POLICY & PRACTICE

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Bimatoprost for Chemo Effects?

The National Cancer Institute and the pharmaceutical maker Allergan Inc. are jointly supporting a trial to determine whether bimatoprost (Latisse) can stimulate regrowth of eyelashes and eyebrows after their loss in chemotherapy. The company told a Food and Drug Administration advisory committee in December 2008 that it would explore that potential use of the drug. The study began enrolling patients in October and will be led by Dr. Jenny Kim of the Jonsson Comprehensive Cancer Center at University of California, Los Angeles. Men and women who have been diagnosed with breast cancer will be enrolled at nine sites and followed for 6 months.

FDA Releases Tanning Warning

The FDA has created a Web site that details for consumers what the agency calls the risks of indoor tanning, skin cancer being among the biggest. "It's well established that UV radiation from the sun causes skin cancer," FDA scientist Sharon Miller writes on the site. "Since lamps used in tanning beds emit UV radiation, the use of indoor tanning devices also increases your risk of skin cancer." The agency Web site also lists premature aging, immune suppression, eye damage, and allergic reactions as indoor-tanning downsides. Children and teens are particularly at risk, according to the FDA. The site includes the story of a former Miss Maryland who was diagnosed with melanoma at age 20, after 3 years of heavy indoor tanning.

Adverse Event Reports Go Unused

The FDA's Center for Devices and Radiological Health fails to use adverse event reports in a systematic manner to detect and address medical device safety problems, a report from the HHS Office of Inspector General found. Manufacturers and medical facilities are required to promptly submit reports to the FDA center following adverse events, which can include deaths, serious injuries, and device malfunctions. But the center has no documentation of following up on these events, and it fails to read most reports in a timely fashion, according to the report. Meanwhile, reports of problems with medical devices are increasing, the Inspector General's office found: The FDA center received about 73,000 adverse event reports in 2003 but more than 150,000 in 2007. The Inspector General recommended that the center develop better protocols for reviewing and tracking the reports.

Drug Pipeline Is Full

Pharmaceutical and biotechnology companies have nearly 1,000 medications and vaccines in the pipeline to treat diseases that disproportionately affect women, according to a report released by the Pharmaceutical Research and Manufacturers of America. The 969 medicines are in clinical trials or under review by the FDA. They include 155 medications for diabetes and 114 for autoimmune diseases, which affect women at a rate three times that for men. Other treatments in the pipeline include 112 for breast cancer, 86 for ob.gyn. conditions, 76 for asthma, 131 for arthritis, and 80 for Alzheimer's disease, according to PhRMA.

Biosimilars May Change Market

The manufacturers of tumor necrosis factor–alpha inhibitors could lose billions of dollars in revenue with the introduction of biosimilars in the United States and Europe, according to the research firm Decision Resources. By 2018, biosimilars of TNF-alpha drugs could cut $9.6 billion from brand sales in the United States, France, Germany, Italy, Spain, and the United Kingdom. But the development could also be a boon for payers in those countries, which could save $4 billion during that period. Decision Resources said it expects the movement to TNF-alpha biosimilars to be driven largely by payers, not physicians. "For the second year in a row, surveyed U.S. payers rank TNF-alpha inhibitors as their top priority" for reducing biologics spending, MaryEllen Klusacek, Ph.D., an analyst at the research firm, said in a statement. "Based on this finding, we anticipate that payer pressure on physicians to prescribe biosimilar TNF-alpha inhibitors will be high."

Electronic Tools Effective: AHRQ

Consumer health informatics (electronic tools and applications designed to provide tailored health advice to patients) could save money by eliminating the need for some health education activities now performed by clinicians, according to a report from the Agency for Healthcare Research and Quality. Health informatics also could improve clinician-patient interactions that deal with a wide variety of diseases and health issues, the AHRQ noted. The agency reviewed more than 100 studies of consumers getting health information via the Web, computer programs, and other electronic avenues such as texting and chat groups. The analysis found that the most effective health informatics applications tailor messages using a patients' own health information and provide feedback about the person's progress as the intervention unfolds. The AHRQ report also found that feedback provided by a clinician doesn't seem to be any more effective than that provided by computer.

