POLICY & PRACTICE

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U.K. Set to Clear Use of New RA Tx

The United Kingdom's National Institute for Health and Clinical Excellence (NICE) recently recommended that Cimzia (certolizumab pegol) be available as a treatment option for adults with severe active rheumatoid arthritis. But the recommendation is still in draft form, and the NICE will hear appeals before it formally issues its guidance to the U.K.'s National Health Service. Under the recommendation, Cimzia would be used in combination with methotrexate for those patients who have had an inadequate response to disease-modifying antirheumatic drugs. The new treatment could also be used as monotherapy in cases where continued treatment with methotrexate is not appropriate. As part of an agreement with the U.K. Department of Health, Cimzia maker UCB Pharma has agreed to provide the drug for free to patients during the first 12 weeks of treatment.

Enbrel to Retain Hold of Top Spot

Enbrel (etanercept) is likely to maintain its position as the clinical standard and sales leader in RA treatment through 2018, according to an analysis from the market research firm Decision Resources Inc. One major factor is that rheumatologists don't want to prescribe drugs that may be less efficacious, even if they are less costly. As part of its new analysis, researchers at Decision Resources surveyed rheumatologists and found that their prescribing decisions are most affected by a drug's impact on reducing the signs and symptoms of RA at 1 year, and they see Enbrel as currently unmatched at inhibiting structural damage progression. "High price, intravenous delivery route, and the potential for harmful side effects are all drawbacks to current biologic agents used to treat TNF-alpha inhibitor-refractory patients," Kyle Crowell, a Decision Resources analyst, said in a statement. "However, given a drug with incremental safety, delivery, and even cost advantages, physicians are still unwilling to compromise on efficacy," according to Mr. Crowell.

Focus on Lupus Provider Education

Patient advocates, rheumatologists, and government officials recently met to discuss efforts to improve the diagnosis and treatment of lupus among minorities. At a meeting held in Atlanta in January, participants discussed how they could develop a national health care provider education initiative. About $1.6 million in government funding is available for projects that promote comprehensive lupus curricula in medical and nursing schools and among health professionals already in practice. A survey from the Lupus Foundation of America shows that, on average, a person will wait 3 years and visit four physicians before receiving an accurate diagnosis of lupus. The condition disproportionately affects women and minorities. More than 90% of individuals with lupus are women, and the condition is two to three times more likely among blacks, Hispanics, Asian Americans, and Native Americans than among whites, according to the Lupus Foundation of America.

Tobacco Act Gets Singed

A federal district court has struck down parts of the Family Smoking Prevention and Tobacco Control Act of 2009, saying that some of the landmark law violates tobacco makers' free speech rights. The U.S. District Court for the Western District of Kentucky ruled it unconstitutional for government to ban color and images in tobacco advertising. However, the court upheld provisions of the law requiring large, strongly worded warnings on tobacco packaging, prohibiting companies from making health claims about tobacco products without Food and Drug Administration review, and banning tobacco-branded events and merchandise, such as T-shirts. American Thoracic Society president Dr. J.R. Curtis said in a statement that the society is still "confident that the FDA will exercise its new authority to reduce tobacco use [in the United States] by stopping the efforts of big tobacco to market its dangerous products to minors, and by giving current smokers more motivation to stop smoking."

Adverse Event Reports Are Limited

Little information is being made public about adverse events that occur in hospitals, even though public disclosure can help medical practitioners improve patient safety, according to a government report. The safety data in question are collected by organizations other than the hospitals. The Department of Health and Human Services Inspector General reviewed eight federally approved patient safety organizations and 17 systems that collect adverse event information for states. It found that only seven state systems passed along to providers adverse event analyses that led to changes in practice. The other states passed along reports without any analysis. A nationwide database of adverse events collected by the patient safety organizations won't be operational until at least 2011, according to the report.

—Mary Ellen Schneider

Don't Be Shy About Money: Code Smartly, Appeal Always

BY SALLY KOCH KUBETIN

SANTA MONICA, CALIF. — Recommendations that you adjust your default coding for an office visit upward and appeal all denied insurance claims were among numerous tips on how to increase income that were offered by Dr. Joseph S. Eastern at a meeting sponsored by RHEUMATOLOGY NEWS and Skin Disease Education Foundation (SDEF).

With the demise of consultation codes on Jan. 1, 2010, many rheumatologists are concerned about balancing their budgets. When assessing their bottom line, physicians tend to put undue emphasis on reducing their practice overhead. However, it is unlikely that overhead is the problem.

Most practices have cut overhead to the bone, said Dr. Eastern, a dermatologist in Belleville, N.J. Cutting overhead too much, by reducing the number of office staff and/or hiring unskilled workers, will lessen practice efficiency and—in the end—reduce revenue.

"Your ability to decrease costs is limited, while your ability to increase revenue is unlimited. Putting it another way: Would you rather keep 60% of $800,000 or 40% of $2 million?" challenged Dr. Eastern, who also is on the faculty of Seton Hall University, South Orange, N.J.

So rather than asking how to decrease overhead, the better question is how to increase revenue. The first step is to renegotiate your contracts with your third-party payers every year. This is not a time to be shy. Third-party payers are not going to call to announce they've been underpaying you. When Dr. Eastern asked the attendees to raise their hands if they renegotiated their contracts yearly, few hands went up.

"Every year, we send a letter to the lowest payer that says: 'We'll keep you if you pay us the going rate rather than what you are paying us now.' They may not give you what you ask for, but they'll give you more if you make a good case for the increase."

Most physicians tend to under-code because of their fear of being audited. But they do more than they are coding for. By changing their default office visit code from level 2 to level 3, physicians can increase their income by about $100,000 a year. "That's pure profit," said Dr. Eastern, who said his observation is based on a study he did of N.J. physicians.

"If you are doing level 3 worth of work, you should code for it. You are entitled to it. According to the CPR code book, a level 3 exam involves an established patient with either one worsening problem or one new problem or two or more chronic or inactive problems, plus documentation of a pertinent review of systems, which in rheumatology comes down to asking 'How are your joints? Are you having problems with any of your joints?' Then a 99213 code is justified. The key word is documentation," he said.

Appeal all denied claims, he advised. The code examiner often knows nothing about medicine and has just a few months experience in the job. Data on dermatologists show that they file 30 million Medicare claims yearly. An estimated 6%, or almost 2 million claims, are denied. Of those, fewer than 5% are appealed, "which is just inexcusable," Dr. Eastern said. The data on dermatologists show the chance that the appeal will increase payment is 50%. "What else are you doing that has a 50% return?" Dr. Eastern challenged.

Rather than letting people walk out of your office without paying, take an imprint of their credit card.

DR. EASTERN

People in other lines of business are amazed that physicians let patients walk out without paying. Instead, he said, take an imprint of each patient's credit card. Then, when the insurance payment comes in, charge the balance on the credit card. "We have decreased our accounts receivable by 50% just by having people do this.

"Patients sign an authorization that we can charge the unpaid balance to their card. Our office manager calls the patient if the charge is greater than $50. We keep the credit card number in the patient's chart, with all the other confidential information," Dr. Eastern said. ■

Disclosures: *Dr. Eastern reported that he has no financial disclosures to make. SDEF and* RHEUMATOLOGY NEWS *are owned by Elsevier.*

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