Insurance Reimbursement: An Expert Discussion on Best Practices and Avoiding Pitfalls

Moderators: Richard C. Niemtzow, MD, PhD, MPH,^{1,*} and Marshall Sager, DO, DABMA, FAAMA²

Participants: Claudia Cooke, MD, FACP, MPH,³ Aaron Michelfelder, MD, FAAFP, FAAMA,⁴
and Ali Safayan, MD⁵

Medical Acupuncture's Editor-in-Chief, Richard C. Niemtzow, MD, PhD, MPH, and Marshall Sager, DO, DABMA, FAAMA, conducted a Roundtable Discussion with experienced medical acupuncturists—Claudia Cooke, MD, FACP, MPH, Aaron Michelfelder, MD, FAAFP, FAAMA, and Ali Safayan, MD—to discuss best insurance billing strategies related to their scope of practice and geographical locations, and related to compliance with the eventual changes from the Affordable Healthcare Act. This Roundtable offers valuable insight for frequently asked questions from both new and seasoned medical acupuncturists. The Journal welcomes further comments from the readership.

Marshall Sager: I am a board member and a past president of the American Academy of Medical Acupuncture. I am also a board member of the International Council of Medical Acupuncture and Related Techniques and the American Board of Medical Acupuncture. I have been practicing acupuncture for about 23 years.

Richard C. Niemtzow: I am the past president of the American Academy of Medical Acupuncture [AAMA]. I have been practicing medical acupuncture for about 19 years. I have been a medical doctor for about 38 years. I am also the Editor-in-Chief of the journal *Medical Acupuncture*. I thank everyone for participating today.

Claudia Cooke: I am a board-certified internist and Fellow of the American College of Physicians. I have been practicing acupuncture for 18 years, and have an integrative internal medicine practice in Manhattan, New York City.

Aaron Michelfelder: I am a professor of Family Medicine and Bioethics and Health Policy at the Loyola University–Chicago Stritch School of Medicine. I am a family physician and medical acupuncturist. I have been practicing acupuncture for about 13 years, and have a combined integrative hybrid practice, where about half of my clinical time is devoted to acupuncture.

Marshall Sager: Richard and I are hosting this Roundtable Discussion. It can go in a number of directions. We are talking about insurance acupuncture codes and how to handle them, and how to handle insurance matters with respect to acupuncture.

Richard C. Niemtzow: One topic we need to cover is how to avoid traps and pitfalls in dealing with insurance.

Marshall Sager: There are some assumptions we have to make here regarding what people understand about

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insurance codes and what they represent. We can get very basic, or we can start out as you suggested.

Richard C. Niemtzow: Our readership will include practitioners already involved in medical acupuncture and some individuals just beginning their acupuncture practices. It might be worthwhile to go over codes briefly so all readers understand essentially what we are discussing.

Marshall Sager: We will focus on four insurance codes—97810, 97811, 97813, and 97814. Codes 97810 and 97811 cover patient care without electrical stimulation. 97813 and 97814 cover stimulation, initial and subsequent treatment at one sitting. What we will discuss is how to bill insurance companies using these codes.

Claudia Cooke: I think that a brief review of how people are applying the codes is good. I, personally, am interested in the appropriate use of the Evaluation and Management [E&M] issue in terms of billing E&M and acupuncture codes conjointly. I know that this has been a tricky issue for a number of practitioners. I would also like to discuss the coding for the first and following visits.

Marshall Sager: The E&M is a stickler, and is one, I believe everybody is interested in, so, perhaps, we should begin there. I use Medicare as my primary source with respect to reimbursement. If Medicare says something, I try to follow the way Medicare wants it done, assuming that other insurances will follow along. If I am able to satisfy Medicare, I am likely to satisfy the other insurances.

Some practitioners in the Academy suggest that you cannot do an E&M, an office visit, and acupuncture and bill for the acupuncture, using an acupuncture code. I think that is wrong.

Claudia Cooke: I do not disagree with the *modus operandi*, but a scenario that has repeated itself a number of times in my office is the following: I receive a number of calls from people who want to come to me just for acupuncture. For both reasons of billing, coding, and liability, I will not do acupuncture for anybody without doing an E&M first.

In some situations, when it would seem reasonable to do an E&M appended to an acupuncture treatment at the time of the first visit, I never bill for the two together at the time of the first visit. I really end up slighting myself in this, because, very often, I do administer acupuncture in an initial visit, but I simply do not bill for it, and I just bill my standard E&M. I have found that, occasionally, with Medicare patients whom I have billed for both E&M and acupuncture, that the greater of the two charges is thrown out.

