Devaluing a Specialty: The Centers for Medicare and Medicaid Services Proposal to Eliminate Consultation Codes

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The Centers for Medicare and Medicaid Services (CMS) has proposed to eliminate payments for the Inpatient and Outpatient Consultation codes beginning on 1 January 2010. The intent appears to be to promote an increase in the supply of primary physicians by increasing payments for other Evaluation and Management services. This will worsen an already inequitable disparity in the payments for complex cognitive services in comparison to procedure-based specialties, to the detriment of infectious diseases physicians. Infectious diseases as a specialty is committed to health care reform that makes sense for both patients and providers. An unintended consequence of the CMS proposal may be that few infectious diseases physicians remain to confront current or future infectious diseases challenges.

The consensus in the United States is that we have a dysfunctional health care system that relies too heavily on high-cost, uncoordinated, and redundant care. We suffer in comparison to other developed countries with respect to health care measures and per capita health care spending [1]. At the same time, the number of uninsured Americans is high relative to other developed nations that provide universal health care coverage to their citizens [1].

Many experts have postulated that the major shortcoming of our health care system is a shortage of primary care physicians. Specialty-driven health care and the fee-for-service model are thought to emphasize the wrong incentives, paying for the quantity of care rather than for high-quality and cost-effective care. This has led to a number of proposals to de-emphasize specialty care and incentivize primary care.

On 1 July 2009 the Centers for Medicare and Medicaid Services (CMS) published the Physician Fee Schedule Proposed Rule for Calendar Year 2010 [2]. A key provision is the proposed elimination of payments for the Inpatient and Outpatient Consultation codes. In this proposal, these services would be billed using the Initial Hospital Care and New Office Patient codes, respectively. The funds previously allocated to the consultation codes would be shifted to other Evaluation and Management services, particularly in the outpatient setting. The intent appears to be to promote an increase in the supply of primary care physicians. Although this may appear to be an essential goal, it will come at the expense of purely cognitive specialties, such as infectious diseases. In the budget-neutral Medicare Part B system under which physicians are paid, increased payments in one area must come at the expense of others.

The system that CMS uses to allocate payments among physicians is the Resource-Based Relative Value Scale (RBRVS), which measures and accounts for physician work via relative value units. The RBRVS was created in 1991, partly as a response to a perceived crisis in primary care. Since the origin of the RBRVS, complex cognitive services, such as those provided by infectious diseases physicians, have been undervalued [3].

This suggests that, despite primary care being used as a key example in the current health care crisis, primary care specialties are not the only ones that may be disadvantaged under the current payment system. As an almost purely cognitive specialty, infectious diseases is as disadvantaged under the current system as primary care. In fact, infectious diseases physicians bill CMS a higher proportion of Evaluation and Management (ie, cognitive) services (92%) than do general internists (82%) and family practitioners (85%) [4] (American Medical Association/Specialty Society RVS Update Committee, personal communication).

The CMS proposal to eliminate payments for the consultation codes perpetuates and worsens an already inequitable system. The mandate to use Initial Hospital Care codes to bill for complex cog-
nitive services does not account for the work infectious diseases physicians do when first evaluating critically ill hospitalized patients, who are often immunocompromised, who have multiple organ system dysfunctions and comorbidities, and who have endured prolonged inpatient stays. In doing so, the proposal sustains the disparity between the valuation of work and the intensity of service during high-level, complex consultations rendered in the inpatient setting.

A proper assessment of all but the most basic infectious diseases problems requires a full understanding of the entire patient. This entails an exhaustive clinical evaluation accompanied by a review of medical history, imaging, and additional medical data that may not be available or fully understood prior to an infectious diseases consultation. This not only requires time, but also the expertise to synthesize the data into meaningful and relevant recommendations for the individual patient.

Infectious diseases physicians provide clinical and strategic planning support in facilities that perform complex procedures, including organ transplantsations, trauma-related care, neurosurgery, and orthopedic surgery, and that have active oncology programs. Without infectious diseases support to prevent and treat adverse infectious complications, morbidity and mortality in these facilities would be greater. Moreover, infectious diseases physicians are critical to transitioning hospitalized patients with serious infections to alternate settings of care for treatment, thereby reducing the frequency of avoidable hospital complications or readmissions. The end result of these patient-focused infectious diseases interventions is high-quality care that conserves health care system resources, minimizes complications, and improves patient outcomes.

The CMS proposal devalues, discounts, and ignores the work done by infectious diseases physicians. Unlike most other physician specialties, infectious diseases does not “own” an organ or have a procedure. This is reflected in the Medical Group Management Association’s national salary data for physician specialties [5]. The mean infectious diseases physician’s earnings are only 10% greater than those of a general internist, despite an additional 2–3 years of training and a patient population consisting of the sickest and most complex patients in our health care system. This already small gap in reimbursement will narrow further if CMS eliminates payments for consultations.

Even more concerning over the long term, enactment of the CMS proposal to eliminate payments for the consultation codes and the resulting further devaluation of high-level, complex cognitive services would have a foreseeable adverse impact on the infectious diseases workforce that extends far beyond the provision of consultative services in 2010. Infectious diseases is the only specialty specifically trained to think on a global and epidemiologic basis, looking at the “big picture” as a matter of routine. Our unique training and cognitive skill set make infectious diseases physicians essential in the response to new and emerging infections and disease outbreaks, including H1N1 influenza, severe acute respiratory syndrome, and dengue, which have the potential to spread around the globe. Infectious diseases physicians are also the health care system’s “first responders” to bioterrorism events. To quote Jeffrey Levi, PhD, Executive Director of the Trust for America’s Health, “infectious diseases…are a real threat right here, right now to America’s economy, security, and health system” [6]. Maintaining an adequate supply of infectious diseases physicians is critical to ensure an appropriate response to these threats.

As a small specialty by numbers, but one with a disproportionately broad footprint across our health care system, infectious diseases is committed to health care reform that makes sense for both patients and their providers. Unfortunately, by continuing the status quo of devaluing the work of complex cognitive services, the CMS’s proposal to eliminate payments for consultations would further disadvantage infectious diseases and other cognitive physicians and threaten patient access to necessary specialty services. The Institute of Medicine has raised concerns regarding unintended consequences of health care reform [7]. An unintended consequence of this CMS proposal may be that few infectious diseases physicians remain to confront current or future local, national, and global infectious diseases challenges.

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