Editorial:

CPT Coding: Practice of Medicine or Insurance Function?

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Current procedural terminology (CPT) codes were developed by the American Medical Association (AMA) and were first published in 1966. According to the AMA website, CPT codes "…helped communicate accurate information on procedures and services to agencies concerned with insurance claims…."[1]

CPT codes provide a standardized means for reporting medical services and surgical procedures to third-party payers (government programs and private insurance) on claim forms so that payment can be made for services provided.

In 1983, the AMA made a secret pact with the Health Care Financing Administration (HCFA) to impose use of the CPT coding system on all physicians.[2] HCFA was the precursor of the Centers for Medicare and Medicaid Services (CMS), the government agency that runs the Medicare and Medicaid programs. A copy of the secret pact is posted on our AAPS website.[3]

In a lawsuit filed against the AMA (*Practice Management Information Corp. v. the American Medical Association*, 121 F.3d 516, 520-21 (9th Cir. 1997), modified on reconsid. 133 F.3d 1140 (9t Cir. 1998)), a three-judge panel in the 9th Circuit found:

> On the undisputed facts in the record before us, we conclude the AMA misused its copyright by licensing the CPT to HCFA in exchange for HCFA's agreement not to use a competing coding system…. [T]he plain language of the AMA's licensing agreement requires HCFA to use the AMA's copyrighted coding system and prohibits HCFA from using any other….The controlling fact is that HCFA is prohibited from using any other coding system by virtue of the binding commitment it made to the AMA to use the AMA's copyrighted material exclusively…. Conditioning the license on HCFA's promise not to use competitors' products constituted a misuse of the copyright by the AMA.[2]

The AMA's CPT monopoly, which imposes significant annual unreimbursed costs on physicians, provides a very lucrative revenue stream for the AMA.

CPT codes do not aid in the diagnosis or treatment of any patient. Although CPT codes are used for data-mining purposes by private bounty hunters contracted by CMS to recoup money paid to physicians, the primary purpose remains standardized reporting of medical services in order to obtain payment from third-party payers. Certification as a coding specialist does not qualify one to practice medicine, and use of CPT codes clearly does not constitute the practice of medicine.

Elimination of CPT Coding: Administrative Simplification, Improved Access, and Lower Cost of Care

Physicians who legally opt out of Medicare (Sec. 4507 of the Balanced Budget Act of 1997) and who do not have contracts with private insurers (third-party-free physicians) often find that they are able to provide care at a much more affordable cost. They have eliminated the huge administrative expense of coding and claims filing, a choice that ultimately results in significant savings for patients. Moreover, time not spent on coding, or staying current with coding requirements and changes, is time that can be spent providing actual medical care. Elimination of CPT coding also eliminates a lot of physician frustration associated with obtuse evaluation and management (E&M) bullet-point requirements, bundling rules, and "gaming" of the system in an attempt to obtain fair reimbursement in an environment of government devaluation of physician services. Elimination of CPT coding is the epitome of administrative simplification, and benefits both patients and physicians. Less stress for physicians enables more mutually satisfying patient-physician encounters.

Is CPT Coding Part of Medical Practice?

In July 2011, AAPS member Kathleen Brown, M.D., left the clinic where she had practiced since 1997 and opened her own third-party-free dermatology practice. Working directly for patients, instead of working for government and insurance companies, Dr. Brown decided to eliminate the unnecessary bureaucratic hassle and expense of using CPT codes in her third-party-free practice. All of her fees are transparent, listed on her website (www.oregonderm.com), and are affordable for both insured and uninsured patients. It was a win-win situation for Dr. Brown and her patients.