Marshall Sager: I have never had that problem. Are you adding a dash-25 to your E&M code indicating that you performed the procedure on the same day as the E&M?

Claudia Cooke: Yes. I use an offsite biller and her recovery rate otherwise has been very good. But, this does not always

work for initial visits. So, Marshall, are you saying you have been successful in collecting on both?

Marshall Sager: No. Acupuncture is not paid for by Medicare. Are you talking about Medicare?

Claudia Cooke: Not exclusively. Excuse me, when you bill the private insurance, have you been successful in collecting on both the E&M and acupuncture on an initial visit?

Marshall Sager: If the insurers pay for acupuncture, yes. However, like you say, you cannot do a treatment—an acupuncture treatment—without doing an E&M. So what do they tell you? They tell you that they are not going to pay for the E&M?

Claudia Cooke: A few do say that. In fact, it is not only the problem with acupuncture, but with many procedures now. I use some physical therapy codes, and some insurance companies do not reimburse physical therapy codes for physical therapy administered the same day as an E&M. I also administer nutrient I.V.s in my office. Similarly, the patient cannot collect on an I.V. administration and an E&M that were administered on the same day. So this is a recurring theme across a number of insurance submissions.

Within the non-Medicare part of my practice, my fees are paid upfront in full by the patients, and insurance reimbursements are made directly to the patients. Where Medicare is concerned, in which I participate, what shortfall is not covered by Medicare and the secondary insurer is billed to the patient.

Aaron Michelfelder: We have long struggled with how best to bill for reimbursement from insurance companies, and we have actually created a hybrid model for billing patients. We previously asked patients to call their insurance companies, and if their insurance companies said that they would pay for acupuncture, the patients would obtain that in writing from the insurers, present that to us, and then we would bill the insurance company.

What we found is that, for some insurers, after four or five visits, we would receive a letter advising that, while the insurers had initially approved acupuncture, upon further review they decided not to cover acupuncture. This would be four or five treatments into taking care of the patient, which is also expensive for the practice.

What we do now is have patients self-pay for all acupuncture, including the initial visit. In the initial visit I do either a consultation for a new patient, if it is private insurance, or an E&M code for Medicare and submit that to insurance for reimbursement. If the patient submits the bill directly to insurance, then the patient will be reimbursed directly. This is an older model, but it still works. For the acupuncture visit, we create a visit with a second hospital account record number, which is self-pay for the patient. We have each patient sign a form acknowledging that he or she

is aware that acupuncture is likely to be a noncovered service. We can submit claims for patients, or they do it themselves. But we will submit the initial consultation or new patient visit to their insurances, and the patients will pay separately for acupuncture on that day.

Marshall Sager: And for the second day, and for the second visit, do you submit a claim for an E&M?

Aaron Michelfelder: No. The patient pays for acupuncture only. I am in Chicago, where many acupuncturists practice. We have found that patients want consistent prices for their visits. For us to compete with all the other acupuncturists around us, we need to be able to tell each patient how much acupuncture is going to cost, because, on multiple occasions, the insurer will then turn an acupuncture charge down, and then the bill goes to the patient.

To make our practice competitive with those of other acupuncturists, all we bill is 97810, because it has a set fee, and, then, we provide a self-pay discount so that every patient gets charged exactly the same for acupuncture at each session. The patients know how much they will pay. If insurers pay for the sessions, the patients are reimbursed. This ensures that we receive consistent reimbursement, and the patients receive consistent charges.

Richard C. Niemtow: That makes sense.

Marshall Sager: I agree. I would like to comment and say that I feel that the patients are paying for the insurances, and they should be able to recover the costs, or the insurers should pay for the E&M. The acupuncture is another story. Maybe patients should pay for that out-of-pocket. That is what I do with Medicare patients. Medicare does not pay for the acupuncture but will pay for the E&M. Patients have actually told me that they do not want to be billed for acupuncture, because Medicare will not pay for it. But they do want to be billed for the E&M because Medicare will pay for it. I think other insurers will pay for the E&M, so we submit that and collect out-of-pocket for the acupuncture.

Richard C. Niemtow: Marshall, thank you very much. What I would like to do now is discuss the challenges of obtaining reimbursement for acupuncture. I would also like to focus on potential traps and pitfalls of insurance billing.

Marshall Sager: O.K. Let me note one important item here, and I will talk about that.

I had the pleasure of being audited by Medicare because a patient sent in a bill (to Medicare). Even though I told that patient Medicare would not pay for acupuncture, the patient sent the claim to Medicare. We went to a hearing. To make a long story short, we won hands-down. In fact, the judge used our arguments in the final judgment and said everything was fine.

