monthly payment and billing procedures. Carriers will, of course, have the responsibility of applying the instructions to specific situations. Any questions should be directed to the Chronic Renal Disease Branch.

The factors used in determining the amounts of the monthly payments described herein will be reevaluated periodically and, where necessary to reflect changes in prevailing charge levels (but not to exceed any lesser limit established by application of the physician fee index under Section 224 of the Social Security Amendments of 1972) and to assure their fairness to the physician, the beneficiary and the program, may be adjusted accordingly (after appropriate notice). The services covered by the payment will also be reevaluated over time to reflect program experience and advances in the method of providing therapy to end-stage renal disease patients. Physicians are free to change the method

(either the current one or the monthly payment) under which they are reimbursed, provided reasonable notice (60 days before the change would actually take place) is given to the carrier and part A intermediary, as appropriate, so that a timely processing change can be made.

Intermediaries and carriers must dispense information on the monthly payment as an alternative billing method to all dialysis facilities and physicians known to be engaged in providing services to renal patients.

I. ALTERNATIVE MONTHLY PAYMENTS FOR PHYSICIANS' SERVICES TO MAINTENANCE DIALYSIS PATIENTS NOT ON SELF-DIALYSIS

A. Determining the Monthly Payment

A monthly payment (subject to the deductible and coinsurance) for each dialysis patient physicians attend will be made to the physician (or patients in non-assignment claims) where the physicians elect this alternative method of reimbursement for the services they render to maintenance dialysis patients in outpatient facilities. This monthly payment will be based on the lesser of (1) the amount derived by multiplying the physician's customary charge for a followup office visit (as described below) by a conversion factor of 20, or (2) the amount derived by multiplying the arithmetic average of the prevailing charges in all localities (for months up to July 1, 1975, not to be less than $8 or more than $12) in the carrier's service area for followup visits (as described below) by a conversion factor of 20. (With a minimum of $8 times 20, or $160, and a maximum of $12 x 20, or $240, the amounts of the monthly payments will result in a national average charge of about $200.)

The customary and prevailing charge data for followup office visits used in this methodology should reflect those services which are routine and where a charge difference is recognized for more than one level of routine followup visit, require a brief period of time. For example, carriers using the 1964 California Relative Value Studies (CRVS) or relative value studies with similar coding should use the physician's customary charges under procedure code 9004, or its equivalent in other relative value studies. Similarly, carriers should use the arithmetic mean of the prevailing charge ceilings they apply to internists' services in their various localities under procedure code 9004 or its equivalent in other relative value studies. (This will assure use of a sufficiently large data base which is likely then to better reflect area variations in charges than any that might be derived from charge data for nephrologists only.) Additionally, the prevailing charge data in the above calculation should be derived from the screens the carriers use to determine reasonable charges for internists' services.

Where carriers have not established prevailing charge screens for internists or other specialists, they will then use the average followup office visit amount obtained from the prevailing charge screens for internists (or if none, for other specialists) of another nearby carrier; namely, California Blue Shield will use that amount obtained from the prevailing charge screens of Occidental Life Insurance Company of California; North Dakota Physicians Service and South Dakota Medical Services, Inc., will use that amount obtained from the prevailing charge screens of Montana Physicians' Service; and Kansas Blue Shield will use that amount obtained from the prevailing charge screens of Blue Shield of Kansas City.

In effect, the use of the conversion factors and followup office visits yields a reimbursable monthly amount which reflects an averaging out of the frequency and kinds of services, and payments therefor, that the physician may render to stabilized patients on maintenance dialysis. They are used also with a view toward arriving at a monthly payment that would be appropriate and fair to the beneficiary, physician, and the program—considering the variable medical conditions involved in dialyzing stabilized patients. In addition, this methodology is responsive to physicians' charging experiences because the monthly payment is periodically adjusted when carriers' customary and prevailing charge screens are routinely updated each year. Where a physician who bills under the alternative monthly payment method is provider-based and receives a salary from the provider and has not established a customary charge for a followup office visit, the carrier should consult with the part A intermediary to find what the provider charges in the outpatient facility where the patient visits the physician (internists or nephrologists) for a followup visit of a type similar to the office visits discussed above. This charge will then be considered the customary charge for the physician for followup office visits which would be multiplied by the conversion

