

CORRESPONDENCE

Evaluation of allergy practice

To the Editor:

The time is rapidly approaching (if it has not already passed) for clinical practitioners of allergy to critically evaluate the practice of allergy. I am referring to: (1) disease terminology; (2) criteria of care—diagnostic and therapeutic procedures, indications, and contraindications, and quantity and quality of care given; (3) a relative value study.

Everyone should be aware of the Bennett Amendment to the Social Security Act which would have provided a Professional Services Review Organization (PSRO). The Bennett Amendment has been reintroduced and still may be enacted. The amendment has not passed as yet, but the idea has been initiated and the impetus provided to inaugurate some type of federally controlled evaluation of quality and quantity of medical care given patients, if this evaluation is not provided elsewhere.

In addition, the foundation concept of health care delivery (FMC) is rapidly growing, and Health Maintenance Organization (HMO) implementation is just around the corner. In order to clarify these terms, some brief explanation of HMO's and FMC's may be in order. A Health Maintenance Organization (HMO) is a delivery system which may be initiated and administered by either a governmental agency, an industry, a private insurance carrier, or a separately established medical society corporation. It generally encompasses total health care, therapeutic and preventive medicine, and is paid for on an individual or family-computed basis of capitation payments. The Kaiser Permanente Organization is probably the best known example of an industry-organized HMO.

The Foundation for Medical Care (FMC) concept was initiated in San Joaquin County, California, in 1954, and has been spreading quite rapidly during the past year or two. FMC's are established by a county or state medical society as separate nonprofit organizations. Standards of coverage are prescribed which cooperating health insurance carriers must incorporate with policies written for foundation patients. Criteria of care and review approval of claims for foundation-approved programs are also included, as well as fee maximums for services rendered. In FMC's the basic structure for the practice of medicine is unchanged in respect to patient-doctor relationships, choice of physician, and the fee-for-service concept. Physician membership in an FMC is voluntary, while compulsory participation in an HMO is accepted as part of the employment agreement between an HMO and physician.

Both FMC's and HMO's require peer review—hopefully at local levels. Peer review for HMO's and FMC's requires delineation of criteria of care for the outpatient practice of medicine as well as inpatient care. As the chairman of a county Foundation Committee and a member of the Illinois State Medical Society Council on Peer Review, I have had the opportunity to seek out, review, and evaluate these criteria of care. If one would desire an exercise in frustration and confusion, this type of review would provide much satisfaction. For example, in the management of bronchial asthma, under the category "frequency of visits" the following criteria are stated:

San Joaquin FMC—under the diagnosis, "Asthma, allergic or infectious."

"Acute cases, two to four times per attack. Visits may be daily. Three times a week for four months for desensitizing the chronic, then once every three to four weeks. Doctor must be present at desensitization."

Hennepin County FMC—in Allergy Section

Under diagnosis, "Seasonal asthma."

"Evaluation and acute management—one to six visits. Chronic management—two to four visits annually. Immunotherapy—twice per week for three months or once per week for six months, followed by one visit every one to four weeks."

Under diagnosis, "Perennial Asthma"

"Identical to above except "chronic management—once per month."

Hennepin County FMC—in Internal Medicine Section under diagnosis, "Asthma—Allergic or Infectious."

"Acute cases—two to four times per attack. Three times a week for four months

for desensitizing the chronic, then once every three to four weeks. Physician must be present at desensitizations."

Hennepin County FMC—in Pediatrics Section under diagnosis, "Asthma—Allergic or Infectious."

"Two to four times per attack—in acute cases. Visits may be daily. Physician must be present at desensitization. Desensitization program may vary."

Santa Clara FMC—"Asthma (acute)—2 outpatient visits/month."

"Chronic (may add on to acute)." "Asthma—1 outpatient visit/month."

San Diego FMC—Any claims submitted for more than 2 members of a family is subject to peer review—implying that this is an unusual occurrence.

Add to this the confusing differences in diagnostic and therapeutic criteria as well as the variations in 1964 California Relative Value Study (RVS) and the 1969 California Relative Value Study (RVS) and the American Society of Internal Medicine (ASIM) Code. I am sure that we must give any third-party carrier the accurate impression that the science of clinical allergy, if such exists, is highly individualized and/or that it is secondary to such factors as the art of medicine and the economics of medical practice.

I recognize the fact that both allergic patients and the physicians treating them are individuals, resulting in bivalent individualized treatment. However, there are general guidelines which can and must be established. Good medical practice is the same in Florida as in Oregon—bad medical practice is the same in Maine as in California. FMC's, HMO's, and State Peer Review Committees and Councils are going to be looking to specialty societies for guidance and guidelines. It is not unusual for national specialty societies to be involved in the development of these guidelines. It occurs in ob-gyn, urology, and neurosurgery, as specific examples. It appears to me that the American Academy of Allergy can and should play a role in initiating such a study (unless the Academy does not and will not represent the clinicians). This study should jointly involve the American Academy of Allergy, The American College of Allergists, and the American Association for Clinical Immunology and Allergy. General guidelines should be established which can be modified at regional, state, or local levels—provided that the variations are not medically contraindicated. The guidelines should reflect quantity and quality of care necessary to assure good medical care with no over-utilization. Specifically, the following should be evaluated:

1. *Terminology or diagnostic nomenclature* (The AMA's *Current Medical Information and Terminology*, fourth edition, notwithstanding).

2. *Diagnostic Procedures and Therapeutic Procedures* (indicating quality and quantity of diagnostic and therapeutic procedures to be employed). (The repetition is deliberate to emphasize these points.)

3. A *relative value study* (RVS) which should indicate exactly what the name implies—the relative time and skill value relating to the performance of various diagnostic and therapeutic procedures. The conversion or multiplier factor may be individually, locally, or regionally varied.

4. At some early point in time, definitive decisions will have to be made about controversial diagnostic and therapeutic procedures such as provocative testing, neutralization procedures, cytotoxic studies, etc.

What is our alternative if none of the above is done by the "allergy establishment"? I think that answer is obvious. It will be attempted by scattered, splintered, and fringe groups. At some point, third parties, such as HEW or Congress, will become fed up with the confusion, the mixed up senses of values, the self-serving approaches of various groups—and then it will be done by an agency of the federal government. The people then deciding the criteria probably will not be allergy oriented and possibly not even clinically oriented. (As an example of what we might then anticipate, look at allergy education in medical schools in which the chairman of the Department of Internal Medicine is not allergy oriented.)

If, however, these evaluation studies and guidelines are implemented, allergy may be practiced with guidelines which reflect sound clinical thinking regardless of whether the bill is paid by the patient, a private insurance carrier, Medicare, Medicaid, or a national health insurance.

Robert J. Becker, M.D.
Joliet, Ill.