And, basically, what Medicare was saying is that, whenever you saw a patient, it had to be medically reasonable, medically necessary. It had to be a separately billed

service distinctly recorded and documented—I am talking about the E&M service here—and not related solely to acupuncture. The operative word there is “solely.”

Here is what you have to do—and most people do not understand this—if you are going to bill Medicare, or any other insurance company, when you see a patient on the first visit, you are obligated to do an E&M to determine if acupuncture, or any other treatment, is warranted. That is not a problem. It is the subsequent visits that can be a problem. If you see a patient a second time, and it is to evaluate the efficacy of the acupuncture, and only that, then Medicare will not pay. Medicare will not cover that second office visit for E&M.

However, if, at that first visit you, had given a patient a prescription for some medication, and the subsequent visit was for follow-up on how the patient did with the medication—even though you are doing acupuncture—or if you did a laboratory test and you want to schedule a follow-up visit to discuss the results of the laboratory test with the patient, then that was O.K. In other words, you had to do something in addition to acupuncture to satisfy the criteria of Medicare. Most practitioners do not understand that. That is one thing to keep in mind. Any comments about that?

Claudia Cooke: Yes, this is good information. I am going to review some of the past billing that was rejected, because our biller was using the –25, and I know that we have had rejections on the combined E&M and acupuncture. I always include some additional comment in the E&M note. Thank you. That is a really important pearl.

Marshall Sager: I mentioned we had a hearing with Medicare. My summary of this court case is in *Medical Acupuncture*, Volume 16, Number 1, 2004, page 5.¹ It is a Guest Editorial in that issue. It defines “medically reasonable,” and “solely,” and other terminology useful for readers who are learning about insurance reimbursement.

Richard C. Niemtow: Aaron, Do you have any comment on this issue?

Aaron Michelfelder: Yes, I think the comments from Marshall and Claudia are excellent and reasonable. Our approach of separating the E&M and the acupuncture to completely separate visits has definitely ensured that we maximize our reimbursement on the E&M side of it.

So, in the electronic medical record, if we are going to do acupuncture and an E&M visit, the patient shows up with two separate visits, and each one has a different billing record number. The E&M is documented separately, just as any other E&M visit, so there is no question that it is completely separate from the acupuncture. Now, acupuncture might be mentioned in that visit, but we have the documentation to back up that we had a separate E&M visit, or that we did a full, complete E&M visit.

Claudia Cooke: Are these documented as two separate visits on the same day?

Aaron Michelfelder: They are, but remember, we are submitting one bill to insurance and the other bill we are submitting to the patient.

Marshall Sager: But are they both done on the same day?

Aaron Michelfelder: Correct.

Claudia Cooke: You are discounting Medicare here? This is with your private insurers?

Aaron Michelfelder: This is with private insurers or Medicare.

Marshall Sager: So it is not two separate visits, it is two different codes, and one goes to one person, and one goes to another person?

Aaron Michelfelder: That is correct, yes.

Claudia Cooke: But I understood that you were writing it up as though they were two entirely separate visits, or both services written up within the context of a single note.

Aaron Michelfelder: They are completely separated, so they are within different notes. Different bills are submitted under a different visit code number so that it really does look like two separate visits on the same day.

Marshall Sager: You know, that is an offshoot of keeping a separate set of books.

Richard C. Niemtzow: Ali, we have not heard from you on the question of reimbursement. Do you have any comments to make regarding insurance code billing?

Ali Safayan: No. I understand Marshall's position on this, and I certainly understand what the other speakers have mentioned regarding trying to separate procedures, and the difficulty of billing for an E&M and a procedure on the same day for Medicare or for insurance companies that do cover medical acupuncture. Where I work, we have had the same problems that have been mentioned thus far, and I am in total agreement with the options that have been provided thus far.

The only question that I have is regarding insurance denial. What was the reason for the denial after two or three visits from insurance-based or insurance-reimbursable acupuncture? In our practice, in Washington, DC, we do exactly as you suggested. If the patient states that he or she has medical acupuncture coverage, the patient provides this documentation from the insurance plan, the insurance plan clearly states that it has "X" amount of

visits covered in a year, and thus, we bill the insurer appropriately, doing the initial E&M code. We then have the patient come in the next day or 2 days later for medical acupuncture. We do a series of two or three medical acupuncture treatments. Then we do a follow-up in a separate E&M visit. Then we resume the medical acupuncture, based on that follow-up.

Thus, we have, as far as I know, never actually had a denial unless the code that we had used was inappropriate. In that case, we would then contact the insurance company to find out what the problem was. We would figure out what the issue was and then resubmit the claim, and we would get paid for it.

