



California Society of Pathologists

WINTER 2006-2007

VOLUME 33 No. 1

Annual Report to the Membership

*Submitted by David B. Kaminsky, M.D., FIAC
President*

The year 2006 was active for the California Society of Pathologists. Our ranks continue to increase. We participate actively and assertively in the legislative process. With the unparalleled talents of Dr. Balaram Puligandla and the education committee, we produce superior learning experiences.

The 2006 Annual Report highlights the Society's activities and major accomplishments. The impact of the CSP on the healthcare community is dynamic and continuously evolving.

Legislative Activities

The CSP continues its legislative advocacy. Following is a highlight of some of the issues that were monitored in 2006. Also, the Legislative section of the CSP website, www.calpath.org, provides access to CSP's entire legislative bill tracking activity throughout the year.

Balance Billing

There was a lot of activity in 2006 on the issue of balance billing by non-contracted hospital-based physicians. One was in the form of an appellate court decision, which sparked an Executive Order by the Governor to the Department of Managed Health Care (DMHC).

Appellate Court Decision

An appellate court decision was is-

sued on 2/17/06 that provided a favorable and important ruling on the rights of non-contracted hospital based physicians to balance bill for their portion of the fees that are not paid by a health plan or their delegated medical group.

The ruling came in the case of Prospect Medical Group vs. Northridge Emergency Medical Group which was appealed by Prospect Medical Group after a judgment in the favor of the E.R. group at the trial court level. The case involved a suit by Prospect against a non-contracted emergency medical group that provided emergency services to patients for which Prospect was the delegate of the health care service plan and therefore responsible for those services. There were three issues decided by Court of Appeal in the second appellate district that were raised by Prospect in their appeal.

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1. The Court ruled that section 1379 does not prohibit balance billing when there is no contract between the physician group and the plan or delegated medical group. Section 1379 does protect the enrollee/subscriber of a plan from being billed excess charges by a contracted provider but finding no evidence of a contract the section has no effect. The Court ruled that 1379 only applies to voluntarily negotiated agreements and would not include any "implied contracts."
2. The Court rejected that argument that E.R physicians must accept 100% of the equivalent Medicare payment for the same services and that any charge is excess of that amount was unreasonable. The court noted that Prospect cited no authority statutory



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SOCIETY MEMBERSHIP

Applications for membership can be obtained by writing: CSP Central Office, One Capitol Mall, Suite 320, Sacramento, CA 95814. The Society offers four categories of membership. You can access membership information on-line at www.calpath.org.

or otherwise that would allow them to set that rate or any other as the only reasonable rate. The Department of Managed Health Care (DMHC) did publish a regulation setting forth factors that could be used in determining the rate of payment for non-contracted providers using criteria from a prior court decision in the Gould case. Those criteria included prevailing charges in the geographic area, UCR, providers training etc., but the Court was not persuaded that 100% of Medicare was what was intended.

3. The Court concluded that since Prospect is a delegated medical group and responsible to pay for the services of the E.R. physicians that they could litigate whether or not those charges were in fact reasonable. The case was remanded for that purpose. The Court also dismissed a cause of action against the E.R. physicians wherein Prospect claimed that the act of balance billing was prohibited as an unfair business practice under section 17200 of the Business and Professions Code.

This is obviously a very important decision for hospital based physicians. The CSP has participated in a workgroup assembled by the CMA in an attempt to find an agreeable dispute resolution mechanism between non-contracted HBPs and plans or medical groups.

Governor Issues Executive Order on Balance Billing

In August the Governor issued an Executive Order requiring the DMHC to take action to protect patients from balance billing by non-contracted providers. It would have prohibited balance billing by an emergency service provider for emergency services that are covered by the insured's health plan. That emergency regulation was rescinded the next day with the expectation that the issue would return shortly in another form.

On August 18th the DMHC released a package of regulations that address balance billing establishing a dispute resolu-

tion mechanism for fee disputes between non-contracted physicians and health plans and provides new standards for determining reasonable and customary value for health care services (otherwise known as the Gould criteria). This regulation package is currently in the middle of the normal regulatory process.

The regulation background basically labels balance billing as an unfair billing practice and claims it is within the regulatory authority of DMHC to prohibit such billing. It appears to be narrowly limited to emergency services required to be provided under EMTALA but all hospital based physicians are impacted. The CSP will work with the CMA and other specialty societies in opposing the balance billing prohibition, which may include a legal challenge if the regulation is adopted. Even if the prohibition is limited to emergency services the principal of removing the ability of non-contracted physicians to be fairly paid for their services will shift all leverage to the plans and insurers in any negotiation of reimbursement.

