



California Society of Pathologists

WINTER 2008-09

VOLUME 34 No. 2

New Medicare Carriers for California

We are aware that CMS is attempting to combine the administration of the Medicare Part A and Part B programs by converting to one entity to handle claims payment for both types of claims. The new entity is referred to as a MAC (Medicare Administrative Contractor). CMS believes that by consolidating these functions it will be more efficient and cost effective. NHIC had been processing Medicare Part B claims in Jurisdiction 1 that includes California while Part A claims for services provided by hospitals, SNFs and other institutions were processed by another carrier.

CMS awarded the contract for California and other western regions

The CSP has worked with a number of individual members in attempting to resolve major problems...

to Palmetto, based in South Carolina. That transition began in early September. There have been major problems for all physicians since the transition with a lack of timely payment and provider enrollment issues.

The CSP has worked with a number of individual members in attempting to resolve these major problems in pathology groups not receiving payments. There was a major problem identified in paperwork for group enrollment changes and legacy NPI num-

bers that was never completed. As a result some pathology groups went without Medicare payments for months. Independent lab place of service payments were also inappropriately denied for a period of time.

The CSP continues to work with Palmetto representatives to resolve pathology and specific member issues. ■

Mark Your Calendar

California Society of Pathologists

62nd Annual Convention

"Seminars in Pathology"

December 2 - 5, 2009

Hyatt San Francisco in Embarcadero Center

San Francisco, CA

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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.

Healthcare Reform Legislation

There was an attempt to enact health care reform based upon an alliance between the Governor and then Speaker of the Assembly Fabian Nunez. That framework included coverage for about 2/3rds of the uninsured by focusing on employees and exempting the self employed and unemployed. The final version would require employers to either provide insurance or pay into a state fund that would offer it to uninsured workers and those who can't afford policies. Neither version contains the 2% fee/tax on physician revenues contained in the Governor's plan that was released but never introduced as actual legislation.

The Democrats plan would now require all businesses to pay at least 7.5% of payroll on healthcare or pay into a fund that provides coverage. The plans would exempt the self-employed and any business with gross revenues of \$100,000 or less per year and with two or fewer employees.

The legislation ultimately failed passage earlier this year in the Senate Health Committee with many Senators expressing concern

about the growing state budget deficit and the ability of the state to absorb any new programs.

There was an announced effort by the Governor late in the session to resurrect a portion of the elements of his reform package but it was never actually placed in legislation. Meanwhile the Governor again vetoed Sen. Kuehl's SB 840 universal healthcare proposal via a single payer.

The need for healthcare reform at both the state and national level will continue to be a high profile policy issue. The continued economic pressures will likely make that goal unattainable in the next year. ■

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Legislation to Expand Patient Access to Medical Records

SB 1415 by Senator Kuehl, Chair of the Senate Health Committee, as introduced would have required all physicians outside of the hospital setting, to retain medical records for 10 years, inform patients that they are archived, and notify all patients with records 60 days in advance of the physicians intent to destroy records. The author had heard from constituents who were unable to access their prior records because the physician practices had closed and destroyed their records.

Existing law allows patient access to medical records but there is no statutory retention period or requirement for notice to patients prior to destruction. In some respects the creation of a statutory minimum might have been helpful.

There are specific retention periods for certain types of lab records and specimens. The CSP, along with other medical specialties, met with the author to express our concerns with the breadth of this new mandate and its effectiveness.

The author initially agreed to remove everything from the bill but the requirement to provide notice to all patients of the physician's record retention policy, e.g. how long they retained them, and a requirement to provide notice to all patients if they intended to destroy the records before that time period had elapsed.

The CSP advocated successfully to exempt pathologists and clinical labs from even this requirement to notify since reports on your services are provided to the ordering physician and are part of their

medical record. You are also likely to see thousands of patients over the likely time retention period and it would be an onerous requirement to contact all of those patients. SB 1415 exempted a health care provider, "For medical records that are created for a patient who is referred to the provider solely for diagnostic evaluation if the provider does not provide treatment to the patient and reports the results of the diagnostic evaluation to the patient's referring provider."

SB 1415 passed the Legislature but was ultimately vetoed by the Governor. He vetoed a high percentage of bills that he deemed not immediately necessary for policy or practical reasons. ■

Medi-Cal Provider Rate Cuts and the State Budget Meltdown

The California Legislature struggled through a budget deficit of record proportions in 2008. The Governor called a special session in January to request the Legislature to adopt mid-year spending corrections to address a current fiscal year shortfall of \$4 billion and a then-projected additional deficit of \$8 billion for the fiscal year beginning July 1, 2008.

The Legislature and Governor approved mid-year spending reductions that include a 10% provider rate cut that will take effect on July 1, 2008. They also included delays in check writes for June and no check writes in August for "institutional" providers. Independent clinical labs are considered "institutional" provid-

ers. The legislation called for the last two Medi-Cal check writes in June to be delayed and paid on July 2, 2008.

