Ready or Not, NPI-Only Policy Is Implemented

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WASHINGTON — Medicare has stopped accepting claims that contain outdated provider identifying numbers, even if the claims also include a National Provider Identifier, despite concerns voiced by physician groups that many of them are still not ready.

The original deadline for switching to exclusive use of the National Provider Identifier (NPI) was May 23, 2007, but the Centers for Medicare and Medicaid Services gave the medical community another year to prepare. According to the agency's statistics before the deadline, nearly 99% of claims were already being submitted with an NPI. However, a much lower number, about 37%, were being submitted without a legacy number as well.

Just days before the deadline, members of Medicare's Practicing Physicians Advisory Council voiced their concerns aboutworking toward compliance with the NPI requirements. "The potential of claims not being paid looms large," said Dr. Arthur Snow, a PPAC member and family physician from Shawnee Mission, Kan.

Previous deadlines, such as the March 1 requirement to use an NPI for all primary provider fields, have already created payment backlogs, said several PPAC members who complained they have dedicated hours of staff time to digging up NPI numbers manually because their software has not been updated to meet the new requirements.

"It's been a major, major headache," said PPAC member Dr. Jeffrey Ross, a physician and podiatrist from Houston.

The physicians made several recommendations to CMS, such as delaying the move to NPI-only or at least closely monitoring implementation for potential problems.

The American Medical Association, the Medical Group Management Association and the American Hospital Association delivered a similar message a couple of days later in a letter to Health and Human Services Secretary Michael Leavitt.

"Although we and our members have worked diligently and invested significant time and resources to comply with the NPI deadline, the health care industry is not well served by terminating the one-year NPI contingency time frame. [It] will only make what has been a complex undertaking, an exceedingly disruptive transition," the groups wrote.

The letter cites an analysis by Emdeon Business Services, the nation's largest medical claims clearinghouse, which suggests that as of the end of April, 10% of claims were being submitted without an NPI, and close to 70% were carrying a legacy number for a secondary provider, potentially impacting billions of dollars worth of claims for Emdeon alone.

Although it is still too early to know whether the NPI-only policy will lead to delays in reimbursement, a Medicare official said there have been few complaints to Medicare so far.

Medicare has been advising physicians to either contact secondary providers for their NPI numbers or to get it off the Web-based registry for the identifiers. However, there have also been early reports of the network being overwhelmed by demand.

If neither approach works, physicians can put their own NPI in place of the secondary provider's to avoid having the claim rejected, according to CMS guidance. ■

Medicare Coverage of Screening CTC Colonography Under Consideration

Computed tomographic colonography could get a boost, thanks to the Centers for Medicare and Medicaid Services' proposal to pay for the nascent colorectal cancer screening technology.

Colonoscopy is one of the most commonly performed medical procedures in the United States, with estimates of up to 14 million procedures performed in 2003, according to the American Cancer Society.

Computed tomographic colonography (CTC) is relatively new, but it was identified as a viable alternative to colonoscopy and other colorectal cancer screening methods in guidelines compiled by the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology (http://caonline.amcancersoc.org/cgi/content/full/CA.2007.0018v1).

Medicare currently covers colorectal screening for average-risk individuals aged 50 years and older through colonoscopy, fecal occult blood testing, sigmoidoscopy, and barium enema. The new screening guidelines prompted the CMS proposal.

The guidelines state that CTC screening of average-risk adults should start after age 50, but noted that the interval for repeat exams was uncertain. The guidelines urged a colonoscopy exam when polyps of 6 mm or greater were discovered with CTC.

The CMS will make a decision by Nov. 19, according to the agency.

Private insurers generally follow Medicare payment policy, said Dr. Joel V. Brill, a fellow of the American Gastroenterological Association and chair of the AGA Institute practice management and economics committee. "Commercial insurers are also poised to begin coverage of screening CTC this year," he said, speaking at Digestive Disease Week in San Diego.

CTC has not been assigned a current procedural terminology code; that is not likely to happen until 2010, said Dr. Brill, who is also chief medical officer of Predictive Health LLC, a medical management company in Phoenix.

