COA Report

A publication of the California Orthopaedic Association

Fall, 2008

Out-of-Network Reimbursement Rates On-Call Emergency Services

There are two important issues that I want to focus on in this column:

1) Department of Managed Health Care Regulations declaring it an "illegal billing pattern" for non-contracted physicians to bill emergency room patients for services that are the responsibility of their managed care health plan; and,
2) Efforts by the AAOS to develop an On-Call Emergency Services Position Statement.

Both are potentially onerous issues for COA members.

Out-of-Network Reimbursement Rates – Non-contracted providers
In spite of vigorous opposition from medicine for the last several years, the Department of Managed Health Care (DMHC) has adopted regulations which make it an "illegal billing pattern" for non-contracted physicians to bill emergency room patients for services that are the responsibility of their managed care health plan. During the hearings, DMHC provided examples where patients had been billed several times more what the physician would have been reimbursed had they been contracted with the plan. Governor Schwarzenegger issued an Executive Order demanding that the DMHC correct this situation. The DMHC solution has been to take the patient out of the middle by prohibiting providers from balance billing the patient. The regulations are effective October 15, 2008.

COA opposed these regulations on the main principle that if our ability to bill patients for services rendered by non-contracted physicians is diminished, our ability to negotiate reasonable contracts with carriers will be lessened. The plans will know they can dictate the payment rates and will have no incentive to negotiate reasonable rates with physicians.

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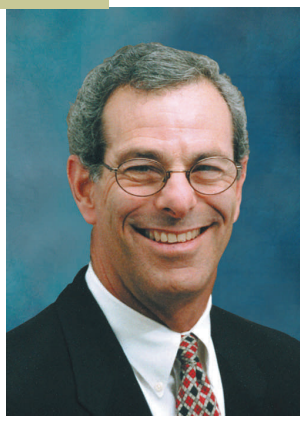

Mark B. Wellisch, M.D.
President

Upcoming Events

February 26, 2009—Harrah's Hotel—5:30 pm—10:00 pm
COA QME Course at the AAOS 2009 Annual Meeting—Las Vegas
Accredited for 6 hours of QME Continuing Medical Education Credits.

May 14-17, 2009—Fess Parker's Doubletree Resort in Santa Barbara
COA 2009 Annual Meeting/QME Course
Meeting will be accredited for Category I and QME CME hours.

COA is an effective organization because of the involvement of its members.

President's Column (continued from Page 1)

COA has joined with the California Medical Association, the California Chapter of the American College of Emergency Physicians, the California Radiological Society, the California Society of Anesthesiologists, and the California Hospital Association to file a lawsuit to challenge the legality of these regulations. One main contention of the lawsuit is that the DMHC is empowered to regulate health plans, but not physicians. Thus, the regulations exceed the authority of the Department. The lawsuit also points out several areas that are vague, not the least of which is the definition of "emergency medical services" and how far does the duty of the on-call specialist extend. Obviously, services rendered at the time of the urgent event are covered by the regulations. But what about surgeries performed several days later after the patient has been stabilized? What about follow-up care? We don't believe that these services would be included in the definition of "emergency medical services" as long as the patient has been stabilized. If this holds to be true, the impact on orthopaedic surgeons will be lessened, although we still oppose the underlying principle. A ToolKit prepared by CMA is posted on COA's website: www.coa.org. It contains information which will help you understand the impact of the regulations.

Along with this activity, a federal district court in New York is working to rein in activities of carriers who use third party carrier-owned subsidiaries to establish what they call "fair market value" for a service. The value is biased in favor of the carrier and is generally set artificially low, not representing the true cost of rendering the service. This practice puts patients more at-risk for monies not paid by their insurer.

Take heart at last. The cavalry may be coming over the hill and perhaps we will be rescued. A federal district court in New York found Health Net guilty of cheating their policyholders in setting out-of-network reimbursement rates too low. It turned out that the database that they relied on to set the "usual, customary, and reasonable rates" was created by Ingenix, a subsidiary of UnitedHealth Group, making their rates suspect.

As little as we like to see additional regulations, we have all recently learned that "self regulation" often means no regulation in banking as well as in health insurance. The old saying, "Trust me. I've got your best interest at heart." just does not mean anything when corporate profits are at stake. Perhaps the era of insurers setting artificially low reimbursement rates is finally starting to be reined in. The driver in this court decision was patients seeking care "out-of-network." The patients sought reimbursement from Health Net for the out-of-network payments they made to providers. Additional details on the New York court ruling is on Page 3 of this newsletter.