—Alicia Ault

MANAGING YOUR DERMATOLOGY PRACTICE

Farewell Consultation Codes

A brand new year has begun, and that, as usual, means brand new surprises from our friends at the Centers for Medicare and Medicaid Services. This year's big surprise: The CMS has decided it will no longer pay for consultations in either outpatient (99241-99245) or inpatient (99251-99255) settings.

This decree has caused a great deal of protest, particularly from neurologists, rheumatologists, and other specialists who depend on consultations for a majority of their income. After all, specialists should be appropriately compensated for the special expertise they provide.

BY JOSEPH S. EASTERN, M.D.

It is hard to envision how eliminating consultation payments could be anything but detrimental to patient care. At the least, consulting physicians may feel less inclined to provide reports to referring physicians, which will substantially hurt coordination of care at a time when policymakers claim to be looking for ways to improve it.

Further objections abound; nevertheless, the decision has been made, and adjustments must be taken to accommodate it.

For office visits, the CMS expects consultation codes to be replaced with new or established visit codes (99201-99205 or 99212-99215). They have increased relative value units for those visit codes by 6% to soften the blow, but the difference will be substantially noticeable if a lot of consultations were billed last year.

On the inpatient side, admission codes (99221-99223) are to be used in lieu of consultation codes. The "true" admitting physician will use a new modifier (not yet published at press time) along with the admit code, while all consulting physicians will use the admit code unmodified.

Physicians performing a lot of inpatient consultations should anticipate denials, appeals, and confusion as admitting physicians and consultants alike adjust to this change.

As usual, some commercial insurers will follow the CMS lead, while others will continue recognizing the consultation codes (which remain in the 2010 CPT book). This means a decision will need to be made about whether to continue billing consultations for non-Medicare patients whose insurers continue to pay for them. If this route is chosen, Medicare will provide secondary coverage, and will, of course, not pay its portion. So this situation needs to be recognized in advance.

It is probably worth reviewing some past explanation of benefits to determine how often Medicare is a secondary payer, and whether any extra revenue will be worth the extra vigilance and work involved.

Discussions on this issue have been widespread and heated, and opinions vary widely.

Some specialists claim they actually welcome the change because they will no longer need to worry about complying with the CMS's confusing and ever-changing consultation rules.

Others are understandably concerned about a potentially significant loss of income. Do not be tempted, however, to bill for more services, such as biopsies and surgical procedures, as compensation for lost revenue. The CMS is well aware of that tendency (they even have a name for it: "code creep"), and they will be watching.

If billing patterns change significantly, an audit can be expected; increased billings must be proved to be of medical necessity, not compensatory revenue generation. If increased billings cannot be proved to be medically necessary, abuse or fraud charges will come. In an audit, remember, everyone is guilty until proven innocent.

Billing patients directly for consults has been proposed as a way to recover lost revenue. If consults are no longer covered by the CMS, physicians have reasoned that they should be able to use a "noncovered service" code (such as 99199-GA) and have Medicare patients sign an Advance Beneficiary Notice (ABN). This signifies their understanding that Medicare will not pay for the service, the same procedure used for noncovered cosmetic services. It is not clear, however, if this is permissible by the CMS.

Another proposed counter strategy is to bill Medicare for a new patient visit and add a "surcharge" for consultative care, billed directly to the patient (again using a National Supplier Clearinghouse [NSC] code and an ABN). This would be considered a "priority service," analogous to "concierge services" offered by some internists. No one knows if the CMS (or patients) would go along with this option either.

Even proponents of such strategies admit they are speculative and untested; I would not advise attempting them without a careful legal review with an experienced health care attorney.

No matter how individuals choose to deal with the loss of consultation codes, I believe physicians should continue sending reports to referring physicians even though they will not specifically be paid for them.

Doing what is best for patients should always be the top priority. ■

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