The independent dispute resolution process (IDRP) would be voluntary for physicians and mandatory for plans. A non-contracted provider claims payment dispute would first have to go through the plan's internal dispute resolution mechanism, which is mandated under existing law. DMHC will select an independent organization to administer the IDRP and that organization will establish a filing fee and cost structure for using the system.

The IDRP will be "baseball style" arbitration or final offer model in which both parties would submit their final offer to the arbitrator and the arbitrator must adopt one of those offers as the best approximation of reasonable and customary value for the services. If the non-contracted provider submits an amount that is the same as their original charge then the plan must submit an amount that is at least their original payment plus any additional amount that they feel is warranted based upon the documentation provided by the provider during the plans dispute resolution pro-

CSP Establishes Fund on Balance Billing Prohibition

We have been providing our members with information on the escalating legislative and regulatory effort that would prohibit fair compensation to non-contracted hospital based physicians who choose not to contract with a patient's health plan or their delegated medical plan.

Organized medicine, led by the CMA, has been a focal point in providing a means for discussion, debate and leadership in challenging the Department of Managed Health Care (DMHC) and their regulatory proposals that would eliminate the ability of hospital based physicians to negotiate and enter into contracts on equitable terms. The CSP has been an active participant in those discussions and strategies for challenging the regulations and possible legal action if the regulation package goes forward.

The focus of the effort to restrict physician billing has been on emergency services in the hospital typically within the first 48 hours of admission. The impact on pathology is therefore limited but the principle is too important to ignore. It is fundamental to the freedom of physicians to contract and be fairly compensated for their services.

This kind of effort obviously comes with substantial new costs for legal and media activity and the recognition that the prospects of an ultimate legal challenge to the regulations would be costly. The CMA has established a budget of approximately \$455,000 for the activities related to this issue. They have in turn asked each of the specialty societies to assist in providing funding for this important effort.

The CSP Board strongly endorses the need for the pathology community to contribute financially to this effort. Unfortunately the CSP does not have sufficient reserves to contribute Society funds. We prefer to solicit contributions from our members and contribute aggregate donations directly to the CMA Fund created for this effort. Donations will be used for this purpose only and passed on to the CMA.

We encourage all members to participate and would suggest a contribution by pathology groups of \$100 per group member.

We have provided a form below that can be used by groups to send a contribution for this fund which will in turn be provided to the CMA jointly on behalf of the pathology community. We ask that you discuss this issue within your group and contribute funds at your earliest convenience.

Thank you for your cooperation and support.

Sincerely,

David Kaminsky, MD
President

CSP Fair Compensation Fund

Name _____

Amount of contribution _____

(suggested \$100 per pathologist)

Address _____

Email Address _____

Please make check payable to the California Society of Pathologists.

All contributions will be established in a separate fund that will be aggregated and contributed to the CMA effort of behalf of the CSP.

If Contribution is made on behalf of pathology groups please indicate the name of the group and the members. You may attach a separate list if preferable.

Return to:

California Society of Pathologists

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Sacramento, CA 95814

cess. If the provider submits an amount less than their original charge then the plan can also submit an amount that is different from their prior claim payment amount. Providers are also able to bundle substantially similar claims in a single filing.

The arbitrator must make a determination within 60 days. Within 60 days of the arbitrator decision either party may appeal the decision in civil court. Before a plan can appeal the decision they must pay the arbitrator award to the non-contracted provider.

The last element of the regulation package is to add a new factor to the Gould criteria on how to determine reasonable and customary value of medical services. The Gould Court case established several factors for that determination that included; (1) provider's training and qualifications, (2) nature of the services provided, (3) fees usually charged by the provider, (4) prevailing provider rates in the general geographic area, (5) other aspects of the economics of the provider's practice.

The proposed regulation would add one new criterion, "any other relevant documentation necessary to determine reasonable and customary value." That could include Medicare rates which was presented by the medical group as their preference in the Prospect case that is currently pending in the Ca. Supreme Court over these and other issues for non-contracted providers.

The CSP submitted comments in opposition to all three of the regulation packages. We will remain part of a coalition, led by the CMA, to pursue all means to stop the implementation of this approach to non-contracted physician payment. That may include a legal challenge and certainly alternative approaches via new legislation. We will be contacting our members to encourage contribution to a fund to enable organized medicine to mount these efforts.

We have been informed that the DMHC also intends to announce the availability of a pilot project for IDRPs which will be partially funded by a recent fine paid by Blue Shield to the DMHC.