I also have a comment about physical therapy codes. As far as I am aware—and I am an internist—but my understanding in talking with Robert Shulman [MD], who has assisted the AAMA in writing the White Paper on the AAMA's position on insurance reimbursement for medical acupuncture,² my understanding from Robert, who is a physiatrist, is that, if you are actually not a physiatrist, you cannot use physical therapy codes. I do not know if that is the case. I do not use physical therapy codes. I use standard internal medicine codes for all of my billing. I was just curious. It was mentioned earlier that there was billing done using physical therapy codes. My understanding is that an internist, for example, cannot use physical therapy codes.

Claudia Cooke: I made that comment and I also am an internist. Some of the physical therapy codes I believe can be used. For example, I use microcurrent stimulation and myofascial release. These are physical therapy codes. The issue that I have had with reimbursement is, if the procedure codes are combined with an E&M code, there is a problem. For the most part, we have occasionally had problems with claims that we or the patients have submitted. I do not participate with any private insurance, and I have a limited number of Medicare patients. When acupuncture has been billed solely, our reimbursement rate has been good. The difficulty has been combining E&M codes and procedure codes. I also do biofeedback in my office. The insurance companies will not allow billing of 90901, which is the biofeedback code, in combination with the E&M, and the same situation applies to the acupuncture in many instances.

Marshall Sager: Do insurers want you to do the acupuncture without an E&M?

Claudia Cooke: Yes, that is what it seems. I write an E&M-type note. But in terms of the billing, the billing does not reflect that, very often.

Marshall Sager: I suggest you get your malpractice insurer to write a letter saying that they will not insure you unless you do an E&M every time you see a patient.

Claudia Cooke: That is an interesting idea. But Aaron is essentially doing the same thing, right? You are billing just acupuncture without an E&M?

Aaron Michelfelder: That is correct, yes.

Marshall Sager: No, he is doing an E&M the same day but keeping another set of books.

Claudia Cooke: But he is billing it as a separate visit that is unrelated to the acupuncture.

Aaron Michelfelder: That is correct. We are separating it out. I would say, for most visits, I do not do an E&M. On the first visit, absolutely, I do it, and then, occasionally, on subsequent visits. These procedures are billed separately.

Marshall Sager: Aaron, this may cause a problem somewhere along the line, don't you think?

Aaron Michelfelder: Remember, the insurance company for the most part has never even seen the acupuncture bill, because we are collecting cash from the patient for that. I would say it is unusual for the patients to submit it to their insurers, because, at least in the Chicago market, they are often rejected.

Ali, to answer your question about the denials, there is one large insurer in Chicago—you can probably all imagine which one that is—and that large insurer does not really feel it needs to compete with all the little insurers. It is the little insurers that say they will cover acupuncture, because they want to compete with the huge, large insurer that covers 80% of people in the Chicago area.

So the little insurers say they will cover acupuncture, and they will give us a letter saying acupuncture is a covered benefit, and then, like I said, after three or four treatments, we will get a denial, and the denial will say: "Upon further review, acupuncture did not meet Milliman criteria and, therefore, we have decided to deny the claims."

Ali Safayan: Is that not kind-of like "bait-and-switch"?

Aaron Michelfelder: Absolutely. So we have talked about whether or not there should be a large class-action lawsuit, because we do feel that bait-and-switch is exactly what the insurers are doing to us, and, therefore, they are lying to the patients and to the practitioners about their coverage.

Ali Safayan: Well, I am sure it disturbs the patients, who are thinking they are getting covered, and, then, all of a sudden, they are not.

Aaron Michelfelder: Absolutely.

Marshall Sager: I want to make a few other comments, just individual things. Then, perhaps we should move on to the challenges of billing insurance. Is everyone aware that the Medicare Advance Benefits Notice [ABN], is not required for acupuncture treatment? The ABN states that acupuncture is not covered by Medicare. If you do not have it signed, if you have not had it signed previously, you have not done anything wrong, because it is not required by Medicare—for acupuncture.

Richard C. Niemtzow: Right. That's good to know, thank you. Let's turn to challenges, traps, and pitfalls of billing insurance

Claudia Cooke: Richard, I would like to hear from you and from Marshall what changes you expect to medical acupuncture reimbursement under the Affordable Care Act, also known as "Obamacare."

Richard C. Niemtzow: Thank you for bringing that up. According to my quick analysis of physicians across the country, a considerable number believe that Obamacare will be problematic for acupuncture reimbursement. However, a greater number of people believe that, because Obamacare recognizes that there is merit in integrative medicine, Obamacare has lower-cost benefits and so, it might be easier to achieve more-rapid reimbursement. Aaron, what do you think?