Hostile Response from Insurers

Insurance companies, however, were not happy with Dr. Brown's decision to eliminate CPT codes in her practice. An article in *The Lund Report* stated:

> When she left to start her practice, Brown told *The Lund Report*, her patients received phone calls from representatives at Regence BlueCross BlueShield and ODS

[Oregon Dental Service Health Plans] telling them not to see her, and ODS counsel sent a letter to her office threatening to report her to the Oregon Medical Board.… Regence spokesperson Scott Burton declined to comment for this story…. Jonathan Nicholas, ODS' vice president of corporate branding and communication, said he was unaware of any ODS employees having contacted Brown's patients, and added that ODS is unable to reimburse patients for services if their providers don't submit billing codes. CPT billing codes are mandatory, Nicholas said. "You can't be half in and half out. If you want to bill insurance companies [which Dr. Brown did not wish to do], you have to have a code."[4]

Thinking she had escaped the abuse, power, and control of insurance companies by going third-party-free, Dr. Brown instead found, "I didn't anticipate that insurance companies would still attempt to control the way I practice."[4]

Response from Oregon Medical Association

Seeking help and support from her state medical association, Dr. Brown received a response from the Oregon Medical Association (OMA) that showed lack of courage at best, and enablement of an abusive position involving the role of CPT codes in medical practice at worst.

Dr. Robert Orfaly, who chairs OMA's Health Care Finance Committee, wrote:

> [M]any committee members were supportive of your right to practice medicine in a way you feel best serves your patients to the greatest extent possible…. However, given the realities of current systems in place, the OMA cannot support your billing practices…. Committee members expressed that while you are entitled to not use CPT codes, this practice is ultimately onerous to the patient who often times is unable to be reimbursed.[5]

So in the tradition of doublespeak, the OMA claimed to support her choice to practice in the best way to serve her patients, but in reality could not support her choice to practice in a manner that fails to serve the needs of insurance companies and the CPT monopoly. Like the AMA, the OMA derives revenue as a result of the CPT monopoly by offering CPT coding courses to physicians ($269 per person for members, $338 per person for non-members).[6]

Dr. Orfaly's letter goes on to state:

> The OMB [Oregon Medical Board] has indicated that it has decided to uphold the current rule stating that "the use of procedure codes are an important part of practice, and the Board does not want to change the rule to allow practitioners to use codes OR a narrative description of the procedure. Instead, both will continue to be required. The Board considers such procedure codes to be necessary as a standardized way to document procedures." While it has not indicated the intent to pursue any action at this time, you will understand that the Board retains exclusive rights to set the standards for licensure in the state.[5]

If this is indeed the position taken by the Oregon Medical Board, as quoted in Dr. Orfaly's letter, it represents overreaching and a blatant abuse of power by the Oregon Medical Board.

Declaring that CPT coding is part of medical practice or standard of care has led to some very inappropriate and adverse consequences. In a case of sham peer review in another state, for example, a hospital attorney alleged that the physician breached the standard of care by not providing documentation to support each of the E&M bullet points for a history and physical the physician conducted in the hospital. Bureaucratic bullet points, used for the sole purpose of billing, were offered as a medical standard of care to justify taking adverse action against the physician's hospital privileges!

Dr. Orfaly went on to state:

> The second development was that both ODS and Regence informed the OMA that they were amending the language in their contracts with patients to state that in order for members to be reimbursed, they need to provide CPT and ICD-9 codes. Given this situation, there is effectively no option to practice in a fee for service model without the use of these codes.[5]

This desperate action by insurance companies, to avoid incurring the full cost of claims processing by foisting the responsibility for CPT coding onto patients, is a clear attempt to use patients as pawns to pressure third-party-free physicians to provide free labor to insurance companies.

Dr. Orfaly also told Dr. Brown: "Committee members also expressed that your billing methodology is not aligned with the administrative simplification efforts that the OMA has been strongly involved in and could, potentially, add to health care expenses."[5] However, it defies both logic and common sense as to how a physician's choice not to use CPT codes adds to administrative complexity or health care expenses. Eliminating CPT coding from a medical practice has the exact opposite effect.