I believe that a movement is slowly gathering momentum in the United States where doctors are directly billing patients for their services and letting the patient recoup the cost of care themselves from their carrier. While common some 25 years ago, this practice has only started to reoccur as those providing the services learn the true cost of care and are billing patients for those costs and a reasonable profit margin. Counting on an insurer to pay a fair amount for their services has driven many providers out of business, into an employment arrangement with a hospital or other entity, or threatens to do that soon.

It seems this recent federal court decision is evidence that there is tacit support for that approach to reimbursement.

Recent "resets" in the rates for reimbursement by major insurers in California has shown that trying to negotiate rates is fruitless without leverage (market share) so just refusing to deal with the carrier is the only tactic that is viable. The insurers claim that those providers who have dropped out of their networks have had no impact on their networks since there are so many providers still willing to participate. That may be, but many good doctors have closed relationships with their patients and have opted out of the network. Who needs the headache of dealing with the insurers' bureaucracy?

The blue coming over the top of the hill may be the cavalry, not just the "Blues."

On-Call Emergency Services

On another note, we are very fortunate to have Dr. Richard Barry representing COA on the national level. Dr. Barry is COA's First Vice President and is also on the AAOS Board of Councilors representing the Sacramento Valley District and the AAOS Board of Directors. Dr. Barry has personally led the opposition opposing efforts by the AAOS to develop a "Standard of Professionalism (SOP)" on Emergency Room On-Call Services which would have declared it a moral obligation for community orthopaedic surgeons to take call. Representatives of the American Orthopaedic Association (AOA) and the Orthopaedic Trauma Association (OTA) have been pushing the AAOS to develop the SOP. They have also used their influence on the American Board of Orthopaedic Surgery (ABOS) to at least get the ABOS to include a question on their application as to whether you take call. The ABOS says it is only one of many issues they consider when someone applies for board certification or recertification, but it starts a disturbing trend.

COA and other state orthopaedic societies have adamantly opposed these efforts. As a result of that opposition, the AAOS has backed away from the SOP, but continues discussions on developing a position statement that declares on-call service a responsibility for community orthopaedic surgeons. We must, instead make emergency coverage the responsibility of <u>all</u> stakeholders so we can negotiate a fair scenario for the community, the emergency room, and the doctors taking call. If it becomes a moral obligation to take call, you might as well mandate call. Hospitals will have no incentive to work out acceptable arrangements and stipends for your call service. The position statement has the potential to effectively shift the call responsibility which currently lies with the hospital, to the community orthopaedic surgeons. This is unacceptable and will be opposed by COA.

As you can see, it's an important time to be involved and support your state orthopaedic association.

Mark B. Wellisch, M.D.
President

CMA Toolkit on the DMHC Balance Billing Regulations

can be found on COA's website: www.coa.org

Court OKs Health Net deal over out-of-network pay

Reprinted from: AMNews Sept. 22/29, 2008

An opinion in the settlement detailed several "flaws" with a UnitedHealth Group subsidiary's database used industry wide to set physician payment rates.

A federal judge's approval of a $255 million settlement in a case alleging that Health Net used a faulty database to underpay members for out-of-network care may bode well for physicians in their fight against the managed care industry's widespread use of the database.

The agreement resolved three class-action lawsuits targeting Health Net's reliance on Ingenix, a UnitedHealth Group subsidiary that sells a database used by most insurers to determine the usual, customary and reasonable charges for out-of-network services. Plaintiffs alleged that Ingenix underset UCR rates and that Health Net used the database to short-change patients and providers on medical bills.

Health Net admitted no liability but agreed to pay $215 million to more than 2 million members. The company also consented to several business practice changes -- valued at $40 million -- including ceasing use of Ingenix within the four-year expiration date of the agreement in 2012. Until then, Health Net will pay 14.5% above Ingenix-determined rates when reimbursing physicians' or patients' out-of-network claims.

Noting several "serious flaws" with the database, New Jersey District Court Judge Faith S. Hochberg, in an Aug. 8 opinion, said the settlement "raises a clarion call for greater disclosure about the databases used for health care coverage." The pact -- among the largest of its kind -- had changes "that will have a lasting impact" on Health Net's out-of-network reimbursement practices. Health Net promised to:

- Establish a process for health plan members to obtain accurate cost estimates before treatment.
- Negotiate fees with physicians ahead of time to avoid balance billing.
- Set up an independent appeals process allowing patients to contest excessive claims.

Rate-setting a long-standing concern

The settlement echoes concerns long held by organized medicine over insurers' rate-setting tactics and is the latest in a series of actions questioning the integrity of the database. In 2000, the American Medical Association, Medical Society of the State of New York and Missouri State Medical Assn. sued United and Metropolitan Life Insurance, alleging that the database uses unreliable data to determine UCR rates and fails to adequately compensate doctors and patients. The class-action lawsuit is pending in the U.S. District Court for the Southern District of New York. Similar concerns prompted New York Attorney General Andrew M. Cuomo to launch an industry wide investigation into alleged rate manipulations. In February, Cuomo subpoenaed 16 health insurers, including Health Net, that used what he called a "defective" database operated by Ingenix to shift costs to patients. The attorney general also announced his intent to file suit against United but has yet to file suit. United has denied any wrongdoing. The AMA endorsed the ongoing probe.