factor as indicated above in determining the monthly payment. Where the provider-based physician has established a customary charge, that customary charge subject to the prevailing charge should be used for purposes of determining the monthly payment. (Of course, where the physicians and the facility choose to remain under the present interim method of reimbursement and the physicians are compensated by the facility, the physicians and facility may agree for payment under the present interim method to reflect the proportion of the physician's compensation attributable to all of the services covered by this alternative monthly payment rendered eligible patients.) The physician will render a single monthly bill to the carrier or patient (in non-assignment bills) for services to each maintenance dialysis patient as described in section I.B.

B. Services Covered by the Monthly Payment

1. Physician services during dialysis—including both supervisory services and direct personal physician services to the patient, rendered in connection with both complicated and uncomplicated sessions. (Examples: (a) a routine predialysis examination; and (b) physician attendance during a dialysis episode where the patient has a serious ailment such as pulmonary edema.) Supervisory services do not include administrative services which the physician may provide in a facility. Such services should be included as a facility cost to the facility that incurs the cost. (Administrative services involve services directly related to the support of the facility. Examples of such services would include staff training, participation in management of the facility, advice on and procurement of facility equipment and supplies, etc.)

2. Office visits for the routine evaluation of patient progress or for treatment of renal disease complications, including the evaluation of diagnostic tests and procedures.

3. All physician services rendered by the attending physician in the course of office visits (i.e., which may reasonably be rendered in the course of such visits), the primary purpose of which is either the routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, where the treatment occurs without increasing the number of physician-patient contacts beyond those occurring at dialysis, normal monitoring sessions, or visits for treatment of renal complications. (All physician services, except as specifically described in section I.C., needed to treat renal conditions including those in addition to the usually scheduled 3 dialyses per week, are covered by the monthly payment.)

C. Physician Services Not Covered by the Monthly Payment

1. Declotting of shunts (see Part A I.L. 73–25, Part B I.L. 73–22).

2. Physician services to inpatients—when patients for whom the physician has agreed to bill on a monthly basis are hospitalized, the monthly fee is to be reduced by $\frac{1}{30}$th for each day of hospitalization, and the physician may bill on a fee-for-individual-service basis for services rendered to inpatients. When inpatient services are rendered, the period between the date of the last outpatient facility dialysis and the next routine facility dialysis should be used as the period of services which should be subtracted from the monthly billing. However, the physician may elect to continue receiving the full monthly payment in lieu of a billing for a fee-for-individual-service rendered during the inpatient stay; in this case there would be no separate fee-for-service billing for inpatient care by the physician.

3. If a patient who is attended by a physician billing under the monthly payment method is dialyzed in an outpatient facility other than his usual treatment setting and that facility includes in its charge an amount for reimbursement of the "supervisory" services of the physician (see section I.B.1. above) the payment to the physician who is reimbursed by a monthly payment must be reduced in accordance with the appropriate number of days (see section I.C.2. above).

4. Physician services—when needed—which are rendered either by the physician providing renal care or by another physician and which are beyond those which are related to the treatment of the patient's renal condition and which are not otherwise covered under section I.B.1., 2., and 3., are covered and may be billed to the carrier on a fee-for-service basis. The physician should provide documentation that the illness is not related to the renal condition and that

added visits are required. The carrier's medical staff, acting also on the basis of medical consultation obtained by the carrier as may be appropriate, would determine whether additional reimbursement is warranted for treatment of the unrelated illness. (Such services are billed on a separate form SSA–1490; i.e., separate from the SSA–1490 billing for the monthly payment.)

5. For physician services rendered by other physicians for concurrent care, the Medicare program permits reimbursement for otherwise covered services rendered by a second physician if the services of both physicians are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury. Thus, for example, services rendered by a second physician in addition to the attending physician would be covered if the services meet the definition of consultative services contained in section 6102 of the Part B Intermediary Manual and are determined by the carrier to be reasonable and necessary to assist the attending physician in assessing or treating the patient's total medical condition.