Dr. Orfaly ended his letter to Dr. Brown by saying: "I hope that you find this information useful in your future deliberations. Thank you for participating in the OMA. We value your membership and hope to assist you again in the future."[5]

So, after refusing to stand up and fight to help her escape the abuse of insurance companies so as to best serve her patients, the OMA offered to "assist" her again in the future. Unfortunately, by refusing to stand up against abuse by insurance companies, as enabled by a medical board, the OMA effectively sealed the fate of both member and non-member physicians in the state of Oregon. By refusing to fight the abuse, the OMA has invited more abuse. Inviting more abuse by insurers harms both patients and physicians.

Antitrust and Constitutional Issues

Coerced physician participation in a CPT monopoly may also be in violation of antitrust laws. Forcing physicians to comply with private insurance company requirements when the physician has voluntarily chosen not to contract with insurance companies is anticompetitive and harmful to patients by increasing the cost of care. As CPT codes are inextricably linked to fixed fees, coerced participation in the CPT monopoly may also constitute a form of illegal price-fixing.

Coerced physician participation in the CPT monopoly also discourages patients from seeking medical care from a physician of their choice, when that physician happens to be a third-party-free physician. Such action enhances the market power of the monopoly by effectively prohibiting competition by third-party-free physicians in the interest of providing better care at a lower cost. Medical associations should not be complicit in coercing physician participation in a monopoly or price-fixing scheme.

Moreover, there are significant constitutional issues to consider. A physician who legally operates a third-party-free practice makes an implicit contract with patients, such that the patient understands and agrees that the physician is not bound by insurance company rules (e.g. CPT coding) and price-setting. Any government agency (e.g. medical board) that interferes with patient-physician contracts of the third-party-free physician in the area of billing practices or fee setting is in violation of Article I Section 10 of the U.S. Constitution, which forbids government from interfering in the obligation of contracts.

Forcing a physician to provide uncompensated labor by spending time providing billing codes to insurance companies violates the Takings Clause of the Fifth Amendment (without just compensation), and violates the Thirteenth Amendment (involuntary servitude) as well. Physicians who voluntarily choose not to contract with insurance companies have no legal obligation to provide free labor to any insurance company for the purpose of claims processing.

Contract Between Patient and Insurer

Patients who have medical insurance and who choose to see a third-party-free physician can utilize their coverage benefits by sending a copy of their office visit record to the insurer should they choose to do so. This does not represent an onerous imposition on patients. Insurance companies clearly have the capability of choosing an appropriate CPT code based on review of a copy of an office visit note provided by the patient so that the claim can be processed and the patient can receive reimbursement. Some patients may choose not to file a claim so as to preserve their privacy.

The third-party-free physician is not party to the contract between patient and insurer, and incurs no legal obligation based on the patient-insurer contract. The administrative cost of claims processing, including CPT coding, is the full responsibility of the insurer. Medical boards and medical associations should not act as enforcers or enablers to allow insurers to forcibly recruit non-contracted physicians to provide free labor (CPT coding) to insurance companies for the purpose of claims processing.

Conclusions

CPT coding is clearly not part of the practice of medicine. Claims processing, including use of CPT codes, is an insurance function. The cost of administrative claims processing, including CPT coding, should be borne by the insurance company, as it represents a normal cost of doing business in the insurance industry.

Third-party-free physicians, who have no contracts with insurance companies, should not be forced to provide unpaid labor to any insurance company for the purpose of claims processing. It is also inappropriate for insurers to foist the responsibility for CPT coding upon patients as part of a patient-insurer contract. This is an abusive insurance practice and an onerous imposition on patients. State legislatures should act to end abuse by insurance companies and medical boards.

Medical boards and medical associations that act to enforce or enable a monopoly and act to place unconstitutional burdens on physicians should be held fully accountable for their actions. They also deserve their place of disgrace in the AAPS Hall of Shame.[5]

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