Cold Iron Truth

The 2019 Medicare proposed rule might just make your head explode

BY BRETT M. COLDIRON, MD

When sitting through interminable meetings, endless reports, and unfocused discussions, I often feel a building pressure in my head that, if it continues, will surely result in my brain exploding. I used to carry in my pocket an elastic compression bandage, intending to wrap it around my head as a signal to the offending speakers, but never had the heart to use it. Still, that bandage in my pocket was the backup resource that gave me solace, gave me patience.

Yet, my emergency bandage was nowhere to be found while I was reading the 2019 Medicare proposed rule, which unexpectedly triggered the threat of a brain explosion.

I was prepared for the usual proposed rule of about 1,500 pages of dense, bureaucratic "Engfish," proposing a cut here, a tuck there, an occasional evisceration, and several correctable errors. This time, though, the proposed rule is wide open, disruptive, uninformed, and disappointing to almost all medical practitioners.

For dermatology, it starts out promisingly, by collapsing the evaluation and management (E/M) codes into two levels, instead of five. That should benefit us slightly, because our coding usually falls at about level three. Also, it would simplify record keeping by requiring only level two documentation and not making docs repeatedly reenter data. Well, OK so far.

Keep reading, though, and then the hammer falls: a proposed 50% reduction in reimbursement for any procedure performed on the same day as the E/M code. What?! Implementation of this change would result in an estimated 20% reduction in reimbursement for dermatologists who, as a courtesy to their patients, do procedures on the same day as an evaluation visit. And this proposed change would likely hurt ophthalmologists, otolaryngologists, and even primary care physicians who do same-day procedures.

There are new extended-care codes that only primary care docs could use, and some other extended-care codes for specialists (dermatology is not mentioned) that pay about $5 extra. There is a bone thrown to telemedicine, since telemedicine coverage is supported, including "store and forward," but not if the patient is seen in person within a week, "or at the soonest available appointment." Very strange.

The current reimbursement system is a carefully honed, carefully balanced, work of reasonable rational thought by the current procedural terminology committee, the American Medical Association's RVS Update Committee (RUC) and the Centers for Medicare & Medicaid Services. CMS officials sit at the table at all these meetings, frequently comment, and the agency has the power of final approval.

No one loves the final product, particularly the participants, but there are procedures and rules, an appeals process, and the process allows for a rough form of justice administered by your medical peers. Who better to decide what is fair to pay anyone out of a fixed reimbursement pool?

Unfortunately, there seems to be no institutional memory in this year's final rule. For example, since it came out, various branches of organized medicine have held urgent meetings at which it was pointed out that a 50% reduction in procedures on the same day as an evaluation and management code is inappropriate, since the overlapping work and practice expense already had been removed for such codes by the relative value update committee. This observation reportedly came as a surprise to the CMS attendees – a most disturbing admission.

There was also discouraging news about the global period survey. Dermatology reported only 3% of the global visits possible.

It turns out that CMS did not look for additional 99024 visits beyond the 10- or 90-day global period in the surveyed states and did not look at practices of fewer than 10 dermatologists, even if they did report. Think about it: How many dermatology groups do you know of 10 or more dermatologists in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island? How often do you delay suture removal beyond 10 days? How many times do you see a patient back for a triamcinolone injection or reassurance at no charge more than 10 days after procedures? Talk about a flawed process destined to fail!

The loss of global periods will hurt much, much more than the 50% cut in procedures on the same day as an E/M code. The premalignant and benign destruction codes could be cut by 75% – and good luck in charging for suture removal after surgery. We are talking about another 20% reimbursement cut if implemented.

The American Academy of Dermatology and other dermatology societies are actively involved in responding to the CMS regarding the shortcomings of the proposed rule. Be prepared to be called upon to submit your comments to CMS soon. I am hopeful that much of these misguided proposals can be corrected, but it will take a concerted effort of numerous individual dermatologists, including you.

Finally, I advise you to read the final rule for yourself. And, unlike me, do not forget to keep your emergency wrap handy! ■

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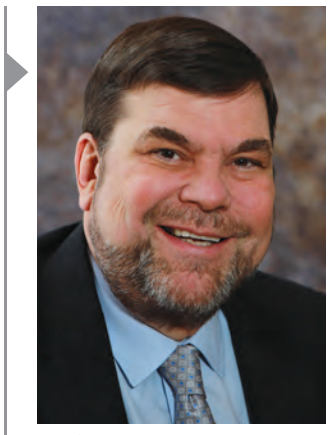

Dr. Coldiron is in private practice but maintains a clinical assistant professorship at the University of Cincinnati. He cares for patients, teaches medical students and residents, and has several active clinical research projects. Dr. Coldiron is the author of more than 80 scientific letters, papers, and several book chapters, and he speaks frequently on a variety of topics. He is a past president of the American Academy of Dermatology. Write to him at dermnews@mdedge.com.