Medicare, Critical Care, and the Clinton Health Plan

I do not like to write about things I do not understand, but that is the whole point when I write about Medicare. This government-run health care plan for the elderly has become so complex that physicians must hire new office personnel to merely keep up with the changes wrought by bureaucrats who do not see patients.

As a simple example, why is it necessary for the physician to contemplate 125 different combinations of levels of disease severity, medical decision making, and physician examination before deciding what kind of an office visit just occurred with each patient? An office visit is an office visit. It may be long or short, may involve a new or previously seen patient, but to have to decide what level of thought and complexity occurred, and then to select the proper combination of codes is an abject waste of time. Moreover, in its infinite wisdom, the Veterans Administration is copying this foolishness, despite the fact that most veterans receive free care. It boggles the mind.

Sometime in 1993, Medicare decision makers suddenly redefined critical care. With the advent of the resource-based relative value scale (RBRVS), I felt that finally it was recognized that taking care of patients in critical care units is different from routine inpatient ward follow-up. One could actually submit bills for the real time spent in critical care units caring for the patient, counseling the family, making tough ethical decisions, etc., and be reimbursed adequately for this stressful activity (critical care codes 99291, 99292). This reality-based reimbursement for critical care must have been too expensive, since suddenly in 1993, critical care delivery was limited to acute unstable situations. Thereafter, by supreme decree, the patient was no longer receiving critical care. This is, of course, ridiculous and not consonant with reality, but nevertheless was accomplished by Medicare.

So confusing was this to Florida, Georgia, and South Carolina physicians that a special session was arranged at the tri-state consecutive case conference in September 1993 in which an acknowledged excellent physician would prepare cases and include his interpretation of proper billing. The moderator of the session was the Manager, Provider Education for Medicare in the state of Florida. Of course, this excellent physician was unable to correctly bill for his services and most of his billing would have been reviewed or turned down. The audience of pulmonary and critical care physicians and surgeons from these three states (including myself) had difficulty understanding some of the reasoning espoused by the Medicare representative. For instance, if a patient suffers a cardiac arrest while residing on one of the hospital wards and is resuscitated, the time spent at the bedside can be billed as critical care. On subsequent days in the medical intensive care unit, however, despite the continued need for intubation, ventilation, pressors, arterial line, and Swan-Ganz catheter, unless the doctor is at the bedside, Medicare no longer considers the patient to be critically ill. Hereafter, daily care as though you visited the patient in his room on the ward and briefly examined him would be the proper code. Until January 1994, at least the physician could also add “daily ventilator care” to the billing, but this “double billing” has now been eliminated also.

Did the government lose its mind? This patient is still critically ill! The effort of the physician is still at maximal levels and deserves adequate reimbursement. Who in the world makes these decisions? For heaven’s sake, do not try to save money on the backs of the most stressful of occupations where patient contact is obvious. Save it elsewhere, if you must; for instance, in the areas of laboratory professional fees, alternative medical therapy, counseling, etc. Critical care is the last place to cut fees.

What was particularly distressing was that the physicians who practice this type of medical care had no role whatever in the decision for Medicare billing or reimbursement. How did the medical profession get into such a position wherein the people who do the service are consulted and whose suggestions are rejected when changes in reimbursement occur? Worse yet, to whom do we turn to seek redress of this type of grievance?

To my delight and astonishment, the American College of Chest Physicians (ACCP) is on the job. The newly formed CPT/RUC committee has been at work. I was aware of the committee, but I had no idea what the initials meant or what the committee might do. The name stands for Current Procedural Terminology/Relative Update Committee (CPT/RUC), and its chairman is Dr. Walter O’Donohue who is the chairman of the department of medicine at Creigh-
ton University in Omaha, Nebraska. Dr. O'Donohue met with Dr. Bart McCann of the Health Care Financing Administration (HCFA) on Jan 13, 1994. The result of the meeting as recorded in the recently published ACCP Key for Spring 1994, indicates that the need for such services to be emergent in nature may be removed, as well as the limits on the numbers of hours or days which can be charged as critical care time. This is great news, but does not affect the practicing physician yet. The confusing statement that the change will be forwarded to the CPT editorial panel of the AMA concludes the discussion of this issue. The meaning of this statement is not exactly clear to me, but I believe that this committee of the AMA recommends changes to HCFA, and these changes are then published in the Federal Register for comment prior to implementation. It is not clear why these changes to increase fees must undergo such a lengthy review process when the changes designed to cut fees were implemented so quickly.

I have no axe to grind, as I personally have stopped attending in the critical care unit so as to be able to edit this journal. But I do know an injustice when I see one, and I do know when nonpracticing physicians and bureaucrats have tried to save money but cannot recognize the damage being done in the name of the all-powerful bottom line. I fear greatly that these same intellects will design the comprehensive health-care plan promoted by the Clinton administration. This is scary, since all decisions will then be made by bureaucrats and not by practicing physicians. Patient care will not be better, working conditions for physicians will be intolerable, and the profession itself will not attract the quality of applicants as in the past. It is heartening that CPT/RUC committees exist and try to rectify such problems. At least there is hope. As I write this editorial, the debate is beginning in Congress concerning modification of the proposed Clinton health plan. I hope that at the time of publication, the practice of medicine as we know it will not be destroyed.

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Reference


Unattended Recording in the Diagnosis and Treatment of Sleep-disordered Breathing

Unproven Accuracy, Untested Assumptions, and Unready for Routine Use

To the casual observer, it would appear that the field of sleep medicine is on the verge of a revolution. Time honored diagnostic and therapeutic practices are, in some cases, being replaced by new, less traditional methodologies. The impetus for these changes arises from the recognition that sleep disorders and, in particular, sleep-disordered breathing (SDB), is prevalent in the general population with potentially serious health and social consequences. Of considerable importance in the context of current economic and sociopolitical imperatives is the evolving awareness that if the diagnosis and treatment of SDB are to be comprehensively undertaken, a substantial commitment of significant healthcare resources, and therefore, dollars, will be necessary. In an effort to accommodate these realities, technology has been developed to evaluate and potentially treat patients with SDB outside the confines of the sleep laboratory in the absence of a polysomnographic technician to monitor the progress of the study. Those who favor this trend claim that such unattended monitoring affords the public health benefits of more widespread access to diagnostic services, particularly for patients living in areas remote from inhosptal or "stand-alone" clinical sleep facilities, as well as reduces the waiting period for evaluation by providing an alternative to existing, overburdened facilities. Furthermore, given the unattended nature of these studies, advocates contend that expanded use of unattended monitoring will reduce the cost of care relative to conventional inlaboratory polysomnography. It has also been argued that unattended diagnostic evaluations afford clinical advantages, including elimination of nonrepresentative studies attributable to "first-night effect" by evaluating patients in more familiar, inhome surroundings. With these arguments as justification, some clinicians now employ unattended monitoring in the evaluation and treatment of patients with SDB.

We, too, believe that the above goals of portable recording in the management of patients with SDB are laudable, and therefore, encourage further investigation into the role and efficacy of this new technology. We are concerned, however, that the rush to institute clinical programs employing these devices and establishing this methodology as the