Approved January 30, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m./p.m. on January 26, 1984 in room 526-S of the Capitol.

All members were present except:

Senator Bogina, excused

Committee staff present:

Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes Office

Conferees appearing before the committee:

Dr. Robert Harder, Secretary, SRS
Jack Roberts, Blue Cross-Blue Shield
Marlon Dauner, Blue Cross-Blue Shield

Others present: see attached list

Dr. Robert Harder, Secretary, SRS, distributed to the committee a memorandum listing the limitations and changes in the Medicaid and Medical Assistance Program dating back to 1977; a memorandum giving Comparison of Medicaid-MediKan Program Limitations; a Kansas Medical Assistance Cost Containment Report; and a Hospital Utilization Review Impact Report. (Attachments #1, #2, #3, and #4.)

Referring to the number of claims which were cutback and denied, Senator Meyers asked if there were people who needed to be served who were not being served. Dr. Harder replied that there were certain people no longer being served who would have been served five years ago.

Dr. Harder said that some procedures that were paid for last year are not being paid for now, and there has been an 8 to 10 million dollar reduction in services previously paid for.

Senator Gordon asked if they were cutting back on any of the providers. Dr. Harder replied that SRS had had a good working relationship with major provider groups and they would like to see some adjustment made on services still rendered.

In answer to a question about Primary Care Network, Dr. Harder said PCN means that a physician signs with the agency to be assigned to certain clients. From the standpoint of longterm care for families, this will ensure their having a better quality of care. However, there will be some problems as some physicians choose not to sign up. If a client is not happy with a physician he may select another one, and they are not precluded from going to a specialist.

Senator Meyers asked Dr. Harder to return Monday for further discussion and questions.

Jack Roberts, Blue Cross-Blue Shield, introduced Marlon Dauner, who distributed information showing similarities and differences in the health care programs, cost increases, and explained the DRG and CAP programs. (Attachment #5).

He said the health care industry has operated in the past in a cost environment. Between 1978 and 1982 there was a 14.5% increase in beds, a reduction of 2.7% in Blue Cross Patient Days, and an increase of 12

million dollars in Blue Cross payments, and it is not unusual to see an increase of $100,000 per month. People now will ask providers for a clear definition of services provided and the prices charged for those services. The market system will determine the price.

Mr. Dauner explained that under the CAP program, maximum reimbursement levels are established. DRG is a method of defining services to patients in the hospital. For each diagnositc related group (DRG), a maximum amount is paid for that service, and the same maximum payment will be paid to every hospital. Blue Cross' agreement requires that the hospital accept DRG as payment in full. If they charge more than their allowance, they write-off that amount. According to Mr. Dauner, 80% of all hospital revenue will come from DRG reimbursement system, and BC-BS is obligated to make payments directly to the hospital.

Senator Ehrlich inquired how many hospitals and doctors had signed with BC-BS, and Mr. Dauner replied that every hospital in the State, 87½% of the physicians, and 72% of the dentists had signed with them.

Mr. Dauner also answered questions concerning the amount spent on media advertising and serious illness in relation to the DRG program.

Senator Meyers inquired as to what effect this program will have on the hospitals. Mr. Dauner answered that he didn't foresee any deterioration of any kind, but will see a slowdown of dollars and less technological advancement.

Senator Meyers asked Mr. Dauner to return Monday, and said the committee would hear from KHA and DH&E tomorrow.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 1-26-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Dr Lois R Laibelle	K. St Bd of Nursing
Marilyn Bradt	KINH
Paul Johnson	PMCK
B.J. SABOL	KDHE
Jeanette Ei Livingston	State Legis. Comm. AARP
Hankie Mary Vinson	State Legis. Comm A.A.R.P.
Barbara Durham	DoA
Mary Corrigan	KDHE
Gary Pelz	KDoA
Bill Overbey	KHA
Rebecca Kupper	KHA
JERRY SLAUGHTER	KS MEDICAL SOCIETY
Carl Schmitthenner	Ks Dental Assn
Ken Schafermeyer	Ks Pharmaceutical Assoc.
PAT SWAFFER	BUDGET
Dick Hummel	Ks Hospital Assn
Paul Hastings Pittsburg	Ks Wheat Growers
Lynne Ho Kipp	K. State Nurses Assoc
Marlon R. Bowmer	Blue Cross and Blue Shield of Ks
Wayne Johnston	BC BS of Ks
John Schmeidler	SRS
JoAnn Klenda	KAPE
Dick Mayo	Aide

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 1-26-09

(PLEASE PRINT)

NAME AND ADDRESS	ORGANIZATION
Christopher Werner 15920 S. Kenneth Rd. Stilwell, KS	KS Legislature Intern - Sen Francisco

#1 - 1-26-84

MEMORANDUM

FROM: Robert C. Harder RCH

DATE : October 28, 1983

TO : Health Planning
Review Commission

SUBJECT: Cost Savings in Medicaid
and Medical Assistance

The following is cost saving and avoidance efforts between 1977 through 1984. It is difficult to place an exact dollar value on the cost savings. However, the fiscal agent reports that during FY-1983 we paid out approximately $235 million cost savings and avoidances amounted to approximately $150 million.