The pilot program, which is entirely voluntary for both the physician and plan or delegated medical group, contains some of the same elements from the regulation proposal referenced above. Here is a summary of the key elements:

- Voluntary for both the provider and payer for purposes of resolving disputes relating to out-of-network EMTLA services.
- Six (6) month pilot IDRPs
- Providers that use the IDRPs cannot bill the enrollee for services rendered at any time.
- Physician fee to file:
 - \$25 for 1 dispute
 - \$50 for 2-10 disputes
 - \$200 for 11-25 disputes
 - \$300 for 26-50 disputes(Fee is not recouped even if party wins in IDRPs. Hospitals are subject to a different fee schedule)
- (Only disputes that are "substantially similar" can be bundled together for purposes of adjudication and the fee schedule.)

Malpractice insurance that's just what the pathologist ordered

The Doctors Company is now exclusively sponsored by the California Society of Pathologists to provide medical malpractice insurance to its members.

For nearly 30 years, we've remained unalterably committed to protecting the practice of good medicine. With 10 physicians on our 14-member Board of Governors—including our medical director, a pathologist—we possess unique insight into what pathologists need from their insurance company.

Our CSP program benefits include:

- Premium discount for eligible members
- Dividend program
- Broad liability limits
- MediGuard disciplinary risk protection

To learn more about the program we've developed for CSP members, call (800) 352-0320.



- Providers, which include hospitals, have to use the health plan's internal dispute process prior to using the DMHC's IDR. However, a physician can bypass the plan's internal dispute process by paying double the fee listed above.
- Maximus will be the arbitrator. <http://www.maximus.com/corporate/pages/index.asp>
- Payment criteria used by Maximus will be Gould and any other criteria deemed appropriate by Maximus.
- Baseball arbitration. Maximus must choose either the initial payment amount or initial billed amount.
- The specific result of each complaint will not be public but the aggregate data will be.
- Claims "should be" adjudicated within 60 days, if the provider uses the plan's internal dispute process, and 90 days, if the plan's internal process is not used.
- Any additional payment amount ordered by Maximus shall be paid within 15 days of the date of Maximus' decision/order.
- The IDR decision is not binding.
- Advisory Board will have oversight of the IDR. The Board will consist of the following members:
 - 2 payers
 - 2 providers
 - 1 consumer
 - 2 DMHC staff

Direct Billing Legislation

The CSP supported legislation, SB 1369 (Maldonado), that would have required direct billing for all anatomic pathology services has stalled in the Assembly. The bill is now not eligible to be passed this session and would have to be re-introduced next year.

SB 1369 moved from the Senate with little difficulty but various groups had raised issues for changes that indicated the emergence of opposition. Those included a request that the direct billing apply to all lab services, that referring physicians be required to provide all labs with correct billing information on their patients, and exemption from lab to lab

referrals. Whatever the decision on any of these issues brought opposition or support from several groups. SB 1369 was double referred to policy committees in the Assembly and the inability to resolve the issues resulted in deadlines for passage effectively killing the bill.

The CSP has been in contact with all affected groups and has worked over the legislative recess to come up with a new version of SB 1369. A new bill will be introduced in the next Legislative session that begins 1/1/07.

Bill to Mandate Insurance Coverage of HPV Testing

The CSP supported SB 1245 (Figueroa) that requires all health plans and insurers to cover HPV testing when ordered by the patient's health care provider. Current law does require plans and insurers to cover an annual cervical cancer screening test, which includes a PAP smear and the option of any other screening test approved by the FDA. Based upon reports from pathology groups coverage of the HPV test is not consistent among all payers and SB 1245 will help to codify the requirement. The bill was signed by the Governor.

Reform of CA Lab Licensing Law and Grossing of Specimens

Last year CSP informed you of an effort late in the Legislative session to reform some of the provisions of the clinical laboratory licensing law and the activities of unlicensed lab personnel. That effort in

AB 1161 (Niello) did not pass and was bogged down in a discussion of the specific provisions.

This year Assemblyman Niello introduced AB 2156 sponsored by the CA Clinical Laboratory Association to tackle some of those issues. After a series of meetings it became clear that the changes that were agreeable to the various segments of the lab community, including the unions that represent lab personnel, would be very limited. Initially the only included provisions

dealt with recognition of the use of autoverification in the lab and some minor technical changes regarding licensing provisions for histocompatibility lab directors. There was a general reluctance to discuss any issues related to the duties of unlicensed laboratory personnel.