PROMISES MADE

Health Net agreed to business practice changes aimed at improving transparency in out-of-network claims. In a recent settlement with members, the health plan promised to:

- Stop using an allegedly flawed database run by Ingenix and used industry wide for calculating usual, customary and reasonable charges for health care services.
- Pay physicians and patients 14.5% above Ingenix rates, excluding co-insurance, for out-of-network claims.
- Establish a process for patients to obtain accurate information on usual, customary and reasonable charges before treatment.
- Negotiate physician charges ahead of time to avoid leaving patients responsible for balances higher than the agreed-upon rates.
- Set up an independent appeals process for patients to contest excessive claims.
- Revise explanation of benefits forms, train personnel, and set up a Web portal to provide patients with more accurate coverage information.

Meanwhile, the Health Net settlement puts other insurers on notice and could help set the stage for other such cases, said D. Brian Hufford, an attorney representing Health Net members. "Now there's knowledge and understanding of the defects [with Ingenix], and it's not the black box it used to be," said Hufford, who also is assisting in the AMA's case. "The court's analysis of those problems is something other courts and parties can focus on."

The New Jersey court detailed what it considered "numerous errors" with Ingenix' process for calculating UCR rates, including:

- Compiling data voluntarily submitted by insurers.
- Editing out so-called "high fees" without determining whether the charges are valid.
- Inaccurately standardizing CPT codes.

Hufford said Health Net's move toward transparency will help preserve a physician-patient relationship often disrupted when insurers fail to cover patients' bills and doctors are forced to collect outstanding balances. Health Net spokeswoman Alice Ferreira characterized the settlement as "good news" for patients. "The business practice changes will just add to the transparency in out-of-network claims so we can help patients make better health care decisions," Ferreira said. Health Net is cooperating with Cuomo's investigation, she added.

Neither United nor Ingenix were parties in the Health Net dispute and did not participate in the settlement. A spokesman said United did "not have any obligations arising out of the settlement" but declined to comment further. In past statements, United has stood by the Ingenix database.

Joan Schimml, Ingenix spokeswoman, called the firm's database a "sound tool" for giving health plans "reliable data on what physicians charge," and helping consumers find affordable out-of-network care.

Palmetto GBA Transition

Palmetto Works to Correct Billing Problems - Physicians Continue to Experience Payment Delays

COA continues to work to resolve transition problems with the new Medicare fiscal intermediary, Palmetto GBA. To handle the huge volume of calls that Palmetto GBA is receiving, they have hired 35 additional staff and operators. It seems some of these activities are starting to have an impact as orthopaedic practices are now reporting that they are seeing some reimbursements from Palmetto.

If you are still having problems, some key phone numbers to help you are:

Provider Enrollment—866-895-1520—operators available from 8:00 am—5:00 pm—Pacific Time
Provider Call Center—866-931-3901—operators available from 7:00 am—5:00 pm—Pacific Time

Palmetto's website can also be helpful in resolving many issues. The site is: http://www.palmettogba.com/J1B. Palmetto is in the process of adding a "**Provider Enrollment Application Status Lookup**" to the site under Resources, so you can check the status of your application. In addition, they will have a "**Modifier Lookup**" to help you correctly use modifiers when submitting your claims. You can also select the "**Alert"** section to get information on problems that have been identified and a summary of what actions Palmetto GBA has taken to resolve the problem. It also lists what action, if any, the provider must take. **If after contacting Palmetto GBA you still cannot resolve your issues, please call the COA office - 916-454-9884, and we will assist you.**

Below are some "**Alerts"** currently posted on the Palmetto GBA site that may impact orthopaedic offices:

Incorrect Payments: Locality vs. Zip Code

Background Information: Claims from some providers in certain zip codes, submitted to Palmetto GBA prior to 9/19/08, were reimbursed incorrectly. Reimbursements for these claims were based on incorrect localities associated with the following zip codes: 91896, 91899, 92281, 92283, 92885, 92886, 92887, 92899, 93063, 93093, 93094, 93099, 94303, and 95033. (FYI, COA received complaints from offices in other zip codes, so the problem may be broader than these zip codes listed.) Claims submitted on or after 9/19/08 should be processed correctly.

MAC Action: Palmetto GBA will correct your reimbursement.

