



Voices of Medicine



By Del Meyer, MD

The growth industry of diagnostic codes, and when consultants go too far.

#@&%! that 5-Digit Number

"And Now-A Minute with Andy Rooney (With Apologies to 60 Minutes)" by Stephen Kamelgarn, MD, discusses the ICD-9 codes, in the December issue of *The Bulletin* of the Humboldt-Del Norte Country Medical Society:

Dontcha just hate little five digit numbers. I know I do. Little numbers that comprise the ICD-9 - this three pound paperback book I'm holding in my hand. (*Camera pans into Andy fanning the pages of a huge tome*) A five digit code that supposedly encompasses the full gamut of medical diagnoses that may ever have entered the mind of humankind. Isn't that a bit of hubris, thinking we can classify all diseases with a five digit code? But people keep trying.

Here's an example: *711.4 Arthropathy associated with other bacterial diseases.*

The fifth digit is Code for the underlying disease, as: *diseases classifiable to 010-040, 090-099, except as in 711.1, 711.3, and 713.5 leprosy (030.0-030.9) tuberculosis (015.0-015.9) Excludes: gonococcal arthritis (098.50) meningococcal arthritis (036.82)*

It's nice to know that we can separate out tuberculous arthritis from gonococcal arthritis. It also makes no sense at all: is leprosy 030.0? or is it 030.9? or is it somewhere in the middle? What happened to the 711.4 code, which was the original number I looked up?

When the folks keeping track of the numbers were mostly medical people (and actually understood this stuff) those five digits were (and still remain) an important way of tracking diseases and disease trends. But somewhere along the line the bean counters and the insurance 'droids and the government bureaucrats hijacked those five digits for their own nefarious purposes. Now those same five numbers have taken on a life of their own and have become a tyranny. Nothing moves anymore without that five digit code accompanying it; and they'd better be the right code, or you can forget it...

"I'm sorry doctor, the patient's insurance plan doesn't pay for the code 'V77.91; Screening for Lipoid Disorders.' I'm afraid the patient will have to pay out of pocket." This, despite the fact that the American Colleges of Everybody say that all adults should be screened for this problem at age 40, or whatever.

"I'm sorry doctor, you've only put down 493, the first three numbers. We need the fourth and fifth." Do they really need to differentiate "extrinsic" asthma from "intrinsic" asthma to pay for a nebulizer? Not only that, but the online reference I've been using icd9.chrisendres.com doesn't even carry 493 out to five places. "I'm sorry doctor,

Incontinence, ICD 788.30, doesn't qualify your patient for adult diapers. We need a code for why the patient is incontinent." Does it matter? The patient has a problem with his/her bladder, and just needs the damn diapers, for goodness sake!...

When did we allow this to happen to us? As medical costs rose, the insurance industry, out of a sense of their perceived necessity, intruded more and more into our autonomy and our ability to advocate for what is right (as opposed to what is cost effective). We found our time slowly being chipped away, as slowly, relentlessly more and more forms and insurances started demanding that we supply the appropriate code, and now we can't put a halt to it as more and more of our office time gets taken up by having to look up and provide the appropriate damn code.

It's become a growth industry unto itself. Just Google ICD-9 and see how many hits one gets: dozens of web sites devoted to telling us the appropriate code for whatever ails us. Our mailboxes (both email and snail-mail) are flooded with junk mail, advertising "coding" conferences, so that we may make the best use of these abstruse codes to obtain, or heaven forbid, increase reimbursement. This must be a financial boon to the companies putting on these dog and pony shows....

I guess that it is nice to know that I've found some part of the economy that's profitable and growing. When I get out of medicine I can always get a job as a coding consultant.

The entire article is at www.humboldt1.com/~medsoc/images/bulletins/DECEMBER%202007%20BULLETIN_for%20web.pdf

They Want What?

Lytton W. Smith, MD, editor of the Orange County Medical Association's Bulletin, urged "Dare to Say No!" in the December 2007 issue.

A presentation on peer review and medical staff issues became a discussion on insurance contracting.

While at the California Medical Association House of Delegates, members of the Solo and Small Group Practice Forum (SSGPF) invited me to attend a presentation by Howard Lang, MD, dealing with peer review and medical staff issues. The evening evolved into a self-confessional discussion about insurance contracting.

At the House of Delegates, the SSGPF represents physicians practicing alone or in a small group of four or fewer. The CMA has more than 8,000 members fitting that category. Other practice forums include the Medium Group Practice Forum (5 to 150 doctors), the Large Group Practice Forum (150 to 1,000) and the Very Large Group Practice Forum (1,000 plus).

After a short presentation about a messenger model developed in Los Angeles County, various members spoke about dropping contracts. The sharing of personal experiences with contract termination has become chic. The solo practitioner sitting beside me made the observation that he felt like an Alcoholics Anonymous meeting erupted. "My name is H-----, and I terminated my contracts!" In response, know-ing sighs from attendees filled the room. Those still afflicted with insurance contracts listened in admiration...

Now shift to the floor of the House of Delegates. We learned that legislation had been passed to study the peer review process in Cali-fornia, and that the Medical Board of California had contracted with Lumetra to perform the as-sessment. Further, we learned that medical staff offices across the state had received letters from Lumetra demanding confidential peer review information.

What? They want what?!? Calls from medical staff offices to chiefs of staff and medical staff attorneys ensued. What information could, should or would be released? Was this information about peer review protected by SB* 1157? Most hospitals collect reams of

data about peer review. Physicians participating in review of other physicians assumed SB 1157 protected them from discovery. Hospital administration feared that exposure of cases with severe criticism of patient management could lead to increased legal liability. Who pays for the collection, copying and mailing of confidential patient and peer review data? Faced with another unfunded mandate from the state, what would medical staffs do? Could they dare to say no?

The House of Delegates passed a resolution requiring that the CMA legal department immediately look into the legality of the Lumetra demands.... It's not that we physicians are a bunch of naysayers. We gladly say yes to proven innovations, evidence-based medicine and new surgical techniques. Yet over the past 20 years, demands by insurers, legislators, regulators and even specialty boards have increased physician angst - and in that environment we must dare to say no.

The article is at www.socalphys.com/article/articles/625/1/OCMA-Viewpoints---Dare-to-Say-No/Page1.html

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* Actually Evidence Code section 1157.

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