POLICY & PRACTICE

Poor Marks for PQRI

Most physicians who participated in Medicare's 2007 Physician Quality Reporting Initiative found the program at least moderately difficult, according to a survey conducted by the American Medical Association. Only 22% of respondents to the online survey were able to successfully download their feedback report. Of those who downloaded the report, fewer than half found it helpful. In an open-ended question about their experience with the program, nearly all the responses were negatives, according to the AMA. The results are based on responses from 408 physicians. The AMA plans to work with Congress and the administration to alter the program to provide physicians with interim feedback reports and an appeals process. A recent survey from the Medical Group Management Association reported similar problems in accessing feedback reports.

Many Have Drug 'Gap' Coverage

A total of 13% of Medicare beneficiaries enrolled in Part D prescription drug plans and 63% of those in Medicare Advantage plans with prescription benefits had some form of coverage in the "doughnut hole," or coverage gap, according to a Centers for Medicare and Medicaid Services study on Part D drug claims. The study, which included data on Medicare drug claims for the 25 million Part D beneficiaries, also indicated that the vast majority of enrollees used the drug benefit: In the program's first year, 90% of enrollees filled at least one prescription. In addition, the use of generic drugs has been high in Part D, rising from 60% in 2006 to nearly 68% in the first quarter of this year.

Resuscitation Practices Ineffective

An overwhelming majority of emergency physicians believe that resuscitation practices in the United States are not very effective, according to a survey released by the American College of Emergency Physicians. In addition, more than half of emergency physicians surveyed believe that poor survival rates from sudden cardiac arrest are related to the aging population, while one-quarter of respondents said that obesity has contributed most to poor survival rates. Increased bystander CPR, faster patient-to-doctor time, improved data collection and sharing, and greater use of technology all are critical to improving resuscitation, the survey concluded. "It is necessary for communities to encourage more CPR trainings, offer more access to a broader range of critical life-saving technologies, and report sudden cardiac arrest cases more consistently," said ACEP president Nick Jouriles.

HIPAA Enforcement 'Limited'

The Centers for Medicare and Medicaid Services has not provided effective oversight and has taken only "limited actions" to ensure that covered entities adequately implement patient privacy regulations contained in the Health Insurance Portability and Accountability Act of 1996, according to a report from the Health and Human Services Department's Office of Inspector General. The OIG found that the CMS had not conducted any compliance reviews of covered entities, and instead relied on complaints to target investigations. However, the CMS has received very few complaints about violations, the report said. "As a result, the CMS had no effective mechanism to ensure that covered entities were complying with the HIPAA security rule" or that electronic health information was being adequately protected, the report concluded. CMS has taken steps to begin conducting compliance reviews in an effort to identify security problems and vulnerabilities under HIPAA, the OIG said.

Mass. Blues Require E-Prescribing

Blue Cross Blue Shield of Massachusetts said it will require all physicians to prescribe electronically beginning in 2011 in order to qualify for any of the health plan's physician incentive programs. Currently, 99% of primary care physicians and 78% of specialists participate in the insurer's incentive programs, which reward physicians for meeting nationally recognized quality standards and patient safety goals. Currently, e-prescribing is an optional measure in the plan's incentive programs. The insurer said it realized that start-up costs involved with implementing an e-prescribing system continue to be a barrier to adoption for physicians, and said it would provide some financial assistance for doctors in 2009 to offset those start-up costs. A 2006 study by the plan showed that physicians who used an e-prescribing device were able to choose more cost-efficient drugs, and therefore saved 5% on their drug costs relative to physicians who did not use the technology.