Provider Action: In order for Palmetto GBA to adjust payments, please take the following steps:

1) E-mail Palmetto at: J1PCC.contact@palmettoGBA.com; 2) Enter in the subject line: "Zip Code Pricing Request", and 3) Include the provider name, NPI, and PTAN, Zip code involved and include the date range to be adjusted in your message.

Physical Medicine and Rehabilitation Local Coverage Determination

Background Information: Procedure codes in the Physical Medicine and Rehabilitation LCD did not have the correct diagnosis coverage allowing services to be paid/denied incorrectly. The issue was corrected on 9/10/08.

Applies To Procedure Code(s):
97012 97032 97150 97140 97537 97755 G0281
97016 97034 97112 97530 97542 97760 G0283
97018 97035 97113 97532 97597 97761 G0329
97022 97036 97116 97533 97598 97762
97028 97110 97124 97535 97750

MAC Action: A mass adjustment will be performed to adjust the incorrectly paid or denied services.

Provider Action: No Action Required

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Legislative News of Interest

The 2007-2008 Legislative Session has now concluded. Legislators left Sacramento after disappointing efforts to reform health care, resolve budget deficits, and fine-tune the Workers' Compensation Utilization Review process. In spite of the inaction on those issues, medicine was successful in defeating efforts by allied health professionals to expand their scope of practice.

The major fight for orthopaedists was with physical therapists who sought to have direct access to patients without a physician first examining the patient and making a diagnosis.

The California Physical Therapy Association (CPTA) sponsored **AB 1444 (Emmerson)**, a bill which would have **expanded the physical therapists' scope of practice to allow physical therapists to have direct access** to patients. With your help, COA was able to convince members of the Assembly Business & Professions Committee that this bill was unnecessary and could potentially put patients at-risk if there was a delay in diagnosing serious medical conditions which could be the source of the patient's pain. This effort is part of a national effort by the American Physical Therapy Association to position physical therapists as independent practitioners. We are expecting the physical therapists to continue these efforts in 2009.

Another physical therapy bill of interest was, **AB 2111 (Smyth).** For purposes of licensure, this bill would have required physical therapists to be tested in examination and evaluation, diagnosis, prognosis, treatment intervention, prevention, and consultation skills. Several of these areas are beyond the scope of practice of a physical therapist. COA opposed this unnecessary testing and the language was deleted. As amended, the bill was signed into law.

COA supported, **AB 2969 (Lieber)** a bill sponsored by the California Society of Industrial Medicine and Surgery (CSIMS). AB 2969 would have required **physicians performing utilization review under the Workers' Compensation system, to be licensed in California.** California licensure is important so that there is oversight and a remedy should these UR physicians make inappropriate medical decisions. COA had included similar language in legislation we sponsored last year. The bill made it to the Governor's desk, but unfortunately was vetoed. COA will continue to look for ways to make UR physicians more accountable for the decisions they are making.

SB 1115 (Migden) - Discrimination in Disability Evaluations
This bill would have prohibited discrimination on the basis of race, religious creed, color, national origin, age, gender, marital status, sex, or genetic predisposition in any Workers' Compensation disability determination. COA opposed this legislation as being unnecessary. The Governor agreed and vetoed this bill indicating that there are already laws prohibiting discrimination.

AB 2146 (Feuer) - Never Events
AB 2146 would have prohibited reimbursement for hospital-acquired conditions and adverse events. The bill attempted to define which conditions are "never events. " This proved to be very difficult. While there was agreement that a hospital or provider should not be reimbursed for performing the wrong procedure or on the wrong limb, many of the conditions included in the definition, were beyond the control of the surgeon. COA opposed the bill as a result of these concerns. The bill died in Committee.

AB 2794 (Blakeslee) - Leased Diagnostic Imaging Services
This bill will prohibit a physician from charging, billing, or soliciting payment for performance of the technical component of the diagnostic service if the physician did not actually perform the service. This bill is to rein in leasing arrangements in which the physician is leasing time on the diagnostic equipment, but not actually performing the service. COA sought amendments to clarify that the bill would not apply to services rendered within a physician's office. The author accepted COA's amendments. As amended, the bill passed and signed into law.

AB 623 (Lieu) - Certification of Radiologist Assistant
This bill would have created a new category of radiologist assistants with their scope of practice to be defined by the Department of Health Services (DHS). Originally, the bill would have prohibited other physicians from supervising these assistants. It was feared that ultimately, the DHS would define that only these "super" assistants would be able to perform the high-end diagnostic tests; effectively taking those tests out of a physician's office. COA sought an amendment to allow other physicians to supervise these assistants within the scope of their regular practice. The author accepted the amendments, but as amended the radiologists dropped the bill and it died.

