The Complexity, Relative Value, and Financial Worth of Curbside Consultations in an Academic Infectious Disease Unit

To the Editor—Grace et al conclude that curbside consultations are “common and complex” and “should be incorporated into measures of infectious diseases providers’ productivity and compensation” [1]. I would argue that the method of valuation is flawed and that curbside consultation should not be valued and should be offered rarely rather than routinely.

The authors state, “curbside consultations are generally complex, with a large majority given CPT codes of level 4 or 5.” However, new consult codes require all 3 elements (history, physical, and complexity/risk) to be documented at defined levels. It is not realistic to assume that “Dr Curbside” has derived all the information for a 99255 review of systems, personal, family, and social history, and an 8- or 9-organ system exam from “Dr Curbsider.” If the entirety of that information is not obtained, the monetary value cited for the service is unmerited.

The 1001 visits evaluated by the authors represent potential earnings but would have required complete evaluations and dictations to be worth $93,979. In reality, each curbside consultation probably consumed no more than 7 minutes [2], which, if generously valued at $140/h, used approximately $16,000 of specialist time. Many businesses provide services that are considered “loss leaders” but are needed to expand consumer awareness. Similarly, practicing infectious diseases specialists may feel that free advice to other physicians builds relationships that result in practice growth. Alternatively, academicians could view the effort as “teaching.”

However, the most vital concern is not revenue but rather doubt that complex consultations should be offered as curbside service. The cited 99255 service requires a condition with severe exacerbation or risk of loss of life or bodily function. It is optimistic and probably unrealistic to believe that a practitioner who needs help with management of such a condition can be expected to accurately and comprehensively provide the specialist with all the information needed to make competent recommendations. It is more likely that important elements of history (such as mesh in a surgical wound) or key physical findings (such as sunburn rash) may be omitted because the examining physician has not recognized the finding or its importance. Analysts frequently quote the phrase, “garbage in, garbage out,” and this applies equally to poor information and free advice. The risk of poor outcome supersedes consideration of revenue valuation.

Furthermore, it is likely that cases involving life-endangering conditions do become actual consults. The method employed does not deduct revenue derived from actual consultation on the previously curbsided patient from tabulated “virtual” revenue. Nobody would argue that one should be credited with 2 identical consults on the same patient. In fact, “discussion with another provider” adds 2 points to the Complexity/Risk data score and contributes to the 99255 code merited when the patient is actually seen.

In my 32-year career, I have learned to defer curbside requests, usually responding, “I am much smarter in person than over the phone. Would you like me to see the patient?” If the authors really believe that curbside consultations are effective and should be valued, why not simply demand that all consults be “deskside.” The 20 or so visits that we might do in a day could be done in the comfort of home, in less than 3 hours, with no dictations, no paperwork, and no responsibility. If the authors want credit for $93,000, they should insist on doing the work. They and their peers’ patients may be better off.

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Alexander A. Stemer
Medical Specialists Centers of Indiana, Munster, Indiana

References


Correspondence: Alexander A. Stemer, MD, Medical Specialists Centers of Indiana, 757 45th St, Munster, IN 46321 (astemer@medspecindiana.com).

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