The CSP continued to push for consideration of changes to existing law regarding the grossing of anatomic pathology specimens by histotechs and pathology assistants, both of whom are not licensed under California law. Under CLIA all anatomic pathology procedures are considered to be high complexity testing and, at a minimum, any personnel involved in those procedures must meet the CLIA personnel standards for high complexity testing. A pathologist can delegate dissection to others but they must have an AA degree in lab science/medical laboratory technology or at least 60 hours of equivalent training.

The CAP inspection checklist was amended in April of 2005 to specifically enumerate these requirements. California currently does not define requirements for individuals who assist pathologists whether they hold formal certification as a Pathology Assistant or histotechnologist but lumps them in the broad category of unlicensed personnel. The specifics of what such unlicensed personnel can do under the supervision of a pathologist in the field of histology have to be updated and made specific.

The CSP has proposed two specific categories of change in the unlicensed personnel category:

- I. In the limited specialty of pathology a certified pathology assistant could, under the general supervision of a pathologist:
 - Prepare human surgical specimens for gross description and dissection, including description of gross features and selection of tissues for histological examination.
 - Prepare and perform human postmortem examinations, including selection of tissues and

- fluids for further examination.
 - Gather other information necessary for an autopsy report.
 - Prepare a body for release.
- II. In the limited specialty of pathology a non-certified pathology assistant, histotechnician, histotechnologist, or lab assistant, under the general supervision of a pathologist may:
- Prepare human surgical specimens for gross description and dissection, including description of gross features and selection of tissues for histological examination.
 - A histologic technician or histotechnologist who meets the requirements may accession specimens; perform maintenance of equipment; stain cover slip, and label slides; and process tissues by embedding in paraffin or performing microtomy.

This new language will better describe the current functions of personnel that assist the pathologist in tissue preparation. Though the types of individuals are not licensed in California they must meet the CLIA standard for high complexity testing personnel as described above. We sought a supervision standard that provides the pathologist the most flexibility, since this standard applies in both hospital and freestanding clinical labs. The CSP Board concluded that a supervision standard of being available by phone and not onsite was acceptable for all functions except dissection of specimens. That standard was incorporated in the final language.

The bill was signed by the governor and took effect on 1/1/07.

Bill to Exempt POLs Fails

Lab Field Services announced last year that they would require state licensing or registration for all labs including POLs (physician office labs). A POL is a lab for 5 or fewer physicians who perform testing only on their own patients and do not perform HIV testing or review of pap smears. There has been strong opposition in the physician community to this

additional licensing requirement.

The CMA sponsored the introduction of AB 2452 (Richman) which would have sought to reinstate the exemption from any state fees for a POL. The bill was opposed by many members of the lab community and emphasized the need for equity and appropriate funding for LFS activities. AB 2452 failed passage in the Assembly Business and Professions Committee and is dead for the session. DHS continues to apply as an exempt state under CLIA with CMS whereby they would enforce all CLIA requirements in California.

Extension on Phlebotomist Licensing Requirement

Senate Bill 169 was signed into law by Governor Schwarzenegger on Wednesday, March 29. This bill has extended the deadline for phlebotomists to be certified to January 1, 2007. Current law had required that all unlicensed individuals functioning as phlebotomists on or before April 2003 to submit an application and be approved by April 2006. There was such a backlog of applications that LFS could not have completed the process. Now an application must be submitted by July 1, 2006. There are some limitations that need to be recognized and communicated to your laboratories.

REGULATORY ACTIVITIES

Change on HIV Reporting By Name

All labs approved to perform HIV testing should have received notice via letter from DHS on changes in reporting by health care providers and labs for cases of HIV infection that require use of the patient's name. These changes were contained in SB 699 which was signed by the Governor and took effect on April 17, 2006. DHS will implement within one year emergency regulations governing name-based HIV reporting. These changes take effect even in the absence of the specific regulations. The changes are;

- All test requisition forms transferred to a lab for testing should include the complete patient name.
- Labs are no longer required to assign a Soundex code for a patient's surname or create a Partial Non-Name Code.
- Labs must now report results of confirmed HIV tests using the patient's complete name.
- Confirmed tests must be reported to the health department with jurisdiction over the provider requesting the HIV related test within 7 calendar days of the confirmed test date.
- Labs should also report the confirmed test result to the submitting provider using the patient's complete name.
- There are enhanced penalties for willful or negligent disclosures of confidential HIV information. The Office of AIDS will provide encryption software available for downloading at no charge.
- Go to the Office of AIDS Website at www.dhs.ca.gov/AIDS click on to the A to Z index and click on HIV reporting. There is additional information posted and a Q&A section on security issues.