Aaron Michelfelder: I found a paper from Milliman Healthcare entitled "Essential Health Benefits: Review of the State Employee Benchmark Plans, an Illustration of Possible Variation in Essential Health Benefits by State."^{3*} This was done in an attempt to predict what state health insurance exchanges would be covering. Acupuncture was listed as a reimbursable expense in 20 states' health insurance exchanges.

Richard C. Niemtzow: As I said earlier, I have read that reimbursement would probably be more favorable. Is that what the document suggests?

Aaron Michelfelder: It did not mention anything about level of reimbursement being favorable in terms of a number of states but may cover acupuncture.

Marshall Sager: There is not an insurance company in the country that will not cover acupuncture as long as they get enough money up front from the premium. As long as the company gets a proper premium, it will cover acupuncture. If, for instance, a patient's employer offers a certain insurance that does not cover acupuncture, that patient can ask his or her employer to dicker with the insurance company to cover acupuncture, and the insurer will do so. But the insurer will charge the patient or employer a higher premium. It is all about money. We know that. It is not that insurers do not want to cover acupuncture. It is not beneficial for the insurers—or they do not see the benefits of the procedure at this point.

Richard C. Niemtzow: Do you think, despite the fact that we are dealing with money, do you think Obamacare will be

*Milliman Care Group to a private organization that makes evidence-based recommendations to insurers and health care providers about medical therapies and procedures.

more favorable toward integrative medicine? Because you have, Claudia, for example, who uses other integrative treatment modalities besides acupuncture. Will it benefit her and physicians like her who use multiple integrative modalities to treat patients?

Marshall Sager: I cannot speak about Obamacare because it is so complex. However, in Europe, insurance plans are integrating complementary and alternative medicine [CAM] procedures, acupuncture among them, into conventional medical plans. These plans are doing this in an aggressive and thoughtful way. So it is possible that, using international paradigms, Obamacare may, at one point, cover for integrative or CAM procedures.

Richard C. Niemtzow: Ali, any comments?

Ali Safayan: Although I am an internist, I have a group practice with a naturopath, a chiropractor, a nutritionist, a psychotherapist, a personal trainer, and a massage therapist, so we have a fairly extensive CAM footprint here in the Washington, DC, area. My sense of Obamacare is that it will be more gentle with complementary and alternative therapies than the conventional insurance system marketplace is at the present time. I think it remains to be seen if that is the case.

My concern has been that claims in the literature I have read about Obamacare suggest that, to be covered, medical care must be evidence-based. When we have to deal with the conventional medical system, we deal with the disease-based model and its evidence-based logic. For CAM, we are trying to create a different paradigm—one of preventive care, rather than chasing down a very expensive disease-based model. CAM does not have the evidence base that is required to legitimize it.

I think an area that we may run into problems with, in terms of, reimbursement is that some of these insurers or exchanges may state: “There is not enough evidence to support providing reimbursement for this particular CAM modality. We will cover this one, but we will not cover that one.” While I think, in acupuncture, there may be sufficient evidence, many researchers are still trying to discover the mechanism of action of medical acupuncture. Definitive results in those investigations could, perhaps, ensure reimbursement. With respect to other CAM modalities, there is still research to be done.

Richard C. Niemtzow: Aaron?

Aaron Michelfelder: I agree. I was reading an article about California’s mandates,^{4,5} and it stated that California’s version of Medicaid will cover acupuncture under Obamacare and it says the copay for acupuncture will be \$30. The article does not mention what the reimbursement to the acupuncturist will be, but it says that will be covered under the

wellness care piece, which is required under the Affordable Care Act. So what I am seeing here looks like people are going to be able to interpret “wellness care” differently.

However, theoretically—and this, of course, has to be given time to see if it will come to fruition—theoretically, if insurance companies are going to compete across state lines, acupuncture would be a very attractive benefit to encourage people to sign up with the insurers’ plans. From that standpoint, the institution of health insurance exchanges—which is integral to Obamacare—acupuncture and other integrative therapies may be looked upon more favorably in terms of reimbursement.

Richard C. Niemtzow: In the remaining time I would like to ask specific questions of each of you. Claudia, many years ago, you said that physicians in New York City who were practicing medical acupuncture found that it was not lucrative and were essentially leaving the field. However, you mentioned that your practice is doing well. Do you have any recommendations for new physicians, especially beginning practice in the New York City area, who wish to do medical acupuncture? What would be your advice that would—should I say—help them to ensure a successful medical acupuncture practice?