Another situation in which the services of more than one physician would be covered is where two (or more) physicians are required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse specialized medical services.

All claims involving such concurrent care should be reviewed by carriers to determine whether the services are reasonable and necessary for the diagnosis or treatment of illness or injury. Where questions arise as to the coverage of such care, the carrier, with the help of the physicians involved and its own medical staff, must resolve this matter. The determination of what is reasonable and necessary in a given case is, of course, a medical judgment and for purposes of the Medicare program should be made on the basis of accepted standards of medical care and practice as applied to the medical circumstances of the patient's case. (See also section IV.C. below.)

D. Conditions for Election of This Optional Method

1. Physicians at a given facility are free to decide whether they will bill for physician services to patients under either the current method of reimbursement or the monthly payment method; however, all physicians attending patients within a given facility may use only one method and must agree to bill for their services under only one method.[1] Where several physicians form a team to provide the monthly continuity of services to a group of patients, one monthly payment would be made for each patient in the group's care.

2. In facilities where agreements exist for reimbursement under the current method and the physicians now elect the optional method, the facility charge should be reduced (but not below any approved charge reflecting the reasonable cost for the facility's services) by an amount equal to the reimbursement for the "supervisory" services (see section I.B.1. regarding reimbursement to the facility for administrative services) that was included in the previous facility charge; i.e., this component is included in the services reimbursed by the physician's monthly payment and should not be paid twice. Calculations of facility allowance that had already been made should be revised where necessary. Similar adjustments need to be made in the applicable $150/$190 limits.

3. When a patient attended by a physician electing the monthly payment method is temporarily attended by another physician for services which are normally included as covered by the monthly payment, it is the responsibility of the primary physician to share reimbursement, if necessary, under the arrangement with the physician who thus becomes associated with him—i.e., for reimbursement purposes the arrangement is viewed as a temporary joint provision of services—in rendering those services covered by the payment and the beneficiary cannot be billed for the services of the associate in the case. Thus, when a physician is temporarily unavailable to his patients he must make any necessary arrangement with an associate physician for providing the services rendered to those patients for whom monthly payments are made. Each physician may cover for the other and then no modification in reimbursement is required. If reimbursement must be shared, the physicians will need to make the appropriate arrangement.

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[1] That is, with respect to that facility. It should be noted that amounts of the monthly payments to physicians are based on the assumption that a facility's patient load requires an average amount of care. Shifting of patients between facilities in which different reimbursement methods are used—the current interim method and this alternative method—will be monitored and physicians' payments may be reduced if unreasonable selection of patients occurs for the sole purpose of increasing reimbursement.

II. ALTERNATIVE MONTHLY PAYMENTS FOR PHYSICIANS' SERVICES TO PATIENTS ON SELF-DIALYSIS AT HOME OR IN A FACILITY

A. Determining the Monthly Payment

Physicians electing this alternative method of reimbursement for physician service rendered to self-dialysis patients will receive a monthly payment for each patient they attend that is determined by using the same methodology discussed in section I.A. above. However, the carrier should use a conversion factor of 14 for self-dialysis cases. The amount of this conversion factor is less than that used for facility dialysis cases because self-dialysis patients usually do not receive or require as extensive services as patients in facilities who are not on self-dialysis.

B. Services Covered by the Monthly Payment

1. Physician services rendered during a dialysis session (see section I.B.1. above) including those back-up dialyses which occur in outpatient facility settings.
2. Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
3. Physician services rendered by the attending physician in the course of office visits, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at normal monitoring sessions or visits for treatment of renal complications. All contacts needed to treat kidney conditions, except those provided for in section I.C., are covered by the monthly payment.
4. General support services (arranging for supplies, etc.).

C. Services Not Covered by the Monthly Payment

(See section I.C. above.)