There were further delays when the Legislature failed to adopt a budget by the June 15th deadline. That period of deadlock extended into September before a deal was struck. Most agree that the budget was based upon unreal expectations and the Governor has called yet another Special Session to deal with a current budget shortfall of \$10-12 Billion.

One of the other mid-year budget fixes adopted by the Legislature and the Governor in March was a 10% Medi-Cal provider rate cut. That 10% cut took effect on July 1, 2008.

The CSP was part of a coalition of health care groups in the Alliance

for Patient Care (APC) that fought these cuts. The APC was able to intervene in federal court to obtain injunctive relief that stopped the 10% cut for physicians of August 18th. It did not stop the 10% reduction to the Medi-Cal rates for freestanding clinical labs. That decision is being appealed by the state. The budget signed by the Governor in September would continue the 10% cut until March 1, 2009 and then reduce it to a 1% provider rate cut for both physicians and clinical labs. Obviously the Court injunction prevents any cut to physician rates. ■

Balance Billing by Non-Contracted Hospital Based Physicians

The Legislature and Department of Managed Health Care (DMHC) have continued to scrutinize potential changes to the ability of non-contracted hospital based physicians to balance bill enrollees of plans or delegated medical groups that have contracts with their hospitals.

This issue has been the subject of multiple legislative proposals and DMHC regulatory proposals over the past five years. The discussion has centered on “emergency services” or those services rendered to patients who enter the hospital through the ER and arrive at a hospital that is contracted to their plan but later discover that one or more hospital based physicians do not have contracts. The problem for hospital based physicians, other than ER, extends beyond emergency services since most services don’t fall into the “emergency” category.

DMHC has issued two previous regulation packages to make balance billing illegal as an “unfair billing practice”. Previous versions would have banned balance billing but provided an interim payment standard of 150% of Medicare rates to the physician with arbitration available if the physician sought to challenge that amount. The interim payment would be provided to the physician pending a baseball style arbitration between the physician and plan or delegated medical group as to what is a reasonable payment amount. That regulation was withdrawn in March and replaced with a new version with a comment period that extended to May 12, 2008. That regulation would ban balance billing and establish an arbitration system, but with no interim payment standard. The CSP submitted comments in opposition to this regulation.

Meanwhile there were several bills that sought to resolve this issue by arbitration mechanisms. Some contain an interim payment standard and apply the provisions to only emergency services in the hospital or

all hospital based services. There is support from the Governor and some Democratic leaders to find a solution to this issue and remove the patient from the middle of a dispute between hospital based physicians and health plans or delegated medical groups.

Senate Majority leader Don Perata authored SB 981 which was sponsored by the emergency physicians and had existed in various forms. SB 981 was amended at the end of session to ban balance billing by HBPs but only applied to emergency room physicians who provided emergency

The CSP has joined with the CMA and other physician speciality groups in filing legal action in Sacramento Superior Court

services provided in the emergency room setting. It set an interim payment standard of 250% of Medicare and was sent to the Governor. It was opposed by the CMA and health plans. The CSP took no position since it did not impact pathology. The bill was vetoed by the Governor in September.

AB 2220 (Jones) would have offered a new version of a solution. In the situation where a hospital has a contract with the plan or delegated medical group but the hospital based physician does not, the hospital could request that the physician group and plan enter into binding arbitration to resolve the contract issues. It would apply where the patients of that plan or delegated medical group account for 5% of the patient base of the physician group. AB 2220 was passed

by the Legislature but was also vetoed by the Governor. One major legal issue with this approach is whether you can require binding arbitration for two parties who do not have a contract or are otherwise contractually bound.

The Department of Managed Health Care (DMHC) filed a third version of a regulatory package that would ban the ability of non-contracted hospital based physicians to balance bill enrollees of plans or delegated medical groups that have contracts with their hospitals. It would apply to emergency services and would define balance billing as an unfair billing practice. This regulation version would ban balance billing, establish an arbitration system, but with no interim payment standard. The CSP submitted comments in opposition to this regulation. The Office of Administrative Law approved the regulation on September 15, 2008 and they take effect 30 days later on October 15, 2008.

The CSP has joined with the CMA and other physician specialty groups in filing legal action in Sacramento Superior Court last Friday. The CSP provided some funds for the effort but is not a named plaintiff in the lawsuit. The writ petition will seek to compel the DMHC to repeal the regulation, a declaration that the regulation is invalid, and an injunction prohibiting the DMHC from enforcing the regulation. This suit however does not seek a Temporary Restraining Order since the writ petition can be heard shortly after the regulation takes effect. We will provide further guidance on what changes HBPs should make in billing patients of non-contracted plans or RBOs until the legal challenge is completed. A hearing is to be held on November 21, 2008 in Sacramento Superior Court.

We realize that non-contracted HBPs will have questions as to what they can do legally in terms of billing patients prior to a Court determination of the validity of the prohibition on balance billing. The CMA

has prepared a tool kit that answers these practical issues and we have placed a link to that material on the CSP website at www.calpath.org.