Claudia Cooke: Acupuncture continues to be a daily part of my practice, but this modality is an ancillary part of that practice. And the percentage of acupuncture activity within my week has declined relative to, say, 10 years ago. I only know of 1 physician currently in Manhattan who practices acupuncture exclusively. I know a few other internists or family practitioners or medical acupuncturists in the city who are still doing acupuncture by increasing the non-acupuncture part of their practices.

I think having an exclusively or chiefly acupuncture-focused physician practice in New York City, at the very least, may be difficult. Having an integrative practice emphasizing complementary therapies is, I think, a significant draw here, and in most of the country.

My advice is that integrating or drawing from functional medicine, nutritional modalities, and, possibly, herbal or botanical approaches, and combining them with a medical acupuncture practice is a wise course for this area of the country.

Richard C. Niemtzow: Ali, as you mentioned, you also are an internist, and you are associated with a group that has various integrated medical practices. How would you feel if you were just performing medical acupuncture in the Washington, DC, area? Would you find it difficult from a financial point of view, and is that the reason you have an integrative medical group practice?

Ali Safayan: Well, the short answer is “I would be bankrupt.” The long answer is that I have been affiliated with the

Helms Medical Institute [HMI] since 1996, and we have trained nearly all the medical acupuncturists that are in my community, in Washington, DC. I am basically training physicians to come out and compete with me. Although I am probably one of the older medical acupuncturists in the metropolitan area, I am putting a lot of “seedlings” around me, and the seedlings are drawing from my former medical acupuncture population.

Over the last 5–6 years, my practice of medical acupuncture may not have declined. What has declined is the way I make money from medical acupuncture. Five years ago, 90% of the patients were coming in as self-paid, and now 80% of the patients are coming in covered by insurance plans, and only 10%–20% are self-paid.

Additionally, as the years have gone by—and this is what happens when the insurance industry controls anything—reimbursement for the services provided have declined, especially as the marketplace has had more competition. Insurance companies can now go across the street, or to the new medical acupuncturist five blocks away, and say: “We can send these guys to you. Are you willing to take something less for reimbursement?” I am being a bit facetious, but that is the logic that I am suggesting that the insurance industry applies every year as it continues to lower our reimbursements to a point at which it is not going to be feasible for an internist like myself, who has to pay \$15,000 a year in malpractice just to have the luxury of practicing in Washington, DC.

I cannot necessarily make enough money doing medical acupuncture to cover that, even though my malpractice insurer does not charge me anything additional for medical acupuncture. I do not make enough money through acupuncture necessarily to cover all of my malpractice insurance.

My interest in acupuncture has always been as one of the many treatment modalities I can provide my patients. At the HMI, that is actually what we teach the physicians who come through the course—we teach them that medical acupuncture is an additional modality. There are many others they can provide to their patients. If a clinician wants to have a medical acupuncture practice only, that is certainly his or her prerogative. But with insurance and health care changes, such as “wellness care” encouraged by Obamacare, I do not think it will be financially viable to offer only acupuncture in a medical practice in the future.

Marshall Sager: Shall we move on?

Aaron Michelfelder: Before we move on to the other pitfalls of reimbursement, I would like to comment on Obamacare and acupuncture, because I have a different viewpoint.

My practice has gone from 50% or 60% insurance reimbursement to about 90% self-pay, and the amount of money my institution makes on me per patient is about 15%

higher than it is for my other family-medicine colleagues. That small financial boost has been so compelling that my clinic has actually adjusted the Relative Value Unit [RVU] calculations for me so that I do not get 0.6 RVUs for a 97810. I actually now get 1.5 RVUs for a 97810. That was an internal adjustment that my clinic negotiated with our health system, because my acupuncture reimbursement is somewhat higher than it is for other patients. So I have had the opposite happen to me—and it has been the case, because we have switched to self-pay for acupuncture.

Marshall Sager: That is interesting.

Richard C. Niemtzow: And it is grounds for further discussion. But, in these final moments, I would like to expand on Claudia’s advice to new practitioners. For a new physician who wants to practice medical acupuncture and is just starting a practice, what would be the key areas that you would touch on?

Ali Safayan: Before we focus on this final discussion point, I wanted to comment on Aaron’s issue about institutionalized acupuncture, which is quite different from the private-practice setting, which I am in. I agree with your comments in terms of the RVUs and your institution being able to offset or change the RVUs based on your ability to attract patients.

However, I am in a fairly robust, medical acupuncture-rich area of the United States. As a result, competition has become fairly aggressive. Many insurance companies are covering medical acupuncture as a fee-for-service capacity in the metropolitan area.