D. Conditions for Election of This Optional Method

1. If a physician elects this method of reimbursement for facility patients he must also be willing to accept the monthly payment for all self-dialysis patients he attends. This option is not available to those physicians who do not bill under the optional method for facility patients.
2. When a patient attended by a physician electing the monthly payment is temporarily attended by another physician for services which are normally included as covered by the monthly payment, the same conditions in section I.D.3. above apply.
3. Self-dialysis in facilities—See section I.D.2. above.

III. PHYSICIAN SERVICES TO PATIENTS UNDERGOING SELF-DIALYSIS TRAINING UNDER THE MONTHLY PAYMENT METHOD OR CURRENT METHOD OF REIMBURSEMENT

Whether or not physicians have elected the monthly payment for physician services to patients in dialysis facilities, the physicians will be reimbursed for physician services rendered to dialysis patients undergoing self-dialysis training with a flat fee of $500—in the period before July 1, 1975; it will be reviewed periodically—per patient (subject to the deductible and coinsurance) under his supervision during the training course. This payment will be made, upon completion of the training course, in addition to the monthly payment or current reimbursement method for physician services rendered to maintenance facility patients. Where the training period is not completed, such as in instances where the patient can no longer be trained, or where the full course of training has not been completed prior to the effective date of this instruction, the reimbursement will be proportionate to the time spent in training and reimbursable under this method. (Intermediaries should have established the average time required for training a self-dialysis patient in each facility. Carriers should use this data for determining the training payment proportion.) Adjustments similar to those mentioned in section I.D.2. need to be made. All those physicians' services required to create the capacity for self-dialysis are covered.

1. Direction of and participation in training of dialysis patients.
2. Review of family and home status and environment and counseling and training of family members.
3. Review of training progress.

IV. CARRIER PROCEDURES FOR PROCESSING BILLS FROM PHYSICIANS WHO ARE REIMBURSED ON A MONTHLY PAYMENT BASIS

A. Billing Methods for the Alternative Monthly Payment Method

1. Services Covered by Monthly Payment (See section I.B. above). At the end of each month assignment claims for the monthly payment will be submitted to the carrier and non-assignment claims will be submitted to the beneficiary. Charges for services not covered by the monthly payment must not be included on these claims. The claim forms must be clearly identified as claims for services provided to maintenance dialysis patients covered by the monthly payment. If the physician (or group of physicians) bills for services covered, by the monthly payment, he must use an SSA–1490. In a group billing, each physician must be identified on the SSA–1490.

2. Services Not Covered by the Monthly Payment (see section I.C. above). If the physician performs services for the dialysis patient during any month which are not covered by the monthly payment (see I.C. above), the physician's charge must be submitted on a separate SSA–1490.

B. Billing Data Required for Claims Involving the Alternative Payment Method

1. Services Covered by the Monthly Payment:

(*a*) Patient's first name, middle initial, and surname.

(*b*) Patient's address.

(*c*) Sex indication.

(*d*) Health Insurance number.

(*e*) Whether the patient is a facility or home patient (self-dialysis in a facility is treated as home) and/or training for self-dialysis.

(*f*) The amount of the monthly charge.

(*g*) The name and address of the facility should be included.

(*h*) Dates of service rendered to the patient in his usual setting (facility or home). If the patient was an inpatient for part of the month (or was a patient in a facility where the "supervisory" services are included in the facility charge, or was not attended by the physician or his substitute for any reason) the physician must reduce the monthly charge period by the number of days between the date of the last dialysis in the usual setting and the date of the next regularly scheduled routine dialysis in the usual setting. For example, the patient was dialyzing at a facility from 11/1 to 11/20 (he was dialyzed on 11/20) and was an inpatient from 11/21 to 11/23 and then returned to facility dialysis and was dialyzed on 11/25 and continued until 11/30 at the facility. The dates of service shown on the billing would be 11/1–20, 11/25–30.

(*i*) Whether the patient's illness or injury was connected with his employment.

2. Services Not Covered by the Monthly Payment. These services are processed in the same manner as other Part B claims (See sections 6325–6325.2 and section 6375 of the Part B Intermediary Manual), except that the additional controls on utilization mentioned in section I.B. above must be exercised (See Section IV.C below).