FY	Limitations & Changes
1977	Limited services provided in the emergency room to emergency services only
	Non-covered payment for Friday and Saturday hospital admissions except for emergencies, since no care is usually provided until Monday
	Limited increases in maximum rates allowed for physician services to office visits. The standard visit was increased to the 75th percentile the rest were increased to the 50th percentile. Most primary care services are in office visits.
	Co-pay for drugs began in 1976
	Limited office visits to 3 per month without medical necessity documentation
	Changed payment method for home health agencies from the lower of cost or changes as paid by Medicare to a fee for service with a maximum limitation
	Established a fraud and recover unit to begin investigations of provider fraud in the Medicaid (Medical Assistance) program
1978	Initiated prior authorization for all non-ambulance medical transportation if over 50 miles
	Developed and implemented the Medicaid Management Information System with enhanced claims processing capability.

Attch. 1

1979 Initiated prior authorization of dentures and eyeglasses (if severe medical hardship), orthodontics and dental services over $300, and durable medical equipment over $500

Limited vision examination to once in 24 months

1980 Restricted reimbursement for 70 surgical procedures to the ambulatory setting unless medical necessity was documented for inpatient admissions

Eliminated coverage of psychotherapy in a nursing home by a psychologist

Initiated coverage of medical attendant care to keep recipient in their own home rather than hospital

Initiated participation in common Medicare/ Medicaid audits of hospital reimbursement

Implemented the requirement that claims indicating third party coverage must have documentation attached of reason for non-payment

Initiated tape-to-tape billing of Medicare cross-over and hospital claims

Initiated coverage of computerized axial tomography (CAT) for diagnosis. This reduced hospital admissions.

1981 Initiated requirement of prior authorization for all out-of-state services beyond 50 miles of Kansas border except emergencies

Limited non-ambulance medical transportation to nursing home recipients, children in EPSDT, and trips over 50 miles one way

Implemented volume purchase of eye glasses

Eliminated general assistance medical only

1982 Implemented statewide prescreen of all nursing home applicants

Implemented $.50 co-pay for chiropractic, optometric and psychology per visit and non-ambulance medical transportation per trip

Made no increase in maximum rates for Community Mental Health Centers

1982 (con't) Increased to 139 the surgical procedures requiring medical necessity documentation for inpatient admission. Reimbursed physicians more when those procedures are done in an outpatient setting

1983 Implemented Home and Community Based Services program to keep elderly and handicapped in the community instead of admitting to nursing homes.

Implemented cap on reimbursement for partial hospitalization at $76 and day treatment for the mentally ill at $52 and all other day treatment at $27

Made non-covered five therapeutic categories of drugs; cough and cold preparations; and vitamins

Initiated prior authorization of all psychological testing

Implemented utilization review of all hospital admissions and continued stays using inter-qual criteria which are completed by the Kansas and Sedgwick County Foundations for Medical Care

Initiated surveillance and utilization review of all inpatient ancillary services

1984 Implement prospective payment plan for all hospital inpatient stays. This is a negotiated rate which includes both per diem and ancillary services.

Implement ancillary review of outpatient hospital services

Implement MediKan program

Limit physician office visits to 24 per year for Medicaid and 12 per year for MediKan

Limit pysychiatric stays in the hospital to 14 days for MediKan

Eliminate reimbursement for all elective surgery in MediKan

Decrease psychotherapy to 2 hours per month for psychiatrists and psychologists

Eliminate all dental, optometric, audiology, and non-ambulance medical transportation in MediKan

1984 (con't) Non-cover - therapeutic categories of drugs for Medicaid recipients

Implement co-pay of $1 for both Medicaid and MediKan for each prescription of drugs, physician office visits, chiropractic visits, dental visits, optometric visits, psychological visits, and non-emergency ambulance per trip. $1 on non-ambulance medical transportation for Medicaid, $10 for out-patient visit, and $25 inpatient admission for MediKan

#2 - 1-26-84

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Division of Medical Programs

COMPARISON OF MEDICAID - MEDIKAN PROGRAM LIMITATIONS

04-13-83

	Medicaid (M.A.) before 05-01-83	Medicaid (& MediKan Children) effective 05-01-83	MediKan adults effective 04-01-83
PHYSICIAN			
Office visits	3 per month - more requires MN, one initial office visit, annual physical.	6 per quarter, no exception. Initial office visit, annual physical included.	12 per year, initial office visit, annual physical included. Non-elective surgery only.
Psychiatrist (Psychotherapy)	3 hrs. per month. More requires MN.	2 hrs. per month. 3 hrs. for EPSDT with PA.	24 hrs. per year.
Co-Pay*	None	$1.00 per office visit.	$1.00 per office visit.
HOSPITAL			
Inpatient	Stays subject to utilization review. Psychiatric care (21 days limit unless prior approved for more.)	Same	Acute Medical Care. Non-elective surgery only. Childbirth (48 hrs. limit for normal delivery) Psychiatric care (14 day limit).
	Alcohol and Drug Treatment in an approved program.	Same	Same
Outpatient	Full range of services.	Same	Non-elective surgery only, C.T. scans, ultra-sound, chemo & radiation therapy, renal dialysis, prior authorized physical rehabilitation if not available in home health agency, emergencies only, as defined in provider manual.

