Payment Decreased for Fast In-Office HbA_{1c} Test

BY JANE ANDERSON
Contributing Writer

The Centers for Medicare and Medicaid Services will cut reimbursement for physicians who provide their diabetic patients with point-of-care hemoglobin A_{1c} testing using a "glycosylated Hb home device" from about $21 a test to about $13.50 a test on April 1, a coding expert from the American Academy of Family Physicians said.

The reimbursement cut was mandated by a provision in the Medicare, Medicaid, and SCHIP Extension Act of 2007, enacted at the end of last year. That provision reverses a decision by CMS in late 2006 to increase reimbursement for the HbA_{1c} test, said American Academy of Family Physicians (AAFP) coding specialist Cynthia Hughes, who noted that the academy had lobbied hard for several years for the increase in reimbursement.

"It was slipped into SCHIP," Ms. Hughes said. "It would take another act of Congress to reverse it."

The language added to the SCHIP legislation states that point-of-care HbA_{1c} testing using the kit and billed under CPT code 83037 should be paid at the same rate as HbA_{1c} testing done with an in-office analyzer in either a physician's office or laboratory setting and billed with CPT code 83036.

Ms. Hughes said that the average cost to physicians' offices for each test kit is about $13, but that costs also include shipping and handling of the kits themselves, staff time to administer the test, supplies, and additional overhead expenses. AAFP has suggested to CMS that an appropriate payment—one that takes into account all the costs of purchasing and administering the test—would be more than $34.

Providing the test at the point of care is more convenient for the patient and augments care because the test results are available in just a few minutes, in time for the physician to counsel the patient about those results, Ms. Hughes said.

The decreased reimbursement for the test kits could lead to fewer patients receiving the HbA_{1c} test at the point-of-care, Ms. Hughes said, adding that reimbursement for testing using the in-office analyzers—which cost about $2,700—is not affected. ■

Higher Drug Utilization Boosting Nation's Health Spending Tab

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — The nation spent $2 trillion, or $7,000 per person, on health care in 2006. While that was only a small increase from the previous year, America's prescription drug tab increased by 8.5%, fueled largely by the new Medicare Part D drug benefit.

Health spending as a share of the nation's gross domestic product continues to rise, hitting 16% in 2006. (See chart.)

Total spending on physician and clinical services grew 5.9% to $448 billion, which was the slowest rate of growth since 1999. Physician pay crawled almost to a halt, largely because of the freeze in Medicare's reimbursement rates in 2006. Private insurers seemed to have followed suit, said Cathy Cowan, an economist at the Centers for Medicare and Medicaid Services. Cowan, a coauthor of an annual analysis of the nation's health spending, spoke at a briefing on the report, which was published in the January/February issue of Health Affairs.

Medicare had the fastest rate of growth since 1981, according to the report. Spending increased 19% in 2006 to $401 billion, driven largely by the prescription drug benefit and the cost of administration for that benefit and for Medicare Advantage, a managed care program.

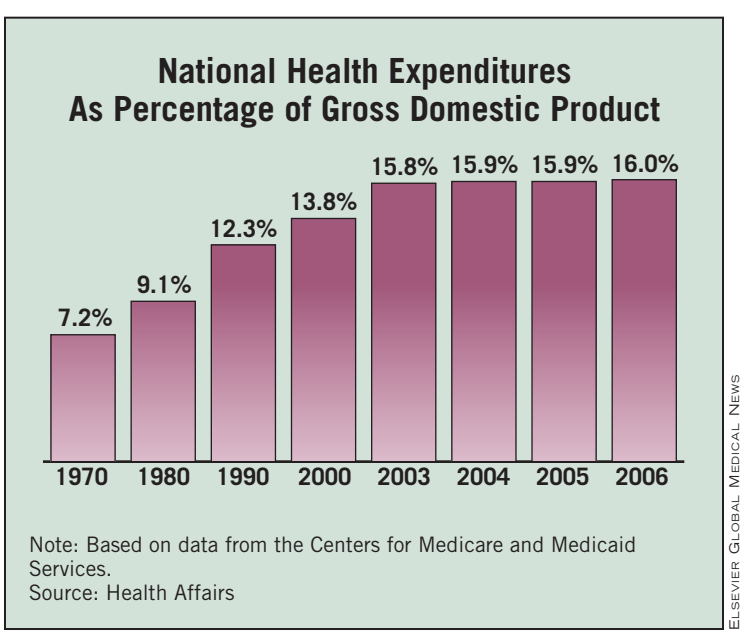
Medicaid spending dropped for the first time since the program began in 1965. The 0.9% decrease was largely due to a large number of Medicaid enrollees who were shifted into Medicare for their prescription drugs.