SB 1415 (Kuehl) - Medical Record Retention
This bill would have required physicians to provide notice to their patients as to their policy on retention of their medical records. The bill went through many different versions of how physicians would be required to give notice to their patients. All of the versions would have clearly been an additional burden on physicians. While

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News of Interest

Imaging Services

Carrier Denials—Low-Field MRIs

On December 1, 2005, the Medical Policy & Technology Assessment Committee of Anthem (Blue Cross) adopted a policy entitled, "Low-Field and Conventional Magnetic Resonance Imaging (MRI) for Screening, Diagnosing, and Monitoring." Low-field MRIs are defined as MRIs utilizing a magnetic field equal to or less than 0.2 Tesla (2,000 Gauss).

The policy states:

> ***"Blue Cross "Policy Statement"***
> *Investigational and Not Medically Necessary:*
>
> *Conventional magnetic resonance imaging (MRI) when used to screen, diagnose, and/or monitor patients for rheumatoid arthritis or other rheumatologic conditions is considered* ***investigational and not medically necessary*** *as there is insufficient evidence to demonstrate that its use results in improved patient outcomes.*
>
> *Conventional magnetic resonance imaging (MRI) when used for monitoring response to medication for rheumatoid arthritis or other rheumatologic conditions is considered* ***investigational and not medically necessary*** *as there is insufficient evidence to demonstrate that its use results in improved patient outcomes.*
>
> *Low-field peripheral magnetic resonance imaging (MRI) of extremities is considered* ***investigational and not medically necessary*** *when used for diagnosing and monitoring rheumatoid arthritis progression or other rheumatologic conditions as there is insufficient evidence to demonstrate that its use results in improve patient outcomes.*
>
> *Low-field peripheral magnetic resonance imaging (MRI) of the extremities when used for monitoring response to medication for rheumatoid arthritis or other rheumatologic conditions is considered* ***investigational and not medically necessary*** *as there is insufficient evidence to demonstrate that its use results in improved patient outcomes.*
>
> *Low-field peripheral magnetic resonance imaging (MRI) is considered* ***investigational and not medically necessary*** *for orthopedic applications. The available literature does not demonstrate clinical utility."*

When the policy was enacted, it was not a problem. Orthopaedic surgeons continued to get approval for low-field extremity MRIs performed in their offices for Blue Cross patients.

On September 1, 2008, Anthem Blue Cross transitioned the utilization review of their Radiology Quality Management and Utilization Management program to American Imaging Management (AIM). At that time, AIM began to ask physicians when they were requesting approval for an MRI, the magnetic strength of their machine. **Whether medically necessary or not, AIM began to deny requests for MRIs performed on low-field—MRIs of 0.2 or less Tesla for Blue Cross patients based on this policy.**

When members complained, COA contacted AIM and Blue Cross and we were made aware of the above policy. COA members have provided copies of published studies that show low-field MRIs provide good quality scans for extremities. The studies show no statistically relevant differences in the quality of the image between low-field and high-field MRIs for these extremity scans. The studies also show good agreement between comparing the MR results obtained using the low-field extremity MR system to the surgical findings for determination of lesions of the rotator cuff and glenoid labrum.

Based on these studies, COA has requested a meeting with the Alan Rosenberg, M.D., the Vice President of Medical Policy for Anthem/Wellpoint and Chair of the Medical Policy & Technology Assessment Committee to request that this policy be changed to allow reimbursement for low-field extremity MRIs. In the meantime, it is likely that AIM will continue to deny approval for low-field MRIs for Blue Cross patients.

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News of Interest—Imaging Services
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United Healthcare Further Delays Imaging Accreditation

Once again, United Healthcare has announced that it is delaying imaging accreditation requirements planned for the third quarter of 2008. Compliance with the policy will not be a condition for reimbursement until the 4th quarter of 2009.

For several years, United Healthcare has attempted to implement a policy that would only reimburse physicians for specified high-end imaging services including MRIs and CT scans, if the physician's office was accredited.

When this accreditation was first proposed, COA representatives met with United Healthcare and requested different standards for physician offices, performing a limited number and type of MRIs/CT scans versus a freestanding diagnostic imaging center. Currently the accreditation and reaccreditation standards are the same.

United Healthcare recognizes accreditation from the American College of Radiology and the Intersocietal Accreditation Commission.

News of Interest—Coding Changes

CMS Adds New Code for Claim Denials

Based on new Centers for Medicare and Medicaid Services (CMS) instructions, Medicare contractors will now use **Claim Adjustment Reason Code (CARC) #213** to deny claims based on non-compliance with the Stark law prohibition on physician self-referral.