Atch. 2

HOSPITAL, cont.

	Medicaid (M.A.) before 05-01-83	Medicaid (& MediKan Children) effective 05-01-83	MediKan adults effective 04-01-83
Psychiatric partial hospitalization	12 hrs. per day.	168 hrs. per month.	120 hrs. per month unless program has prior approval for extended hrs.
Co-pay*	None	None	$25.00 per inpatient admission $10 per outpatient visit (no co-pay psychiatric partial hospitalization).
LAB - X-RAY	Services ordered by a physician in office, hospital or independent laboratory.	Same	Same
DENTAL	Full range of services with limits.	Same	Not covered.
Co-Pay*	$0.50 per visit.	$1.00 per visit.	
VISION	Eye exams, eyeglasses every 2 years. (Except EPSDT)	Eye exams, eyeglasses every 4 years. (Except EPSDT)	Optometric not covered. (Physician ophthalmological services covered for medical conditions, excluding eyeglasses).
Co-Pay*	$0.50 per visit.	$1.00 per visit.	
AUDIOLOGY	Hearing aids, exams, testing, dispensing, repairs.	Same	Not covered.

	Medicaid (M.A.) before 05-01-83	Medicaid (& MediKan Children) effective 05-01-83	MediKan adults effective 04-01-83
CHIROPRACTOR	Treatment for back problems, including manipulation. 3 office visits per month.	Diathermy only, 6 visits per quarter. (Additional services will be added July 1.)	12 visits per year.
Co-Pay*	$0.50 per visit.	$1.00 per visit.	$1.00 per visit.
PODIATRY	Office visits, surgery 3 visits per month.	6 visits per quarter.	12 visits per year, non-elective surgery only.
DURABLE MEDICAL EQUIPMENT	Full range of services.	Life supporting and to prevent institutionalization only.	Life supporting only.
MEDICAL SUPPLIES ORTHOTICS, PROSTHETICS	Full range of services.	Same	Wheelchairs not covered.
DRUGS	Covered drugs, limited by review, prescription required. (Non-covered: cough and cold preparations, all vitamins except prenatal.)	Same	Limited to drugs and supplies listed in a formulary of covered services provided to pharmacy providers.
Co-pay*	$0.50 per prescription.	$1.00 per prescription.	$1.00 per prescription.
FAMILY PLANNING	Procedures and supplies provided by physicians, health departments, and family planning clinics.	Same	Provided by local health departments and clinics funded by the Department of Health and Environment only.
HOME AND COMMUNITY BASED SERVICES	Services for recipients who have a medical need that would require ACH, but recipient chooses HCBS.	Same	Same

	Medicaid (M.A.) before 05-01-83	Medicaid (& MediKan Children) effective 05-01-83	MediKan adults effective 04-01-83
COMMUNITY MENTAL HEALTH CENTERS			
Outpatient	300 units outpatient per quarter.	200 units per quarter.	480 units per year.
Psychiatric partial hospitalization	12 hrs. per day.	168 hrs. per month.	120 hrs. per month (unless program has prior approval for extended hrs.).
Psychological evaluation (testing)	6 hrs. per year with with P.A.	6 hrs. per 2 years with P.A.	6 hrs. per 3 years with P.A.
PSYCHOLOGIST			
Psychotherapy	3 hrs. per month more with MN (no nursing home visits).	2 hrs. per month, 3 hrs. per month for EPSDT.	Not covered.
Psychological Evaluation (Testing)	6 hrs. per year.	6 hrs. per 2 years with PA. Nursing home test requires physician orders.	6 hrs. per 3 years with P.A. Nursing home test requires physician orders.
Co-pay*	$0.50 per visit.	$1.00 per visit.	$1.00 per visit.
HOME HEALTH AGENCY	Skilled nursing, physical rehabilitation, home health aide.	Same	Same
REHABILITATION FACILITIES	Restorative OT, PT, speech for 6 months.	Not covered.	Not covered.
ADULT CARE HOME (SNF, ICF, ICF-MI, ICF-MR)	Recipient must be screened, must choose ACH over HCBS.	Same	Covered only if HCBS not available, up to 2 months.
TRANSPORTATION	Ambulance: emergency, non-emergency services. Limited non-ambulance services.	Same	Emergency Ambulance only.
Co-Pay*	$0.50 non-emergency ambulance.	$1.00 non-emergency ambulance.	
*Co-Pay Exemptions	Under age 18, ACH residents HMO members. Family Planning, pregnancy services.	Same	ACH residents

[MN = Medical Necessity
PA = Prior Authorization]
1519M

ENDUM to the Comparison of Medicaid - MediKan Program Limitations dated April 1983.

The Kansas Legislature, with Senate Concurrent Resolution No.1632, added the following dental service to the MediKan Program. Please make this change on your Comparison sheet - DENTAL - Non-elective Surgery.

