Tort Reform Now

A transcript of a May 15, 2003 speech rallying for support of New Jersey Senate version A50.

As presented by Steven Rubin, DO, FACOFP

I want to thank you for giving me the opportunity to address the finest physicians in the world providing the finest care to the citizens of New Jersey and other persons who seek our care in our state.

I am a board certified osteopathic family physician that has been practicing in Bergen County, New Jersey for 18 years. Unfortunately, I have seen many of our excellent physicians, DOs and M.D.s alike, recently, either leave the state to practice, limit the scope of their practices or just plain retire due to the severe professional liability insurance crisis that has been perpetrated on us.

We are fortunate and thankful that the State Senate with its wisdom and foresight did the right, moral and ethical thing by passing Senate bill 2174 with an overwhelming 32-5 in a bipartisan way. This at first seemed unattainable and we were told that no way would this bill ever pass, but it did.

The Senate understood that liability reform would not only benefit patient access to the finest medical care that they deserve, but at the same time with reform and limits on non-economic losses would allow our physicians to continue to provide the finest medical care to the citizens of New Jersey as we always have.

The Senate understood that not having liability reform would in particular hurt the women and children since many of our obstetrician-gynecologists have limited their practices to only gynecology, thus reducing access to care for obstetrical patients.

The Assembly bill A50 wants to have a subsidized fund that would provide no interest loans to those physicians with the highest premiums. This is not a solution of any sort. It is like putting a band-aid on a ruptured aneurysm; it just will not work.

We do not want to limit a patient’s ability to recover for true negligence and economic losses, but we want a cap on non-economic losses as outlined in New Jersey Senate bill 2174.

MICRA has shown that medical liability reform including limits on non-economic losses actually preserves the patients’ ability to seek redress. A 32-5 vote to do the right, moral and ethical thing and amend A50 to parallel the Senate version so that the citizens of New Jersey will have the access to the finest medical care and the finest physicians without limitations of care that they deserve.

Also, concerning frivolous lawsuits, no one has ever been cured by a frivolous lawsuit.

We plead with the Assembly to do what the Senate did in an overwhelming 32-5 vote and do the right, moral and ethical thing and amend A50 to parallel the Senate version so that the citizens of New Jersey can have the access to the finest medical care and the finest physicians providing the finest care to the citizens of New Jersey and other persons who seek our care in our state.

We do not want to limit a patient’s ability to recover for true negligence and economic losses, but we want a cap on non-economic losses as outlined in New Jersey Senate bill 2174.

In the words of Steve Shikiar “We need tort reform now, tort reform now, tort reform now! Support Senate Version A50.”

Steven Rubin, DO, FACOFP is board certified in family practice and osteopathic manipulative treatment. He is president of the Bergen-Passaic Osteopathic Medical Society and a Board member of ACOFP. This speech was given in front of 3,000 to 5,000 physicians at the steps of the State House in Trenton, N.J.
A good question to ask this payer is: “Do you pay for consultation if I do preoperative cardiopulmonary clearance or as a second opinion?” (C odes 99251-22955 for outpatient or 99241-99245 for inpatient or even 99271-99275 for confirmatory consults). These are services routinely provided by PCPs as consultants. If the answer was yes, then logically they would see that they do indeed pay for consultation, but they are trying to be particular (as I say) potentially distinguishing between what kinds of services PCPs need when they choose to approve such a consultation.

Any primary care providers do not do skin biopsies, colposcopy, endoscopy or vasectomies, not to mention orthopedic consultation. For those that do not do these needed procedures, they seek out others that do. Unless a particular payer has explicitly stated that they do not allow reimbursement for certain services or other PCPs (and the payer can make its own rules as long as it is in writing and you have given notification of it with a predetermine grace period before implementation) there is no federal or CPT doctrine that says you cannot charge for these services assuming it is within the scope of your practice. As my provider (D, MD, N P) who is evaluating another provider’s patient for a second opinion or to determine if a certain procedure is appropriate, and it is at the request of that provider can, in most instances, bill for a consultation. If the procedure is done at the same time as the consultation a –25 modifier should be added to the code and the procedure should be the first CPT code billed. Documentation for each must be appropriately done and the code representative of the work/document done should be submitted for reimbursement.

I have seen some payers try to deny payment for procedures done on one’s own patients or in consultation due to contractual exclusions. A seemingly commonality I have seen is that payers do not agree to pay for reimbursement until the procedures are done.

This needs to be addressed in contract negotiations and you should review your contract with your healthcare attorney to make sure that you are coded for correct services and that you make sure you did not agree in your previous contract to be excluded from reimbursement for consultative services. It is my belief that if it is of credentialing material, you may need the assistance of your state or national organization as these exclusions, although seemingly discriminatory due to their arbitrary nature, can be more formally addressed with a more unified front.

A summing none of the above exists for you and that these payers say they are following the CPT guidelines and the federal E & M document their system, their argument that primary care providers cannot provide consultative services has no merit. As a medical provider whose expertise is being sought by another member of the medical community to take care of their patient, you can and should charge for it if you requested it and you perform and document this service. It should be noted that consultative services have some specific rules relative to them. Please see my article in O F P News A pr 2003; “Consultancy Costs for OMTs and consult codes.” For a review of how to properly use the O M T and consult codes. (Available online at http://www.aocfp.org /member_publications/0403_coding.html)

Best of luck with your practice.

Respectfully,
Doug Jorgensen, D.O.