Overall drug spending grew 8.5% in 2006—a far cry from the double-digit increases seen in the late 1990s, but still an increase from the 5.8% rise in spending in 2005. Half of the 2006 increase was due to greater utilization, not surprising given that about 23 million Medicare beneficiaries took advantage of the new benefit. Prescription prices increased by only a little over 3%, according to an annual analysis by actuaries at the Centers for Medicare and Medicaid Services.

The change in the drug rebate picture also contributed to rising drug costs. Under Medicaid, states received an average 30% rebate from drugmakers. Medicare, however, got only about 5% from manufacturers for the millions of beneficiaries who shifted out of Medicaid.

The rising availability of generic drugs—and programs designed to encourage use of generics, such as smaller copays for that category—also drove an increase in pharmaceutical utilization. A $4 generic program offered by Wal-Mart contributed to that trend and also helped keep prices down, according to the CMS authors. Sixty-three percent of drugs dispensed in the United States in 2006 were generic, according to the report.

Overall, the CMS analysis shows that the largest category of health spending is still hospital care, which consumes 31% of the nation's health dollars. Other spending, which includes dental, home health, durable medical equipment, over-the-counter medications, public health, research, and capital equipment, consumes 25% of the health dollar. Physician and clinical services follow at 21%, then prescription drugs at 10%, administration at 7%, and nursing home care at 6%. ■



Note: Based on data from the Centers for Medicare and Medicaid Services.
Source: Health Affairs

ELSEVIER GLOBAL MEDICAL NEWS

AMA, Aetna Work on Pay Issue

BY JANE ANDERSON
Contributing Writer

Aetna Inc. said that it is working with the American Medical Association and state medical societies to resolve issues involving nonparticipating physicians after the AMA complained that the insurer was paying those physicians just 125% of Medicare rates and then telling patients they didn't need to pay the rest.

In a recent letter to Aetna, Dr. Michael Maves, AMA's chief executive officer and senior vice president, noted that Aetna's policy—implemented last June—fails to take into account different practice costs that are reflected by physicians' billed charges.

The EOBs from Aetna state that the patient has no responsibility to pay the difference between 125% of Medicare rates and the actual charges.

"It is simply arbitrary and capricious for Aetna to deem 125% of Medicare to be a fair payment across the board," Dr. Maves wrote in his letter to Dr. Troyen Brennan, Aetna's chief medical officer.

Dr. Maves also said in the letter that physicians nationwide are reporting receiving Aetna Explanation of Benefits (EOB) forms stating that the patient has no obligation to pay the nonparticipating physician the difference between the physician's charge and the amount Aetna has paid.

This practice, Dr. Maves said, potentially violates the 2003 settlement agreement with Aetna in Multidistrict Litigation 1334, the large class action lawsuit in which physicians sued large managed care companies, including Aetna, over business practices.

However, Dr. Brennan said in an interview that the settlement in that case "clearly differentiates between HMO-based plans and traditional plans." It requires Aetna to tell members in traditional plans that they can be balance-billed by nonparticipating physicians, but it treats HMO plans differently, he said.

HMO members receive an EOB stating that Aetna does not contract with a nonparticipating provider, and that the provider might not accept Aetna's payment as payment in full for services, Dr. Brennan said. "In the notice, we inform the member that we 'seek to ensure that they do not pay this provider any amount above any applicable copayment, coinsurance, or deductible at the in-network (referred) benefit level,' and if they receive a bill for the difference, they should send the bill to us," Dr. Brennan said.

Aetna believes it has complied with the 2003 settlement agreement "in all respects," but is in discussions with the AMA and state medical societies about the issues involved, Dr. Brennan said. However, "no substantive discussions have occurred as of yet with the AMA," said AMA spokesman Robert Mills.

Meanwhile, nonparticipating physicians are being placed in an awkward situation, said Dr. Alan Schorr, a Langhorne, Pa.–based endocrinologist who does not participate with Aetna. Some of his patients have received the Aetna EOBs.

"This puts the patient and physician into adversarial roles," said Dr. Schorr, who added that, although Aetna might believe that 125% of Medicare represents a fair fee, "the patient has to have some sense of responsibility."

But the EOBs from Aetna state that the patient has no responsibility to pay the difference between 125% of Medicare rates and the actual charges, Dr. Schorr said in an interview, and patients therefore don't want to pay the difference. "We've had comments made to our office manager along the lines of 'Just write off the difference—you make enough anyway,' " he said.

Aetna "is trying to force physicians back into the [network] fold," Dr. Schorr said, adding that he had complained to the AMA and his state medical society. "They're trying to ratchet down physicians' fees." ■