#3 - 1-26-84

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

KANSAS MEDICAL ASSISTANCE
COST CONTAINMENT REPORT

January, 1984

REJECTED CLAIM CATEGORY	NUMBER OF CLAIMS CUTBACK AND DENIED	AMOUNT OF CLAIMS CUTBACK/DENIED	TOTAL AMOUNT BILLED	TOTAL AMOUNT PAID
1. Duplicate claims not paid.	3,644	$807,132	$807,132	
2. Claims not paid because the recipient was not eligible on the date of service.	5,543	1,016,424	1,016,504	$80
3. Claims not paid because the recipient was not eligible - other reasons.	6,227	277,589	277,589	0
4. Claims submitted by ineligible providers.	886	24,756	24,756	0
5. The difference between the amount billed vs. the amount allowed.	101,818	2,988,751	9,024,598	6,035,847
6. Claims not paid due to conflict with State policy.	58,239	1,611,940	3,329,879	1,717,939
7. Claims not paid due to procedures contrary to medical necessity.	995	417,850	442,057	24,207
8. Other cost avoidance.	19,355	5,046,285	13,656,690	8,610,405
9. Total claims returned for correction.	6,942	1,906,873	9,154,641	7,247,768
TOTAL	203,649	$14,097,600	$37,733,846	$23,636,246

CLEAN CLAIMS PAYMENT TIME

1. Percent paid within 30 days	99.91%
2. Percent paid within 90 days	100.00%

Sources: HMMR 381H
HMMR 901H

Research & Statistics
January 23, 1984

0074H,7

Att. 1

#4 – 1-26-84

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Hospital Utilization Review Impact

Hospital utilization review was implemented with a new process on October 1, 1982. The purpose of hospital utilization review is to ascertain that only those hospital days that are medically necessary for inpatient care are paid by Medicaid/MediKan. Utilization review was implemented through contracts with the Kansas Foundation for Medical Care and the Sedgwick County Medical Society Medical Review Foundation.

The impact of the utilization review program is as follows:

FY 1983 (3 quarters)

This statement is for 9 months as the project was not implemented until October 1, 1982.

13,343	days saved by decreasing the length of stay from 6.53 to 5.96
21,993	days saved by avoiding admission
35,336	total days saved
x $299	average cost per day
$10,565,464	total saved

The contractual cost was $398,345 for a cost benefit ratio of $25.52/1 (for every dollar spent on review $25.52 was saved).

FY 1984 (first quarter)

2,814	days saved by decreasing the length of stay from 6.54 to 6.18
6,259	days saved by avoiding admission
9,073	total days saved
x $261	average cost per day
$2,368,053	total saved

The contractual cost was $111,082 for a cost benefit ratio of $20.32/1 (for every dollar spent on review $20.32 was saved).

Conclusion:

The hospital utilization review project is cost effective. The length of stay decreased over the first nine months and has increased slightly since then as the more complex cases are the only ones admitted.

dch

January 25, 1984

Att. 4

HF 1-26-84

PERSPECTIVE

Exh. 5

TOPEKA

BETWEEN 1978 AND 1982:

1. INCREASE IN BEDS 14.5%

2. REDUCTION IN BLUE CROSS PATIENT DAYS 2.7%

3. BLUE CROSS PAYMENTS:

   1978: $12,130,570

   1982: $24,151,240

AVERAGE RATE INCREASE

1983	22%
1982	33%
1981	23%
1980	17%

Avg. last four years 23.75%

AVERAGE BC-BS RATE (1988)

Single	Family
$119.11	$251.52

Annual Percent Increase	Monthly Rates in the Year 2000 Single	Family	Annual Famil
20%	$2,644.24	$5,583.74	$67,004
15%	1,286.39	2,716.42	32,597
12%	821.86	1,735.49	20,825
10%	607.46	1,282.75	15,393
5%	273.95	578.50	6,942

MARKET TRENDS

A. First Dollar Deductible

B. Shared Payment

C. Indemnity or Limited Coverage

D. Self Insurance

E. Administrative Services Only

F. Health Maintenance Organizations

G. Preferred Provider Organizations

ALTERNATIVES

1. FEDERALLY CONTROLLED SYSTEM
2. COMPETITION (INDUSTRY ORIENTATION)

INDUSTRY ORIENTATION

1. Product Lines

- Well-Defined
- Choices
- Data

INDUSTRY ORIENTATION

2. Price Competition

- Hospital Services
- Physician Services
- Third Party Services
- Bottom Line

CONSUMER'S DEMAND:

1. CHOICE OF SUPPLIER
   - INSTITUTIONAL
   - PROFESSIONAL (M.D., SOCIAL WORKER, CRNA, ETC.)
2. CLEAR DEFINITION OF CONDITION
   - UNDERSTANDABLE DIAGNOSIS

CONSUMER'S DEMAND (CONTINUED):

3. OPTIONAL TREATMENT PLANS
   - MEASURABLE OUTCOMES
   - PRICES
4. CONVENIENCE

NEW REIMBURSEMENT SYSTEMS

1. ENHANCE COMPETITION FOR PATIENTS
2. PROVIDERS BECOME MARKET PRICE TAKERS

CONTRACTING PROVIDERS

1. NEW PROVIDER CONTRACTS OFFERED

2. NON-ASSIGNMENT PROVISION FOR NON-CONTRACTING PROVIDERS

3. LIST OF CONTRACTING PROVIDERS GIVEN TO SUBSCRIBERS

4. COST CONTAINMENT ACTIVITIES:

   - REIMBURSEMENT LIMITS
   - UTILIZATION REVIEW
   - COORDINATION OF BENEFITS
   - MISC.