Medicare National Provider Identifier

CMS has provided additional information on the NPI and revised CMS 855 enrollment process. As a further reminder: Medicare contractors should be notified immediately of any changes from the original enrollment in Medicare, including address, phone number, addition or removal of members of a group, or closing of an office. Prompt notification of changes will help prevent delays in Medicare reimbursements or potential identity theft of closed practices.

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS 855 Medicare provider enrollment applications. As part of the revised enrollment process, initial enrollees and existing enrollees making changes to their enrollment information must include their National

California Society of Pathologists
60th Annual Convention
California Seminars in Pathology
December 5 - December 8, 2007

The Palace Hotel San Francisco, California

2007 TENTATIVE SCHEDULE AT A GLANCE

Wednesday, December 5

8:30 a.m. - Noon
Inflammatory Dermatoses

Speakers:
Scott Binder
Bruce R. Smoller

1:30 - 5 p.m.
Upper/Lower GI

Speakers:
Joel Greenson
Marie E. Robert

5:30 - 7 p.m.
Microscope Tutorials

Marie E. Robert
Patrick A. Treseler

Video Tutorials
Scott Binder

Thursday, December 6

8:30 a.m. - Noon
Endometrial Pathology

Speakers:
George L. Mutter
Charles Zaloudek

Thursday, December 6

1:30 - 5 p.m.
**Selected Topics in
Hematopathology**

Speakers:
Daniel A. Arber
John K. C. Chan
Patrick A. Treseler

Topics:

- ◆ **Problems in BM Pathology**
- ◆ **Lymphoma Dx in Small Bx Specimens**
- ◆ **Update on Hodgkin's Disease**

5:30 - 7 p.m.
Microscope Tutorials

Bruce R. Smoller
Daniel A. Arber

Video Tutorials
Joel Greenson
George L. Mutter

Friday, December 7

8:30 - 9:50 a.m.
**CP Lecture: Bird Flu - What
Pathologists Need to Know**
Speaker:
Sharon L. Reed

8:30 - 10 a.m.
Microscope Tutorials
Christina S. Kong
Tarik Tihan

Video Tutorials
Kirk Jones
Sanjay Kakar

10 - 10:45 a.m.
Business Meeting

11:00 a.m. - Noon
**Special Lecture:
Common Errors in FNA
Pathology**
Speaker:
Richard M. DeMay

1:30 - 5 p.m.
Tumors of the Salivary Gland
Speaker:
John K. C. Chan

Saturday, December 8

8:30 a.m. - Noon
**Slide Seminar: Diagnostic
Problems in Surgical
Pathology**

Moderator:
John Collin
Speakers:
Richard M. DeMay
Patrick A. Treseler
Bruce R. Smoller
John K. C. Chan
Kirk Jones
Teri A. Longacre





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Provider Identifier (NPI) number and a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with the enrollment application. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information. All health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling in or changing their Medicare enrollment data.

If you are an individual or sole proprietor who furnishes health care, you are eligible for one and only one NPI. If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself and an NPI for your corporation or LLC.

If you are an organization that furnishes health care, you may determine that you have components, called “subparts,” that need their own NPI. For additional information about the NPI, please go to <http://www.cms.hhs.gov/NationalProvIdentStand/>.

If you have not yet obtained your NPI number, CMS encourages you to do so soon even if you are not enrolling or making a change to your Medicare enrollment information. An information sheet designed to provide basic information about the NPI, including the three different ways to apply for your NPI is available at: http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet_WWWWH.pdf.

Whatever method you use to obtain your NPI, be sure to keep

this information, share it with your health care partners, and update your information with NPPES whenever any of the information used to get your NPI changes.

Starting May 23, 2007, the NPI will replace all of your existing provider numbers that you use to bill Medicare, Medicaid, and other health care payers. Although this date is still a year away, you should begin sharing this information with Medicare, other payers, and your other health care partners in order to make the transition to NPI as smooth as possible.

For more information about the revised provider enrollment process, please contact your Medicare contractor or go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll>. ■

CSP New Members

Frank Bavuso *Regular Member*
Fort Bragg, CA

Stephen Bechdolt *Regular Member*
Bakersfield, CA

Mark Carter *Regular Member*
Chico, CA

Xuemo (Sean) Fan *Regular Member*
Los Angeles, CA

Brenda Ng *Regular Member*
San Francisco, CA

Calendar of Events

- **From Dr Fred Silva, Executive Secretary of the USCAP:** Our next USCAP weekend course—Practical Pathology Seminars: Cancun, Mexico, May 3-6, 2007.
More information available on the USCAP Website: www.uscap.org.
- **South Bay Pathology Society Spring Meeting:**
Saturday May 5, 2007
Monterey Conference Center, Monterey, California
For enquiries, contact:
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