C. Claims Processing Requirements

In order to adequately control utilization and duplicate payments the carriers must establish procedures for identifying renal dialysis patient history records as well as the files of physicians who perform services related to renal dialysis for which monthly payments are made.

Carriers may use an appropriate combination of manual and EDP methods for reviewing claims for renal dialysis services. Carriers are required to screen each patient's history a minimum of once each calendar quarter to ascertain if the number and types of services billed separately from the monthly payment should be individually reviewed taking into account the specific patient's medical conditions and the specific billings for treatment over and above those covered by the monthly payment. Carriers with large end-stage renal disease workloads may wish to control the work impact of this review by reviewing the histories of one-third of its renal disease patients each month instead of the entire file at one time each calendar quarter.

In processing the monthly payment claims, the carriers must establish system capabilities which will achieve the following results:

1. Assure that only one monthly payment is made for any one renal disease patient per month.

2. Deny duplicate charges billed as a duplicate monthly payment or as separate charges for services covered by monthly payment. Also, deny concurrent services by other physicians that are not determined to be reasonable and medically necessary under section I.C. If services rendered are reasonable and necessary *and* are covered by the monthly payment *and* a separate claim is filed by the physician receiving the monthly payment, the claim should be denied. If under the same circumstances a physician other than the physician receiving the monthly payment renders the service and a separate claim is filed for the service, the carrier should determine whether it may be reasonably concluded that the patient sought a different physician for a good reason, e.g., the temporary non-availability of the physician receiving the monthly payment or the patient's desire to try another physician as attending for his renal condition; the first instance of a claim for such service in a month may be deemed to meet one of these tests provided the charge does not exceed the charge for a routine office visit and is otherwise appropriate.

3. Verify that the period(s) of service for which a monthly payment is charged is valid per section IV.B.1.g. above.

Example 1.—Dr. Smith claims a monthly payment prorated to account for a period of ten days in the month when the patient was in a hospital. Dr. Smith continued to furnish dialysis-related services to the patient while he was in the hospital. When the bills for inpatient physician services from Dr. Smith are received the carrier will verify that the period covered by the monthly payment in the patient's home or a facility was correct and the carrier will also pay Dr. Smith for those services that are reasonable and necessary while the patient was in the hospital.

Example 2.—Same as example 1 except that Dr. Jones also treated the patient while he was in the hospital. If the services furnished by Dr. Jones are reasonable and necessary and not covered by the monthly payment to Dr. Smith, the carrier can also make payment for the services by Dr. Jones.

Example 3.—Dr. Smith claims a monthly payment for the entire month. The carrier also receives a claim from Dr. Jones which indicates that he (Dr. Jones) treated the patient in a hospital during a part of the month. The carrier must prorate Dr. Smith's monthly payment to eliminate the part of the monthly payment from Dr. Smith's payment that represents the period the patient was in the hospital.

The verification of the period(s) covered by the monthly payment need not be made at the same time that the claim for the monthly payment is processed. Post processing verification for some bills will, necessarily, occur when the bill(s) for the other services arrives in the carrier's office later than the claim for the monthly payment. When overpayments are identified, they can be recovered by offset from succeeding monthly payments.

In order to establish all of the system capabilities described above, the carriers will need to obtain initially a directory from each service area dialysis facility of the physicians who bill on a monthly payment basis or they may develop such a directory from the physicians' agreements on file with the carriers. The facilities must be requested to notify the appropriate carriers of additions or deletions to the directory listing. A continuing education program must also be conducted to insure that the physicians bill properly.

D. Physician Services for the Dialysis Patient Who Is Away From Home or Usual Facility

When a renal dialysis patient whose physician is being paid on a monthly basis travels from his home or the vicinity of his usual care in a facility and uses physician services in another locality either in connection with his dialysis or for some other medical reason, the following rules apply:

1. The physician who performed the services will bill his own carrier on an SSA–1490 (or the beneficiary in non-assignment cases) specifying the individual services performed.