5. FREE CHOICE OF PROVIDER---CONTRACTING PROVIDERS ACCEPT DIRECT PAYMENT AS PAYMENT IN FULL AND HOLD THE PATIENT HARMLESS. NON-CONTRACTING PROVIDERS OBTAIN PAYMENT FROM PATIENT. (BLUE CROSS AND BLUE SHIELD BENEFITS ARE PAID TO PATIENT AT LEVEL PAID TO CONTRACTING PROVIDERS.)

NEW REIMBURSEMENT SYSTEMS

Under the New Reimbursement System, Blue Cross and Blue Shield Establishes "Maximum Allowable Payment" Amounts for Services Rendered to Subscribers.

1. **Institutional Reimbursement**
   - **Diagnosis Related Groupings (DRG) for Inpatient Services**
   - **Procedure Identification for Outpatient Services**
2. **Professional Reimbursement**
   - **Procedure Identification for All Services**

A DRG IS DEFINED AS GROUPINGS OF PATIENTS ACCORDING TO SIMILAR MEDICALLY MEANINGFUL CHARACTERISTICS.

DRG ASSIGNMENT

1. Diagnosis
2. Procedures
3. Age
4. Sex
5. Discharge Status
6. Multiple Diagnosis or Complication

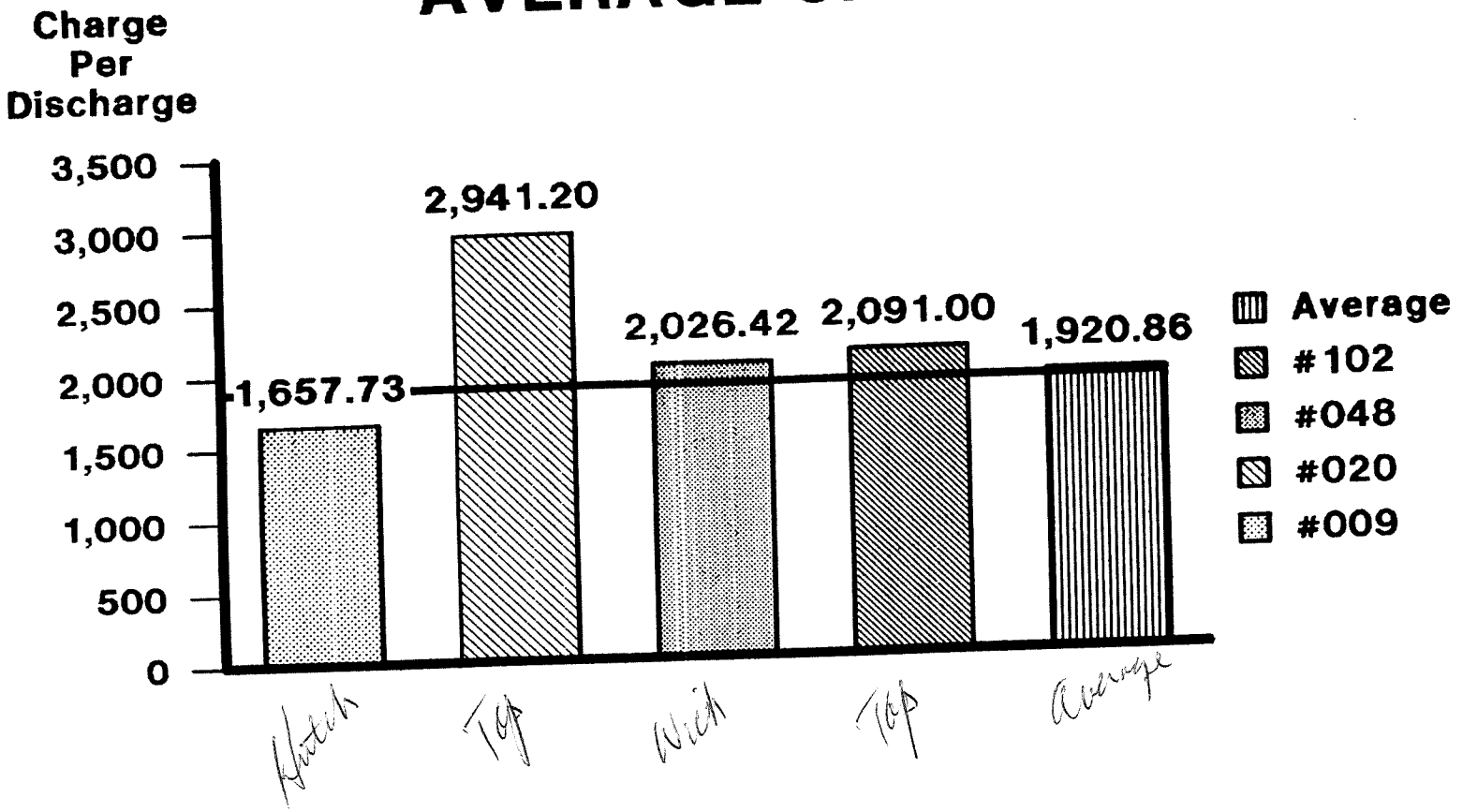
AUDITS

A. DRG Verification Audits
   - Abstract Data

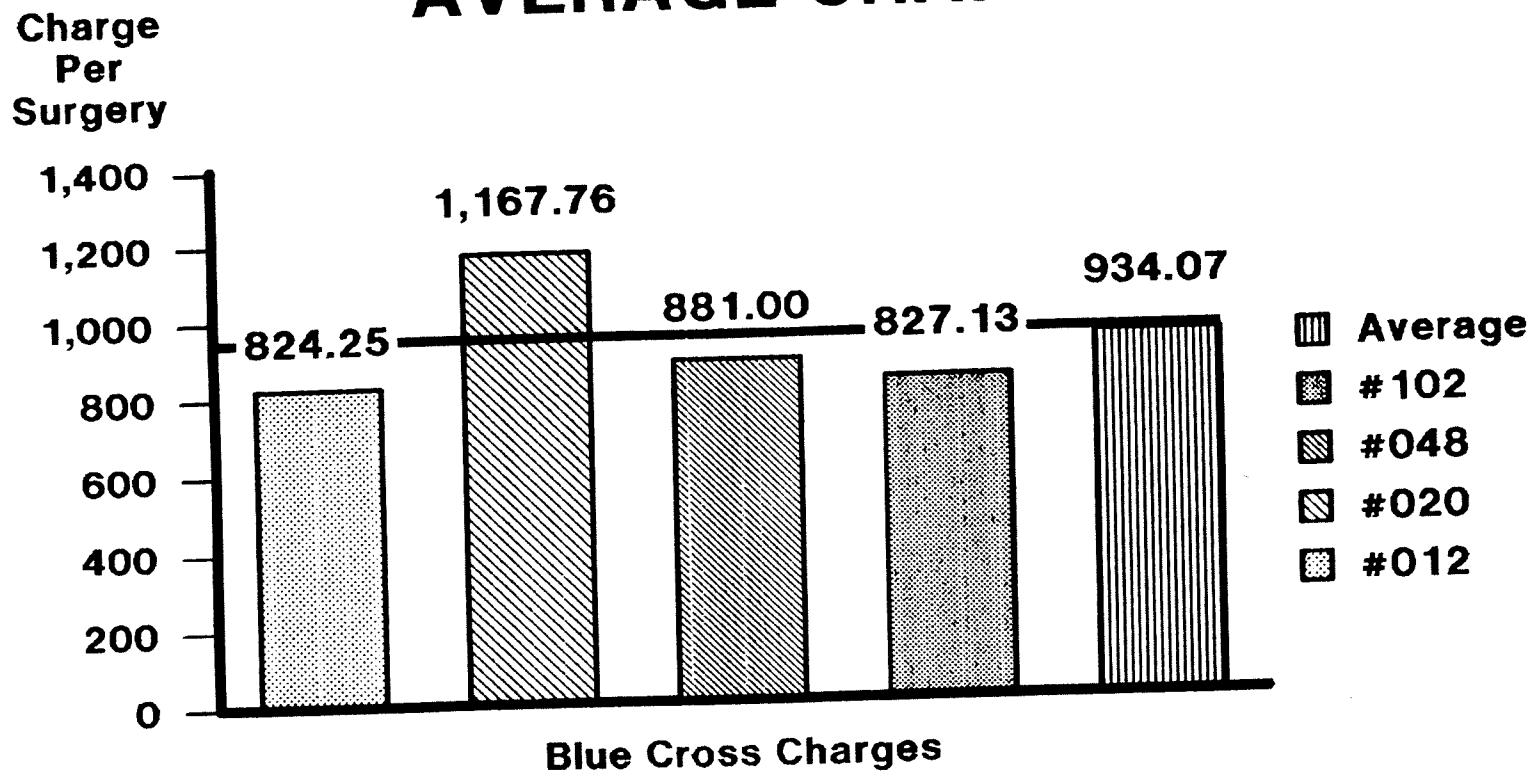
B. UR and Severity Audits
   - Physician/Hospital
   - Abstract Data
   - Clinical Data
   - Medical Record

