Editorial

Medicare on My Mind

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Recently, I received a letter from Medicare. In general, letters from Medicare are scary. They are sent on official government letterhead, much like Internal Revenue Service paperwork, and are worded with a serious and legalistic tone.

As a pediatric and adolescent dermatologist, I have few Medicare patient visits. At this point, my Medicare patients are mostly patients who saw me when I was covering for a colleague on vacation or the occasional elderly patient with a genetic skin disease.

It was with great surprise that I received a letter from Medicare with a bar graph of CPT® (current procedural terminology) codes for follow-up visits as compared to my "peers" in dermatology. I had only 4 Medicare patient visits in the 3 months specified. The letter was observational, and of course, I believe I coded properly.

Furthermore, the letter stated that I was not matching the numbers or curve of my peers. How can 4 visits possibly statistically match a model in which there are 5 visit types and something of a bell-type curve distributing most of the visits as 99212 and 99213? It is not possible for Medicare to gauge my habits, as I do not see typical Medicare patients, while other physicians treat these patients often. If physicians were being statistically evaluated properly (if statistical analysis is proper for physicians at all), including adequate sample size and 95% confidence intervals, only a small percentage of physicians could receive letters and physicians with 4 visits would not be able to receive letters.

Despite all we are taught in medical school about evidence-based medicine and proper usage of statistics, the bar graph sent by Medicare was not turned into a statistically usable curve and had no SD levels for each of the bars in the peer graph. Does Medicare expect physicians to match the exact percentages of these bar graphs? It is statistically improbable to match their bar graph exactly. How can physicians be expected to document and code like robots, conforming to statistical data?

With this system, no one can avoid audit. In my case, I am not distributed along the curve because of my unusual patient population. What about academic physicians who see tertiary referrals? How would they have 99211 or 99212 visits?

Nowadays, as I enter the examination room and say "Hello," I head for the nearest writing surface so I can start the checklists, circling and signing the "documentation" of visit type. I can see patients are put off at times because I am not making eye contact as I document, but all insurance companies require documentation—never written, no reimbursement. Unfortunately, these requirements do not equate to better medicine. In the real world, physicians who foster a better relationship are less likely to be sued and create better patient satisfaction.[1] The insurance system of audit clearly is not assessing real performance. In reality, the system is forcing physicians into checklist medicine. It is not practical to expect physicians near retirement to be herded into checklist medicine and it is disheartening to newbies that this is the nature of medicine of the future.

The punch line is that physician visits, laboratory expenses, and ambulance costs combined constitute only about 6% of estimated overpayments in the recent Medicare auditing that began

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in spring 2005,[2] presuming that all of those medical payments were really overpayments. These numbers were derived by auditing contractors who were paid only by percentage of recovered funds, causing all of the numbers to fall under heavy suspicion.[2]

The current system by which insurance companies assess physicians is arbitrary. The system puts physicians in a needless state of fear and anxiety and does not follow sound statistical principles. Auditing of physicians and reeducation is neither good medicine nor good economics. If we are to be subject to bounty hunters and matched to bar graphs, how are we to help people? Where is the humanity in insurance-based patient care?

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