Aaron Michelfelder: That makes perfect sense to me. These regional differences are real and crucial to maintaining an acupuncture practice.

Ali Safayan: Absolutely. One of the things that we do when we are talking to the students at HMI—when we are talking about practice building—we address regional differences and how the students might plan for the practices in their own regions. Are these students going to be working within institutions? Are these students going into group practices? Will students be in private practice? Are they going to go into solo practice? I think that you can go to an area of the United States, be in solo practice, be the only medical acupuncturist or acupuncturist for miles around, and have a fee-for-service practice, only do medical acupuncture, and do quite well. But I think, by and large, if we look at the population as a whole, when physicians migrate to large metropolitan areas, they are in different settings altogether.

Richard C. Niemtzow: Thank you Ali. Let’s wrap up. Claudia, would you expand on your comments regarding new practitioners? What would you recommend for new physicians who just wanted to practice medical acupuncture in metropolitan cities?

Claudia Cooke: Based on my experience in New York City, my best advice is that these new physicians bring diverse offerings to the table. I think an exclusively medical acupuncture practice is—as a physician who is paying physician marketplace rates—not terribly viable. And I think it is a natural flow that matters of nutrition and herbal therapy and other energy therapies should go hand-in-hand with the medical acupuncture. That is my best advice, to seek a diverse offering, and, if possible, a diverse collection of practitioners if a group is involved.

Richard C. Niemtzow: Aaron?

Aaron Michelfelder: I completely agree with the comments from my colleagues, and not only would I say that it is important to make sure that you are doing other procedures than medical acupuncture for the financial piece of it, it is also important for referrals and for, I think, your health and well-being to have balance in everything you do.

If you do medical acupuncture, you have one phenomenal tool that you can offer people. If you are combining that with family medicine, internal medicine, physiatry, and integrative medicine, then you are offering patients a broad array of options that can help them get better, which I think personally adds to your career satisfaction, as well.

In addition, I think that this opens the door to more referrals from outside providers, because there are a number of needle-phobic patients that do not want to have acupuncture, and you can still have referrals from providers when patients are looking for treatments other than acupuncture, as well. I think an integrated, balanced practice is the smartest, safest thing to do.

Richard c. Niemtzow: Ali, your final comments?

Ali Safayan: Our practice has a three-pronged approach. We have mind–body, nutrition, and functional medicine. Acupuncture is a component of this tripod.

In teaching at HMI, I have been involved in developing the several components of the educational curriculum, in particular, the part having to do with practice development and advertising. I refer our students to our practice's website, www.restorativehealth.org, to indicate the importance of advertising. For very little or no money, in some cases, a physician can develop a marketing strategy and put together an assemblage of his or her own clinical skills. This is absolutely crucial, and, in most cases, it is absolutely free.

Getting physicians out on the internet, on Facebook and Twitter, and suchlike, allows these physicians to be competitive in this increasingly competitive field. It gives them a step up on traditionally trained acupuncturists and a step up on colleagues who have not embraced this advancing social-media technology and its capability to get physicians' messages out.

If physicians can get their messages out and have the messages come from the heart, not come from the pocket-

book, I think it really shows people who are looking for integrative medical care, who the legitimate providers are and who the people are who are solely interested in providing a service to make money.

Richard C. Niemtzow: This was a very interesting discussion. I work with a number of physicians in the military who seek advice because they have practiced medical acupuncture in the military, but are not aware of outside private practice. I think many of them feel that, by practicing medical acupuncture in the community, they could make their livings from that modality alone. And I understand easily now that this is not true. I think these comments are valuable, because we have physicians who read our Journal and who come from many different types of practices, whether they are government, private, or other private practices, with groups.

When we receive the comments from our readership about our discussion we might want to have a Part Two to it. I believe our readers are going to be excited to read your opinions, because, insurance reimbursement for medical practice is a learning process. I will stop here and ask if there are any final comments from participants.

Aaron Michelfelder: I would say thank you to Richard, all of our colleagues on this call, and also all of our colleagues who are out there practicing acupuncture, as well. I would say that practicing acupuncture is really about a philosophical and lifestyle thinking process that includes well-being not just of the patient, but also of the practitioner. I believe strongly that we should continue to teach it, practice it, and make sure that we are working with insurance companies and Medicare to ensure that we get reasonable reimbursement, because it would be really sad to see this art fade away.

Richard C. Niemtzow: Thank you. Claudia?

Claudia Cooke: Yes. Thank you, Richard, for making this conversation possible. Many of your remarks were very helpful. My parting comments are that we always remember to put the patient first, that we remember that the insurance companies are there to serve the patient, not the other way around, and that we seek a diversified base in practice.