C. Billing Audits
   - On-Site

INPATIENT SURGERY
APPENDECTOMY
AVERAGE CHARGE



INPATIENT SURGERY
TONSILLECTOMY WITHOUT ADNOIDECTOMY
AVERAGE CHARGE

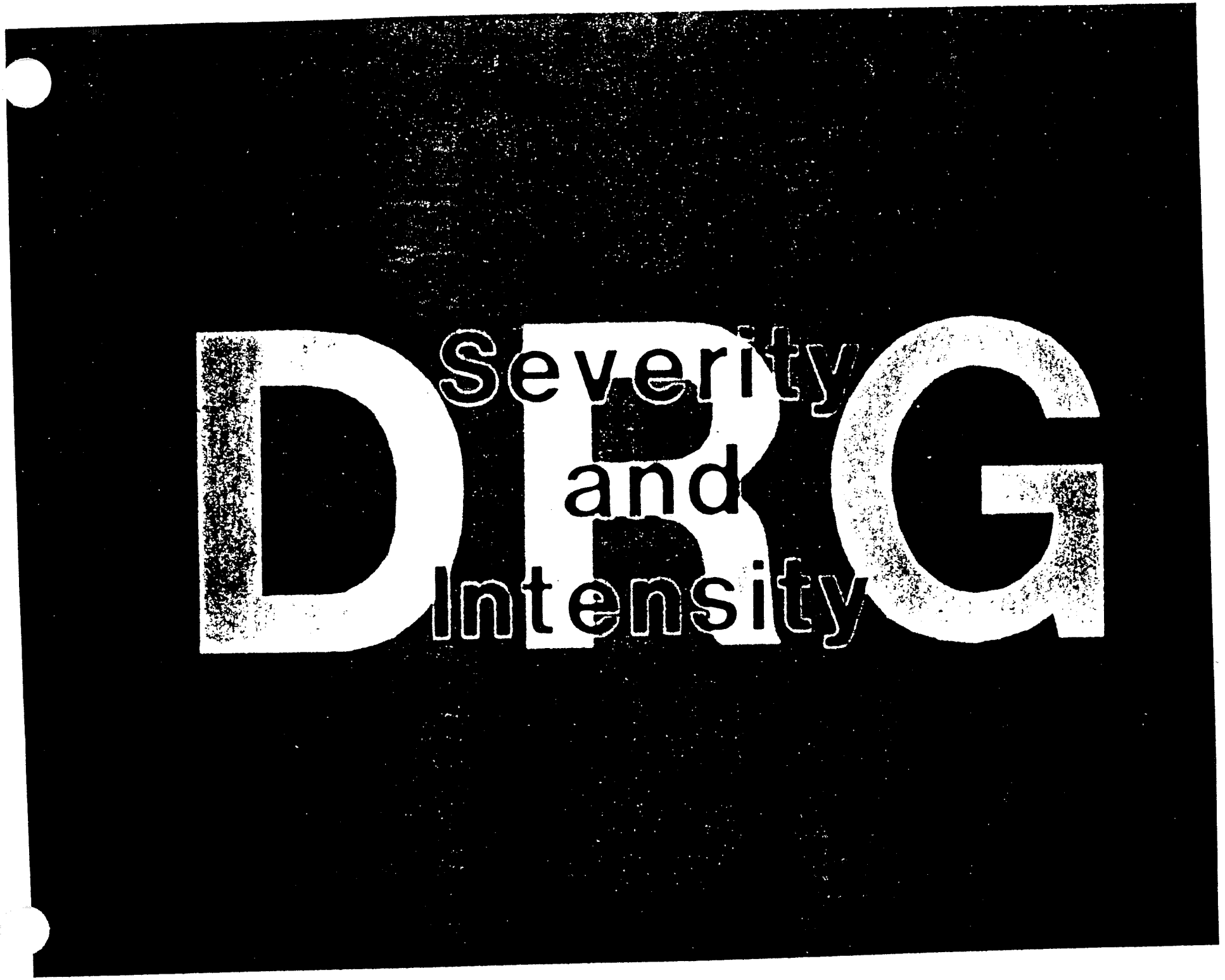


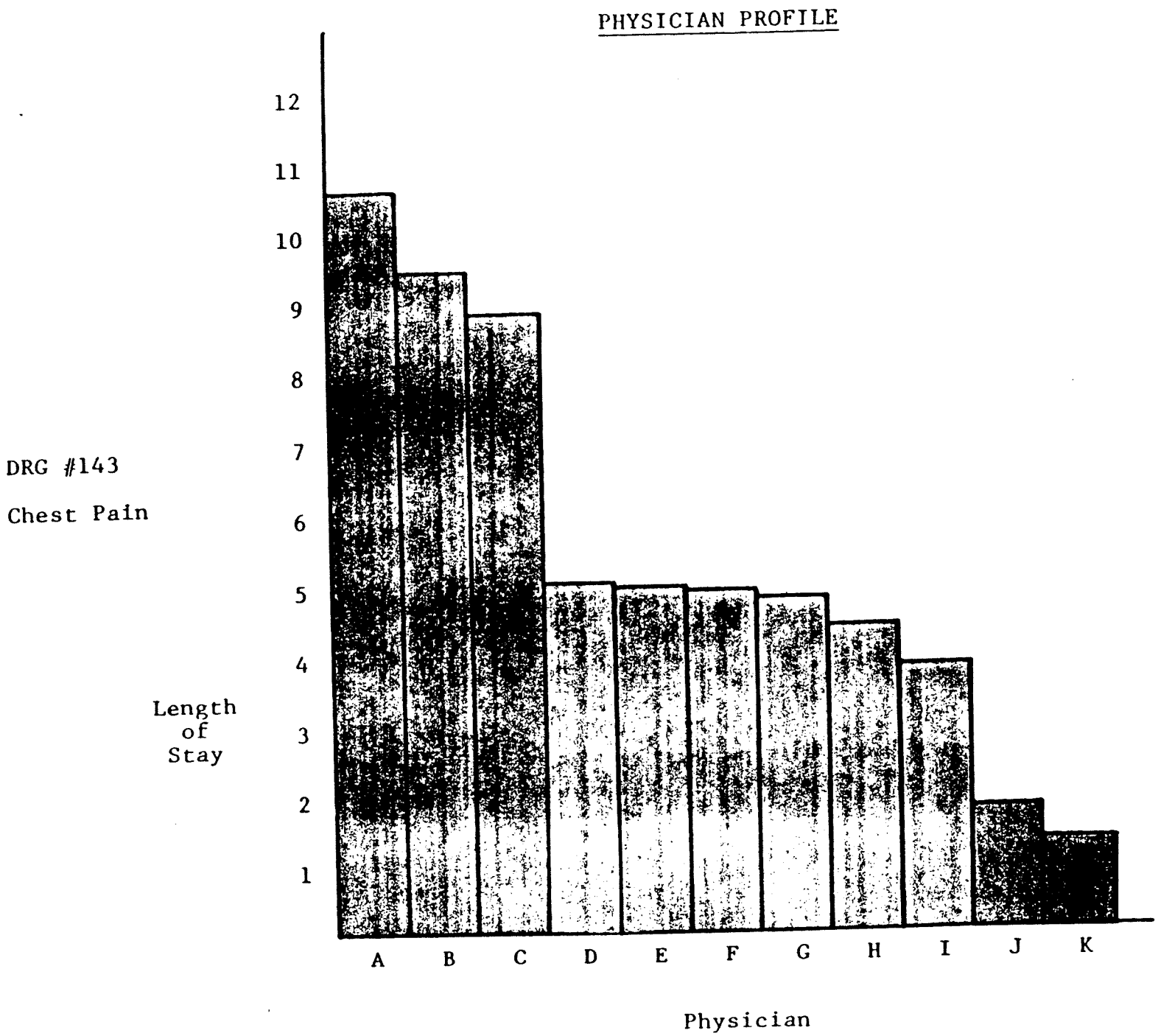
CONTRACT REQUIREMENTS - HOSPITAL

1. Accept DRG Payments as Payment in Full Except for Coinsurance, Deductible, and Non-Covered Amounts.
2. Provide Data Needed to Pay Claims at No Charge.
3. Cooperate in UR Activities.
4. Calendar Year Contract.
5. Cancellation Notification - 120 Days Prior to End of Calendar Year.
6. Abide by Blue Cross and Blue Shield Policies and Regulations.

CONTRACT REQUIREMENTS - BLUE CROSS AND BLUE SHIELD

1. Make Payments Directly to Hospital.
2. Reimburse Hospital's Charges up to DRG Maximum Allowable Payment (MAP).
3. Reimburse Within 14 Days or Provide PIP if Hospital Utilizes Paperless.
4. Provide Hospital with Policies and Regulations Including Appeals Procedures.
5. Include Hospital's Name on List of Contracting Providers to be Distributed to Subscribers.