2. The carrier will process the claim the same as any other claim, without reference to the carrier's files in the service area where the patient ordinarily received dialysis services, and send a copy of the Explanation of Medicare Benefits (EOMB) to the carrier in such service area. Where the patient is away for an extended period (a week or more) an appropriate adjustment would be made in the monthly payment for physicians' services.

V. STATEMENT OF AGREEMENT TO CONDITIONS ON ACCEPTANCE OF THE ALTERNATIVE MONTHLY PAYMENT METHOD

Physicians electing this method must have on file with the carrier a statement which contains substantially the following information. A copy must also be maintained at the facility in which he practices.

"I (name) agree to bill a monthly charge for those services rendered to end-stage renal disease patients who are on dialysis either in a facility or at home which are described in the accompanying enclosure as covered by the monthly payments and in the prescribed manner. I further agree to accept the conditions indicated in the accompanying enclosure and agree to comply with the regulations and other administrative instructions of the Social Security Administration.

"This agreement shall remain in effect until the carrier is notified in writing of my intention to terminate direct billing for services each month, and this termination shall be effective no sooner than the 60th day following the day of its receipt by the Medicare carrier.

_____ _____."

(Signature) (Date)

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

APPENDIX C

LETTER FROM HON. CHARLES A. VANIK, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, TO MR. THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE

FEBRUARY 10, 1976.

Hon. THOMAS M. TIERNEY,
Director, Bureau of Health Insurance, Social Security Administration, Baltimore, Md.

DEAR MR. TIERNEY: The Subcommittee staff has discussed with the End-Stage Renal Disease Branch the feasibility of obtaining specific program data, such as: the type and frequency of physician services provided to kidney patients, the number of kidney patients physicians generally serve, and the amount of reimbursement physicians received during a time certain under both the initial and alternative reimbursement methods.

It is my understanding that without incurring costly systems changes and/or expending a significant amount of staff time, adequate information can only be obtained from certain carriers, and then, only for physicians using the alternative method. I had hoped that this type data, which I believe is basic to effective administration of the ESRD Program, would be available on a nationwide basis by this time. I would appreciate receiving a status report on the type of physician reimbursement information the Subcommittee can expect to receive from the joint BHI–BQA system, and the time frame in which that system will be operational.

The Subcommittee staff has informed me that general agreement on a limited study has been reached with the ESRD Branch. It is my understanding, based on a review of physicians using the alternative method, that the following data will be provided:

(1) A random sample of physicians, representing several geographical areas, which will show the number of patients that each serves and the amount of reimbursement.

The master beneficiary record for these patients will be reviewed on a sample basis to determine the services (and reimbursement) provided by other physicians.

(2) Data from several geographical areas on the number of patients and the dollars paid by Medicare to those physicians receiving the greatest amount of reimbursement.