Program Cuts Illicit Drug Use

A government-supported program used to screen patients seeking health care for signs of substance abuse can reduce illicit drug use among patients seeking medical care in a wide variety of health care settings, a study found. The Screening, Brief Intervention, and Referral to Treatment program uses a variety of techniques to screen patients for signs of substance abuse. If a patient screens positive, immediate steps are taken to help the patient effectively deal with the problem. The study, published in Drug and Alcohol Dependence, found that rates of illicit drug use dropped by nearly 68% 6 months after patients using illicit drugs had received help through the screening program. Illicit drug users receiving brief treatment or referral to specialty treatment also reported other quality-of-life improvements. The Substance Abuse and Mental Health Services Administration has been awarding grants to expand the screening program since 2003.

—Jane Anderson

Medicaid Substance Abuse Screening Funds Go Unused

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — More than $260 million in Medicaid funds set aside to pay physicians to conduct brief screening and interventions for substance abuse are practically untouched, according to federal experts in the White House Office of National Drug Control Policy.

In January, the Centers for Medicare and Medicaid Services designated the matching funds for states that adopt Medicaid codes for substance abuse Screening and Brief Intervention (SBI). But so far, only nine states (Iowa, Indiana, Maine, Maryland, Minnesota, Montana, Oklahoma, Oregon, and Virginia) have begun using the codes, Bertha Madras, Ph.D., deputy director for demand reduction at the ONDCP, said at a meeting to discuss the program. Wisconsin and Washington are reimbursing for SBI in limited circumstances.

The CMS established G codes for SBI in 2006 and followed with H codes. Last year, the American Medical Association established current procedural terminology codes for SBI; they were published for the first time in the 2008 CPT manual.

For CPT 99408, which involves screening and a brief intervention of 15-30 minutes, the reimbursement is $33.41. For SBI longer than 30 minutes (CPT 99409), the rate is $65.51. (See box.)

Dr. Madras did not say how much money has been reimbursed by Medicaid and Medicare, but indicated that the codes are vastly underused.

The ONDCP has been seeking ways to encourage more physicians to conduct SBIs. At the meeting, Dr. Madras cited recently released figures from the Substance Abuse and Mental Health Services Administration showing that 19.9 million people abuse drugs in the United States, but that 93% of those who are addicted are not aware that they have a problem and do not seek treatment.

Dr. Madras said that so far, about 700,000 people have been screened. Almost a quarter were positive for alcohol or drug use; 70% needed a brief intervention and about 16% were referred to treatment, she said. According to self-reports 6 months later, at least a third of those who received treatment said their health status improved.

Citing several recent developments, she said that screening is gaining currency.

At the beginning of 2008, the Federal Employees Health Benefits Plan, which covers 8 million employees and dependents, notified its carriers that the CPT codes for screening and intervention were added and available for use.

In June, the Department of Veterans Affairs directed all VA medical centers to routinely screen for alcohol use and provide brief interventions.

Screening for alcohol intoxication is required at level I and II trauma centers; patients with positive screens should be offered interventions, according to criteria adopted by the American College of Surgeons' Committee on Trauma. The committee decided to institute SBI because alcohol use is the single most important risk factor associated with serious injury, said Dr. John Fildes, who represented the ACS committee at the meeting.

Screening and brief intervention protocols are also incorporated into the latest edition of the Advanced Trauma Life Support manual, said Dr. Fildes, professor of surgery at the University of Nevada, Las Vegas.

The ACS Committee on Trauma hopes to expand SBI to all level II and III trauma centers and have drug and alcohol intoxication data included in the National Trauma Data Bank, Dr. Fildes said.

Health insurer Aetna Inc. is aiming to have more of its participating primary care physicians offer screening and brief interventions, said Dr. Hyong Un, national medical director for behavioral health at the company. Dr. Un said Aetna has the systems in place to pay claims with the SBI codes and that its behavioral health specialists will work with primary care physicians to encourage screening. Aetna will offer training to physicians and office managers.

Some online training is available at www.mdalcoholtraining.org. Physicians can also find information at www.sbirt.samhsa.gov. ■

Coding for SBI Reimbursement

Payer	Code	Description	Fee Schedule
Commercial insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; > 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; > 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	$48.00

Source: Substance Abuse and Mental Health Services Administration