6. Annually Establish MAP.


DRG
Severity
and
Intensity


PHYSICIAN PROFILE
DRG #143
Chest Pain
Length of Stay
12
11
10
9
8
7
6
5
4
3
2
1
A
B
C
D
E
F
G
H
I
J
K
Physician

PROFESSIONAL REIMBURSEMENT

A. CONTRACTS OFFERED TO:

1. DOCTORS OF MEDICINE (M.D.)
2. DOCTORS OF OSTEOPATHY (D.O.)
3. DOCTORS OF PODIATRY (D.P.M.)
4. DOCTORS OF DENTAL SCIENCE (D.D.S.)
5. CERTIFIED PSYCHOLOGISTS
6. COMMUNITY MENTAL HEALTH CENTERS
7. DOCTORS OF OPTOMETRY (O.D.)

B. CONTRACTS ALSO OFFERED TO PRACTITIONERS:

1. LICENSED SOCIAL WORKERS
2. COMMUNITY HEALTH CLINICS
3. CERTIFIED REGISTERED NURSE ANESTHETISTS
4. CHIROPRACTORS
5. PHYSICIAN ASSISTANTS
6. AMBULANCES
7. PHYSICAL THERAPISTS
8. REGISTERED NURSES
9. NURSE CLINICIANS
10. NURSE PRACTITIONERS

C. CONTRACT IS SIMILAR TO CURRENT BLUE SHIELD PARTICIPATING AGREEMENT EXCEPT IN ESTABLISHMENT OF MAP.

PHYSICIAN SERVICES - 1984 MAP

Procedure Code	1982 UCR	1982 SMR	1983 UCR	1983 MAP
#3261 Appendectomy	545	462	583	550
#4242 Bilateral Vasectomy	270	214	289	230
#9022 1st Day Comprehensive	98	76	102	100