—Alicia Ault

POLICY & PRACTICE

CBO Casts Doubt on Health IT Savings

Health information technology, when coupled with other reforms, can help reduce health spending in certain settings, according to a Congressional Budget Office. But the adoption of health IT alone will not produce significant savings, the report concludes. Institutions that have successfully used health IT to lower costs are generally integrated health care systems like Kaiser Permanente's. "Office-based physicians in particular may see no benefit if they purchase [an electronic health record]—and may even suffer financial harm," the CBO said. Recent studies by the RAND Corporation and the Center for Information Technology Leadership estimate savings from health IT at around $80 billion annually. The CBO takes issue with those estimates, noting that the savings figures are derived by assuming changes to the health care system. But without changes to the current payment system, providers would not be incentivized to reduce costs to the system, according to the report (available at www.cbo.gov).

MD Cash Payments Cut Spending

Giving physicians cash payments for reduced hospital spending can help control costs without sacrificing quality or access to care, researchers reported in the policy journal Health Affairs. In a 5-year study of more than 220,000 patients who received coronary stents, Arizona State University researchers showed that "gainsharing" programs, in which physicians are paid for reducing hospital spending, cut costs by more than 7%, or $315 per patient. If these experiences are representative, the report said, then nationwide use of gainsharing would cut hospital costs for stent patients by about $195 million a year. The majority of savings from the gainsharing programs were attributed to lower prices for coronary stents, the study said. The researchers found that the gainsharing programs did not increase the risk of in-lab complications, and were associated with significant decreases in three specific types of complications.

Group Calls for Obesity Action

The advocacy group Campaign to End Obesity, in concert with the American College of Gastroenterology, the American Heart Association, the American Diabetes Association, and others, has issued a call to action outlining what it said Congress must do to address the obesity epidemic. "It is time for the government to take a more comprehensive policy approach to the problem—to look holistically at factors that influence obesity and to look for ways to support people in preventing, managing and treating the disease," the report said. The call to action said that there is much more that lawmakers can do about improving school nutrition and physical activity standards, and that Congress also should consider reimbursement for providers who manage and treat obesity.

Family Spending Up 8%

The average annual medical cost for a typical American family of four increased by nearly 8% from 2007 to 2008, according to consulting firm Milliman Inc.'s fourth annual study of medical spending. Although the $1,109 increase is a big expense, the report said, the rate of increase was down for the second straight year and is the lowest rate of increase in the past 5 years. However, this was the second consecutive year of double-digit increase for the employee's share of spending on health care services, according to the report. The total medical cost in 2008 for a typical American family of four is $15,609, compared with $14,500 in 2007, the report found. Milliman also found wide variation in costs across the country: Among the 14 metropolitan areas studied, health care costs varied by more than 35%.

Few Americans Are Health Literate

Just 12% of America's 228 million adults have the skills to manage their own health care proficiently, according to the Agency for Healthcare Research and Quality. Those deemed proficient in health literacy skills can obtain and use health information to make appropriate health care decisions, can weigh the risks and benefits of different treatments, know how to calculate health insurance costs, and are able to fill out complex medical forms. AHRQ found that about 53% of U.S. adults have intermediate health literacy skills, such as being able to read instructions on a prescription label and determine the right time to take medication. Meanwhile, 22% had basic skills, such as being able to read a pamphlet and understand two reasons why a disease test might be appropriate despite a lack of symptoms, according to the report. And 14% had less than basic skills, meaning they could accomplish only simple tasks, such as understanding a set of short instructions, AHRQ said.

Half of America on Drugs

Medco Health Solutions Inc. has determined that 51% of insured Americans—children and adults—were taking prescription medications for at least one chronic condition in 2007. The pharmacy benefit management company analyzed a representative sample of 2.5 million people from its database. A surprise: In all, 48% of women aged 20-44 years are being treated for a chronic condition, compared with 33% of men their age. Antidepressants were the most common prescription for this age group, whereas the top therapies overall were antihypertensives and cholesterol cutters. Hormone therapy use by women aged 45-64 years declined from 30% in 2001 to 15% in 2007. The data "paint a pretty unhealthy picture of America," Dr. Robert Epstein, Medco's chief medical officer, said in a statement. But, "it does show that people are receiving treatment which can prevent more serious health problems down the road."

—Jane Anderson