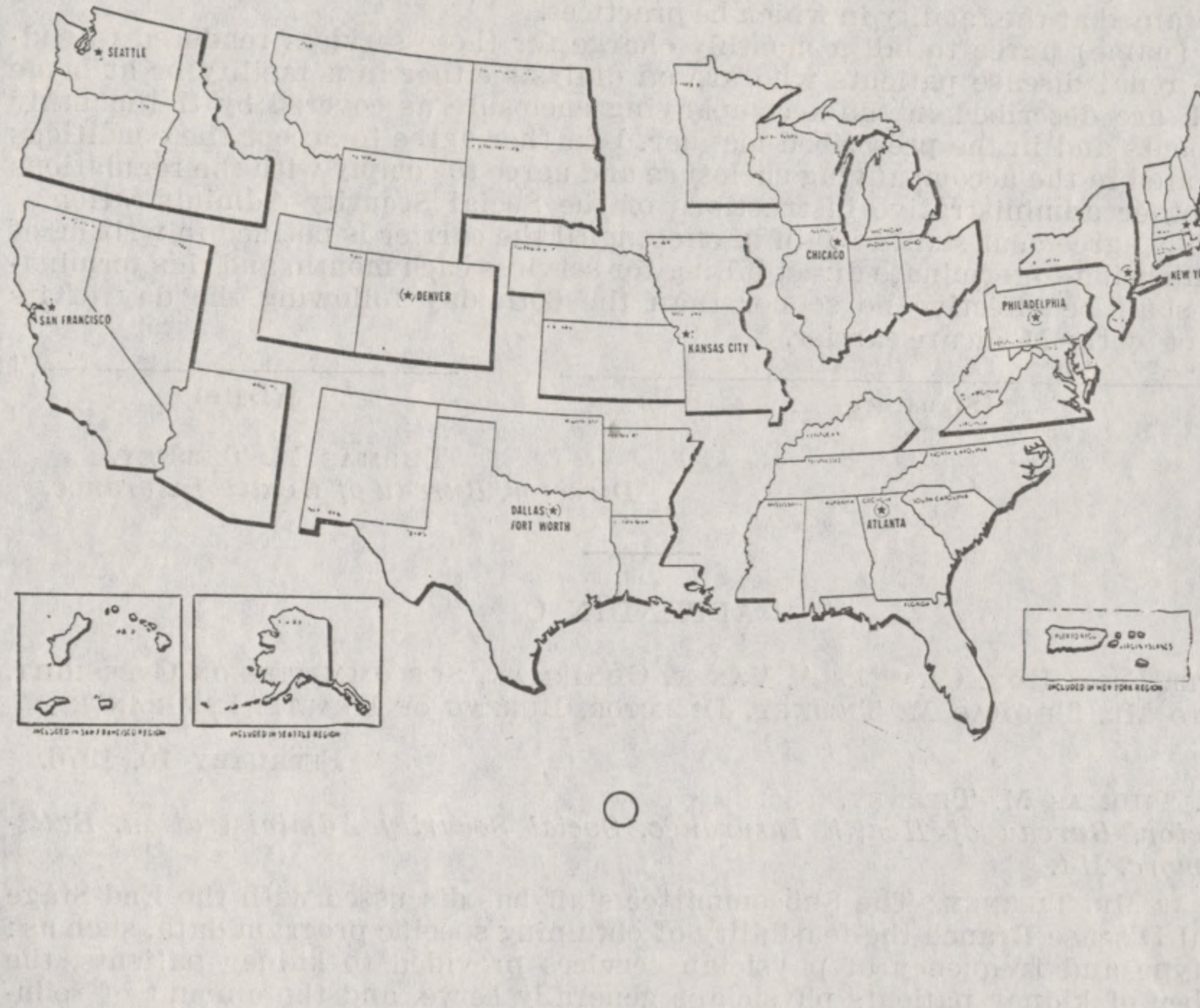
Thank you for your continued assistance in our inquiries into the End-Stage Renal Disease Program.

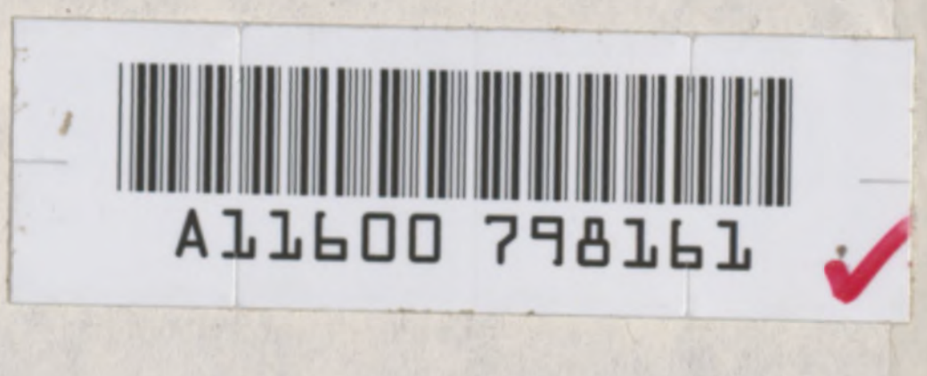
Sincerely yours,

CHARLES A. VANIK,
Chairman, Subcommittee on Oversight.

APPENDIX D

SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEALTH INSURANCE REGIONAL BOUNDARIES




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