The law prohibits physicians from referring a patient for certain designated health services (DHS) to an entity the physician has a financial relationship with, unless a Stark law exception applies. DHS includes the following categories of services:

- Clinical laboratory services
- Physical, occupational, and speech therapy
- Radiology and other imaging services
- Durable medical equipment and supplies
- Inpatient and outpatient hospital services

Medicare contractors have been instructed to use this code whenever a claim is denied because the physician (or an immediate family member of the physician) has a financial interest in a DHS and the provider fails to meet one of the Stark exception. Penalties for violations include payment denial, refunding of claims and civil monetary penalties.

People in the News

Ramon Jimenez, M.D. of Monterey has been elected to the AAOS Nominations Committee. Dr. Jimenez is the only community orthopaedic surgeon on the Committee. Thank you for your votes supporting Dr. Jimenez.

COA Board of Directors/AAOS/Board of Councilors Election Results

Northern California District
Leslie Kim, M.D. of Daly City, has been re-elected to a second term on the AAOS Board of Councilors.
Michael Klassen, M.D., of Monterey has been elected to the AAOS Board of Councilors for his first term.
Basil Besh, M.D., of Monterey has been elected to the open seat on the COA Board of Directors.

Orange District
In a contested race, **Kent Adamson, M.D**. of Mission Viejo has been elected to the COA Board of Directors.

Los Padres District
Paul Castello, M.D. of Santa Maria has been re-elected to a second term on the COA Board of Directors.

Sequoia District
Robert Cash, M.D. of Modesto has been elected to a second term on the AAOS Board of Councilors.

San Diego District
Richard Brown, M.D. of La Jolla has been elected to a second term on the COA Board of Directors.

L. Randall Mohler, M.D. of San Diego has been elected to a second term on the AAOS Board of Councilors.

Terms will begin in 2009.

Advertisement

Palmetto GBA Transition

Palmetto Works to Correct Billing Problems

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Non-Physician Practitioner Claims for Assistant at Surgery

Background Information: Assistant at surgery claims submitted by Non-Physician Practitioners (Specialties 50, 89, and 97) were rejecting when modifier AS was submitted on the claim. Modifier AS is valid for Non-Physician Practitioners.

Applies to Procedure Codes: All TOS2 Procedure codes.

Modifier(s): AS

MAC Action: The editing in the system has been corrected and claims are processing correctly.

Provider Action: Providers must resubmit services that have rejected for this situation.

Denials: Top Reasons and Procedures

Following are five of the top reasons that services submitted to Palmetto GBA are denied:

1) Noncovered services by a chiropractor—the **only** service Medicare will reimburse, when performed by a chiropractor, is manual manipulation of the spine (CPT codes 98940, 98941, and 98942). Physical therapy and x-rays performed by chiropractors **are not covered by Medicare.**
2) "Non-covered services" - these services are **never covered,** including eye refraction, "well person" exams, and hot/cold packs used in physical therapy.
3) **Bundling** due to "Correct Coding Initiative" - services denied most often for these reasons include: pulse oximetry, heparin, creatinine (blood), and some supplies.
4) **Medicare is secondary**, but the claim was submitted as primary.
5) **Pre and Post-op visits** included in the global surgery days.

The Palmetto GBA "Denial Finder" can be helpful in explaining why a claim has been denied. Again, this is accessed on Palmetto GBA's website.

Please continue to report to COA problems you are having with Palmetto GBA, so we can help you resolve them and bring them to the attention of Palmetto GBA management staff.

Membership in COA is Critical

Ralph DiLibero, M.D., Editor
COA Report

We physicians have tried a diversity of tactics to better brand our purpose and goals in the minds of the American public and now seem to be at a roadblock, an impasse, formed by insurance corporations and big government. We must show that our values create a real sustained worth for all Americans by doing something different right now -- change our strategy. Medical innovations and our doctoring culture tell us what we should do; the leadership of our medical associations outline what we want to do; the medical ecolo-nomics of our time dictate what is possible for us to do; and the blending of these three forces act to show us what we can and will do differently.

We have strong competitors in our medical marketplace. The intentions and behaviors of insurance corporations and big government continually work to tear down our corporate bar on medical practice, invite allied health professions to join in our exclusive scope of practice, eliminate our autonomy, take away our rights such as balance billings, and tear apart our physician-patient relationship -- replacing that sacrosanct union with a insurance corporation-government-patient relationship.

We are limited by various constraints and commitments. New governmental rules and regulations never act in our favor and we are bound by anti-trust laws that forbid our united efforts, yet we hold dear to our pledge and demand professional quality care from ourselves and ultimate preservation of our physician-patient relationship.

We look about and observe the responses of our fellow colleagues. Physicians are changing their mode of practice; we are moving from direct healthcare delivery work to more and more administrative work; and many of us are seeking medical practices outside of the USA. Do we have to accept the lowered societal role that is being thrust upon us?

