Consulting Codes Eliminated

Medicare *from page 1*

patients' charts lack the referral letter and other required documentation.

The American College of Rheumatology " has known that CMS has been perturbed about this for a number of years. ACR commented during the comment period over the summer" to little effect, said Dr. Kolba, chair of the ACR's Committee on Rheumatologic Care.

Spared from the cuts are the G codes used for telehealth consultation.

By eliminating the consulting codes, CMS fails to understand that patients who are referred to a subspecialist by a primary care provider are more complicated cases, said Dr. Kolba, who is in private practice in Santa Maria, Calif. The refractory gout patient's evaluation is more complex than that of the patient who walks in the door and says "My big toe hurts," she added.

If the issue underlying the elimination of consultation codes is one of lack of compliance, then enforcement should be stepped up. "The solution is not to stop paying us for this," she said.

Reimbursement for infusions has been reduced in the 2010 fee schedule. The reimbursement paid to rheumatologists for infusions is tied to the amount paid to oncologists for the procedure. CMS has deemed the reimbursement to oncologists to be too high, hence the cuts to both oncologists and rheumatologists.

The issue of accurate use of consultancy codes has been under the microscope for some time. In an article published online, Dr. Joel I. Shalowitz reported on the accuracy of billing and coding in his review of 500 referrals from primary care physicians and other specialties. The coding error rate was 32.4% in the 466 that were complete enough to review. When the requesting physician ordered a consultation, the error rate was 5.5%; however, with lower paid referral requests, the error rate was 78.0%. Changing ambulatory consultation codes for new-patient visits would save Medicare $534.5 million per year, said Dr. Shalowitz of Northwestern University, Evanston, Ill. (Arch. Intern. Med. 2009 Nov. 9 [doi:10.1001/archinternmed. 2009.446]).

Dr. Christopher R. Morris, a rheumatologist in practice in Kingsport, Tenn., said in an interview, "Like most of the 'experts' who are driving decisions, [Dr. Shalowitz] is equating the primary care vs. specialist debate with the cognitive vs. procedurist debate.

"He is likely overlooking the fact that referrals to cognitive care specialists are usually more time consuming than the self-referred initial visit for several reasons: First, we have a pile of records, labs, x-rays to plow through. "Second, we have to spend time explaining and clarifying what the [primary care physician] told (or, in some cases misinformed) the patient. Then, we have to dictate and have transcribed a letter to the referring physician.

"The last time I checked, my transcriptionist was not typing my letters out of the kindness of her heart."

As for the threatened 21.5% fee cut mandated by the Sustainable Growth Rate (SGR) formula for all physicians under Medicare, "everyone fully expects that to be rescinded as always," Dr. Kolba said. The difference is that this year the fix may be permanent. At press time, U.S. House of Representatives agreed to a permanent change to the Medicare physician pay formula, which, if adopted by the Senate, would overturn the current SGR.

Dr. James Rohack, president of the American Medical Association, said in a statement before the House vote that "permanent repeal of the payment formula is an essential element of comprehensive reform." ■

Alicia Ault contributed to this story.

Calif. Balance-Billing Ban Prompts Lawsuits

BY DENISE NAPOLI

It was January 2009 when the California Supreme Court prohibited emergency physicians from balance billing the several million patients covered under that state's HMOs and Blue Cross and Blue Shield PPOs.

But now that the dust has settled, class action attorneys are moving in, both to file lawsuits against illegal balance billing that is still taking place and to have the state court's ruling applied retroactively.

For example, Derek Emge, a consumer class-action attorney in San Diego, said his firm is investigating two possible cases of balance billing that occurred after the Supreme Court's ruling. (No lawsuits have been filed.) His firm's Web site warns former emergency department patients that "a hospital or physician group may not bill or contact you about bills arising from emergency medical services. They may not threaten you with debt collection and/or ruining your credit. Any contact about your bill is prohibited" (www.emgelawfirm.com/CM/Custom/Illegal-charges-for-Emergency-Rooms.asp).

But that's not really true, said Dr. R. Myles Riner, past president of CAL/ACEP. Ads like the one from Mr. Enge's firm seem to imply that all balance billing is illegal, that patients should never receive any bill from an emergency care provider, and that the Supreme Court decision applies to all insured patients, he said. In reality, by one estimate, the ruling applies to fewer than half of all commercially insured patients.