Marshall Sager: In conclusion, if only one thing is remembered from this discussion let me reiterate the following:

It is logical and imperative that every health care professional is obligated to evaluate a patient's complaint(s) thoroughly before an appropriate treatment can be initiated and continued. Evaluation must involve an initial and subsequent interim history review and a concomitant physical examination(s) (i.e., at every office visit). Only after obtaining and documenting this information, can the practitioner render the proper diagnosis and medical management options, which then will determine the correct initial and ongoing treatments.

Office visits allow the provider the opportunity to assess the treatment provided, to determine its efficacy, and, based on that information, to establish an appropriate, progressive plan of care depending on the patient's complaints.

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BRIEF BIOSKETCHES

Richard C. Niemtzow, MD, PhD, MPH, is currently the director of the United States Air Force Acupuncture Center at Joint Base Andrews, MD. He is a 1976 graduate of the Faculte de Medecine, Universite de Montpellier, France, and completed a residency in radiation oncology in 1980 at the University of Texas Med-

ical Branch in Galveston, TX. He is also a 1995 graduate of the University of California–Los Angeles/Helms Medical Acupuncture course in. The Editor in Chief of *Medical Acupuncture* since 1995, Dr. Niemtzow is a former president of the American Academy of Medical Acupuncture. His military service has included numerous military command positions. As the first full-time medical acupuncturist in the Armed Forces, he created the first full-time acupuncture clinic in the Armed Forces. Dr. Niemtzow is currently a consultant for Complementary and Alternative

Medicine for the United States Air Force Surgeon General and the Assistant Secretary of Defense for Health Affairs. He represents the Department of Defense at the National Institutes of Health National Center for Complementary and Alternative Medicine's Advisory Council. Dr. Niemtzow retired from the United States Air Force in April 2010, obtaining the rank of Colonel after almost 30 years of active duty service. He was the organizer of the first Sino–American Military Acupuncture Meeting (in Beijing, China, in 2012). He represents the United States Air Force at a NATO Committee on Integrative Medicine as serves as an assistant professor at the Uniformed Services University of the Health Sciences. Finally, he is the current “Point of Contact” and moderator of a \$5.4-million Army, Navy, Air Force and Veterans Administration Joint Incentive Fund to teach Battlefield Acupuncture.

Marshall Sager, DO, DABMA, FAAMA, is currently in private practice in Bala Cynward PA. Dr. Sager, a graduate of Lehigh University, is a former United States Marine, a licensed physician, and a board-certified medical acupuncturist. He is also a Fellow of the American Academy of Medical Acupuncture (AAMA) and a

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Claudia M. Cooke, MD, FACP, MPH, is an assistant in the department of medicine of New York–Presbyterian Hospital's Columbia University division, in New York, NY. Dr. Cooke is a board-certified physician and has physician certification in acupuncture. As a member of the American College for the Advancement of Medicine and

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integrative approaches to her patients and their families. A long-time preceptor to Columbia University medical students at New York–Presbyterian Hospital, in New York City, she is helping to shape the minds of tomorrow’s physicians. She has served as a clinical preceptor both in physical diagnosis, at Columbia University College of Physicians and Surgeons, and in acupuncture at the University of California, Los Angeles School of Medicine’s Medical Acupuncture for Physicians course.

Aaron Michelfelder, MD, FAAFP, FAAMA, is a professor of family medicine and bioethics at Loyola University–Chicago’s Stritch School of Medicine in Maywood, IL. Dr. Michelfelder is a graduate of that institution. He completed training in medical acupuncture through the University of California–Los Angeles/Helms

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ing medical students and resident physicians at the Loyola Stritch School of Medicine. Dr. Michelfelder’s special interests include bioethics as related to national and international health policies, especially concerning care of underserved patients, as well as end-of-life care, alternative medicine, and humane medical education. He has been on the Loyola University Medical Center Ethics Committee and an ethics consultant since 2000.

Ali Safayan, MD, is currently preceptor in charge, at the Helms Medical Institute and a clinical instructor in prolotherapy for the Hackett Hemwall Foundation, in Madison, WI. He has a private practice in Washington, DC. Dr. Safayan started his medical training in Southeast Asia and completed it through Indiana Uni-

versity Medical School in 1986. He completed his internship in New York City and his residency in internal medicine in Washington, DC. Dr. Safayan completed his medical acupuncture training in 1997. His areas of interest include: integrative medicine; bioidentical hormone replacement therapy; prolotherapy; medical acupuncture; nutritional counseling and supplementation.