We must analyze our competitive environment. Physicians still are the only providers of highly specialized healthcare delivery. Competition is fierce in the area of primary care. Should we draw a line in the sand that will be sustainable? Should that line be somewhere between primary care and specialty care? If we take such a course, what will be our competitors' actions and reactions? Will they continue to increase their level of education and class size so that they can continually expand their scope of practice and the number of mid level practitioners available to take over the entire field of primary care? By controlling their own licensing boards, they are escaping the sterner policies of our medical board. Can we make the assumption that if and when we lose control of primary care, the only limiting factor for our competitors will be malpractice premiums? Will the government selectively then give them the tort relief that we have campaigned for over so many years with our time spent and with so many of our dollars spent in political lobby efforts?

We must now formulate dynamic strategies to sustain the principles and prerequisites of a physician-patient relationship. We must examine the word connotations in our popular language that make the physician point of view disagreeable. We have to change an unfriendly message to a friendly message. A patient's right to healthcare should be a patient's entitlement to healthcare; balance billing should be referred to as remittance for amount not paid by underpaid insurance corporate policies. Our profession is not a simple trade or a commodity that can be turned on or off. No surgeon walks away in the middle of an operation and no internist abandons a medical emergency before stabilization. We need an exception from anti-trust legislation so that we can collectively bargain for our patients' quality healthcare. We must rely on our strengths as a united physician community and seal the holes in our armor that show our weaknesses. We must continually seek every opportunity before any window closes, and we must overcome the threats that have been imposed by government and insurance corporations.

We cannot expect rewards without taking some risks. Our newly chosen strategy will need support, vocal and monetary support, from the entire physician community. We can learn, monitor and amend our tactics as we go along, but we must all go along together, as a united effort. That is the essential ingredient necessary for the attainment of our hope and vision of a future goal. Our unity will grant us that sustainable dynamic strategic advantage. **Make a commitment today -- join the COA.**

The 2009 Dues Statements will be mailed to you in November and the COA's Membership Application is on-line at: www.coa.org

When received, please return the statement with your payment promptly so COA can continue to work on issues vital to your practice.

Legislative News of Interest

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current law on the retention of medical records could use some clarification, there was no consensus on the process. COA opposed this bill because it added this new burden on physicians. The bill passed the Legislature, but was vetoed.

AB 425 (Adams) - Safety Helmets—Motorcycles
This bill would have exempted from the motorcycle helmet law, a driver who is 18 years of age or older who has either completed a motorcycle rider training program or has been issued a class M1 license. The AAOS and CMA were instrumental in requiring motorcycle riders to wear safety helmets. The bill failed passage in the Transportation Committee.

AB 632 (Salas) - Whistleblower Protection
This bill clarifies that a physician and surgeon is protected as a whistleblower when information is given to a health care facility, government accreditation committee, or peer review body. A 1999 bill granted whistleblower protection to employees and patients of health care facilities and prohibited a health facility from discriminating against a patient or employee who presents a grievance or cooperates in any investigation against that facility. AB 632 extends those protections to physicians. This bill passed and was signed into law.

AB 636 (Levine) - Acupuncture
This bill would have added the use of "low-level laser stimulation to the modalities that may be performed by an acupuncturist. This therapy would have been performed with a biostimulation laser device designated as a class IIb laser by the FDA. This bill failed passage in Committee.

AB 1436 (Hernandez) - Scope of Practice-Nurse Practitioners This bill would have significantly expanded the scope of practice of a nurse practitioner. The bill attempted to recognize nurse practitioners as independent practitioners and would have authorized them to provide comprehensive health care including making diagnoses and initiating emergency procedures. The Board of Registered Nursing would have been given the sole authority for oversight. The bill was opposed by medicine and failed passage in Committee

SB 981 (Perata) - Balance Billing
This bill was an effort by the emergency room physicians to resolve the Department of Managed Health Care Services' concerns that non-contracted physicians were inappropriately balance billing patients when their carrier refuses to pay the physician's charges. For the last several years, the DMHC proposed regulations which would have prohibited balance billing. The bill would only have applied to emergency room physicians. COA reviewed the bill, but did not ask to be amended into the bill as we were opposed to the principle of not being able to bill patients for the services we render in the emergency room. The bill passed the Legislature, but was vetoed.

In the meantime, the DMHC has approved regulations which declare balance billing to be an "unfair billing pattern." The regulations went into effect on October 15. COA has joined the CMA and other medical specialties in filing a lawsuit asking the courts to declare the regulations illegal, as we believe they exceed the authority of the Department. The DMHC is authorized to regulate health plans, not physicians. Our first court hearing will be in November, 2008. Please see the President's column on Page 1 of this newsletter and the CMA ToolKit for more information on how the regulation may affect your practice.