"But just the existence of these [ads] is likely to discourage patients from paying legitimate bills from emergency care providers that do not fall under the balance-billing prohibition," such as coinsurance payments and deductibles, added Dr. Riner, director of provider relations for an emergency physician staffing and management company.

Andrew Selesnick, a health care attorney in Los Angeles, agreed. "You're putting out this false information, inaccurate information, and patients don't need much of an excuse not to pay the bill in the first place," said Mr. Selesnick. "Now they can say, 'You were never allowed to send me a bill.' " Mr. Selesnick has been either lead or co-counsel for the defendants on just about all of the nearly half dozen lawsuits that have taken place so far. Mr. Emge said the Web page was simply intended to alert any patient who was billed for emergency department care that "there may be an issue."

The effect is to increase the burden on ED physician groups to dispute these underpayments, often to no avail.

DR. RINER

The essential question for lawsuits that do have standing will be whether the ruling may be applied retroactively, Mr. Selesnick said. Both attorneys agreed that, typically, these types of rulings are applied retroactively—and that could be very bad news for California emergency physician groups, said Mr. Selesnick. "If the court ordered the return of monies, it would be another blow to an already fragile safety net," he said.

There are also privacy concerns. "How would the court presume to contact potential class members?" Mr. Selesnick asked. "Do they send a letter to the minor who went to the ED but never told her parents? Or do they send a letter to the husband who never informed his wife about a visit to the ED?"

Even if the balance-billing ruling is not given retroactive application, the damage may already be done to emergency care in California, Dr. Riner said. "The overall effect is to significantly increase the burden on ED physician groups to dispute these underpayments—often to no avail—and to adjust to the substantial decrease in revenues," he added. That will happen by either cutting back on EP staffing, abandoning EDs with payer mixes that cannot support them, or seeking subsidies from hospitals.

"Longer term, the result will likely be longer waits for care in our EDs, poorer quality of care, closure of more EDs in poorer neighborhoods, and more frequent use of nonphysician practitioners to manage even the sickest patients in our EDs," Dr. Riner said. ■

Read the full text of the January California Supreme Court ruling at www.calacep.org/spaw2/uploads/files/legal%20advocacy/Prospect_v_Northridge_Supreme_Court_Opinion.pdf.

MGMA Study: Medicare Is Best Insurer

BY ERIK GOLDMAN

DENVER — Physicians may not be enamored of Medicare, but they like it a whole lot better than private insurance plans, according to a survey by the Medical Group Management Association.

MGMA's Payer Performance Study—covering more than 1,700 group practices—showed that physicians groups ranked Medicare Part B well ahead of six of the largest private insurance companies in terms of overall satisfaction. The organization released the data at its annual meeting.

The survey asked participants, all of whom were members of MGMA, to rank seven of the largest payers (Medicare Part B, UnitedHealthcare, Aetna, Cigna, Humana, Coventry, and Anthem) on parameters including payer communications, provider credentialing, contract negotiation, payment processing, systems transparency, and overall satisfaction.

Medicare led the pack with a mean aggregate satisfaction score of 3.59 on a 6-point scale. Aetna took second place with a score of 3.14. The big loser? UnitedHealthcare, with a score of 2.45.

Medicare scored particularly well on the amount of time it takes to respond to questions from physicians or practice managers, the accuracy of its responses, and transparency in disclosing fee schedules and reimbursement policies.

The respondents were much less satisfied with Medicare's provider-credentialing processes. On that measure, Medicare ranked last, with Aetna and Anthem taking first and second place. "The Medicare credentialing process is completely out of synch with that of the private payers, and it is a problem," said Dr. William Jessee, president and chief executive officer of MGMA.

Dr. Jessee said that the data show particularly strong member dissatisfaction with the private insurers on the matter of negotiating contracts. "MGMA members feel there is disproportionate power on the side of the payers."

Although Medicare may have scored better than the private insurers, the scores suggest there's much room for improvement in the federal program. Dr. Jessee said that the MGMA survey deliberately did not ask about satisfaction with actual reimbursement rates, but he anticipated that Medicare's relatively favorable ranking could drop considerably if the federal government cuts physician fees in the future.

Medical group operating costs have been increasing at a rate of 6.5% per year, on average, for the last decade, yet Medicare reimbursement has been flat. That, said Dr. Jessee, is making it difficult for many groups to stay in business. Any further cuts in fees will likely discourage many doctors from continuing to participate in Medicare. ■