SB 1379 (Ducheny) - HMO Fines
This bill closes a loophole that allowed health plans to benefit from violating the law. HMO fines will no longer be used to offset the fees they pay to the Department of Managed Health Care. The fines will instead be donated to the Steve Thompson Loan Repayment Program (STLRP) and the Major Risk Medical Insurance Program (MRMIP). STLRP provides loan forgiveness to medical school graduates who agree to practice in underserved areas. MRMIP provides insurance to those with pre-existing medical conditions who cannot obtain coverage in the open market. This bill passed and was signed by the Governor.

AB 1640 (Ashburn) Corporate Ban on the Practice of Medicine This bill would have eliminated the corporate bar on the practice of medicine by affirmatively stating that corporations may have the professional rights, privileges, and powers of physicians. This billed failed passage.

Additional information on legislation COA worked on during the 2007-2008 Legislative Session can be found on COA's website: www.coa.org

ICD-10 Is Coming ...

Since 1979 when the World Health Organization (WHO) developed ICD-9 codes for use worldwide, technology has changed significantly. The ICD-9 codes are no longer descriptive or granular enough and many categories are full. There is a current need to increase quality and facilitate evaluation of medical processes and outcomes while enhancing accurate reimbursement for services rendered. A newer system, flexible enough to quickly incorporate and exact enough to precisely identify emerging diagnoses and procedures is presently in use in the United Kingdom (1995), Nordic countries (1996), France (1997), Belgium (1999), Germany (2000), and Canada (2001). The WHO released this full set of ICD-10 codes in 1994 and has since published them in 42 languages. ICD-10 codes are implemented in 99 countries for morbidity and 138 countries for mortality. The U.S. has implemented ICD-10 for mortality (death certificates) since 1999.

This year, the AAOS is among a list of reviewers of ICD-10 codes that will be released in the U.S. within the next two years. The list of ICD-10 codes is over 17, 000. The system of coding, however, is much simpler.

A seven digit code has a specific designation for each digit such as:

1. SECTION	surgery
2. BODY SYSTEM	orthopaedic
3. ROOT OPERATION	replace
4. REGION	hip
5. APPROACH	limited open
6. DEVISE	prosthesis type
7. QUALIFIER	primary surgery

More information on this new system will be provided as it becomes available.

Welcome to COA's Newest Members

Derek Amanatullah M.D.	Sacramento
Tomasz T. Antkowiak M.D.	Sacramento
Philip Balikian M.D.	Poway
Julian Paul Ballesteros M.D.	Downey
Babak Barcohana M.D.	Van Nuys
Deniz Baysal M.D.	Fresno
Umish T. Bhagia M.D.	West Hills
Karl Buechsenschuetz D.O.	Newbury Park
Alexandra M Burgar M.D.	San Ramon
William R. Campbell M.D.	San Francisco
Joseph R Carney M.D.	Poway
Douglas A. Dennis M.D.	Sacramento
Jamieson Glenn M.D.	Frisco, TX
Frisco Robert Grumet M.D.	Aliso Viejo
Holly J Haight M.D.	Sacramento
Stephen M Hankins M.D.	Loomis
Danny Levi Harrison M.D.	Marina Del Rey
Leonel A. Hunt M.D.	Los Angeles
Jacob H. Ishkhanian M.D.	Rolling Hills Estates
Toby R. Johnson M.D.	Fresno
Andrew C. Karich M.D.	Fullerton
Dimitry Kondrachov M.D.	San Francisco
Lance LeClere M.D.	San Diego
Marvin Lo M.D.	San Francisco
Kyle Low M.D.	La Habra
Steven W Meier M.D.	Newport Beach
Allan K. Mishra M.D.	Menlo Park
James Mok M.D.	San Francisco
Todd J. Oswald M.D.	San Diego
Sachin K. Patel M.D.	Upland
David H. Payne M.D.	Pomona
Soheil A. Payvandi D.O.	Sacramento
Brinceton Phipps M.D.	Mission Viejo
George D. Picetti M.D.	Roseville
Jeffrey A Pratt M.D.	Salinas
Justin D. Saliman M.D.	Los Angeles
Mark L. Schamblin M.D.	Van Nuys
Bindesh Shah M.D.	La Habra
Todd Shapiro M.D.	Bakersfield
Mark Silver M.D.	Downey
Paul M. Simic M.D.	Van Nuys
Shahram Solhpour M.D.	Fullerton
Albert M. Tsai M.D.	Long Beach
Jennifer M. Weiss M.D.	Los Angeles
Ronald B. Wolfson M.D.	Napa

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