Meanwhile we still await the decision from the California Supreme Court that accepted the Prospect Medical Group case for hearing last year. Oral arguments were heard in early November and a decision is expected next spring. The case is an appeal of a decision in favor of an emergency medical group against a medical group with which they had no contract.

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.

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 the 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 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, 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.

The Supreme Court ruling is crucial to this issue and the CMA has filed an amicus brief in support of the emergency medical group. ■

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Proposed Amendments to CSP Bylaws Regarding the Education Committee

The Board of Directors has reviewed the existing bylaws provisions describing the duties of the Education Committee and proposes the following amendments. The new language is in *italics* and any deleted language is noted with a ~~strikeout~~.

Article XI Section 2

An Education Committee shall be appointed by the President. This committee shall plan the scientific and other programs of the meeting.

The Education Committee is charged with the planning and development of the Annual Meeting and other scientific programs. The Committee shall meet at least two times per

year upon the call of the chair.

The Committee consists of no more than ten (10) members of the CSP with at least one (1) and no more than three (3) who shall be members of the Board of Directors. The Chair shall be chosen by the Board for a term of three (3) years. The Chair may serve more than one (1) term and shall act as the liaison between the Committee and the Board.

The term for each member of the Committee shall be three (3) years. Individuals can serve additional terms subject to nomination by the Chair and confirmation by the Board. The terms of members shall be staggered so that there are no more than two potential vacancies per year.

Candidates for vacancies will be

nominated by the Education Committee members and submitted by the Chair to the Board for confirmation.

The Chair is responsible, with assistance from the CSP staff and the Education Committee members, for maintaining CME accreditation for the Annual Meeting. ■



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Bills Introduced to Modify Prohibition on Hospital Employment of Physicians

There were three bills introduced dealing with the ability of either district hospitals or any acute care hospital to employ physicians. There is an aggressive movement by both the association of district hospitals and unions to alter the current restriction. They base the need for change on their difficulty in recruiting physicians to rural district hospitals which also often have a high Medi-Cal patient census.

There is an existing pilot project authorized by statute 3 years ago that expires in 2011 to allow a limited number of district hospitals to employ a small number of physicians. A report was due this fall from the Medical Board on the effectiveness of this pilot program and it was released last month. This pilot allows district hospitals that are in a county with a population of 750,000 or less, had reported net loss in 2000-01 and have at least 50% combined patient days from Medicare, Medi-Cal and uninsured patients to collectively employ no more than 20 physicians statewide and no more than 2 at any one hospital.

The CSP initially opposed all three bills as introduced but worked on amendments with one author on a more modest adjustment to the existing pilot project for district hospitals. All of the bills, as does current law, prohibit the interference with the medical judgment of the physician by the hospital or lay entity. We argued that the control established through the employer/employee relationship can be more subtle and this is an important public policy protection for patients that should not be substantially altered. The difficulty in

recruiting to rural hospitals can involve a variety of factors, not the least of which is inadequate reimbursement from government programs to sustain a physician practice.

SB 1640 (Ashburn) would have repealed the prohibition for any acute care hospital in a medically underserved area. The CSP joined with

*We expect that
this issue will be
revisited in the next
Legislative Session
beginning in
January 2009.*

the CMA in opposing this bill and defeated it twice in Senate Business and Professions Committee.

AB 1944 (Swanson) was sponsored by the district hospitals and had strong union support. It passed the Assembly over our opposition. AB 1944 would repeal the prohibition for most district hospitals with a specific proviso that the hospital

can't interfere with the medical judgment of any physician so employed. We eventually were able to defeat the bill in the Senate Health Committee by a narrow margin.

The CSP supported SB 1294 (Ducheny) which passed the Senate but ultimately failed passage in the Assembly Appropriations Committee due to the opposition of some unions. That argued that the bill was too narrow. It was a more modest approach and a reasonable modification of the existing pilot. SB 1294 would have extended the pilot to 1/1/2016 for certain district hospitals to employ a limited number of physicians. It would delete the population minimum of 750,000, require a net operating loss in the year of the physician recruitment, allow the Medical Board to raise the cap to more than 20 statewide and, on a case by case basis, allow an individual district hospital to employ more than 2 physicians.

We expect that this issue will be revisited in the next Legislative Session beginning in January 2009. ■

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Practice Management Members

The Practice Management Committee has continued to confer on Medicare and Medi-Cal claims processing issues.

The CSP also had extensive dialogue with Blue Shield Medical Policy staff over new numerical limits on the prostate and other biopsy specimens. Their policy initiated earlier this year would have limited the number payable to 6 and required the pathologist to appeal any number in excess of 6. After extensive discussion Blue Shield has amended their internal guidelines to address our concern. There is now no published numerical edit but we have been assured that the number was increased to reflect

common practice. We will continue to monitor claims experience and revisit the issue if necessary.

We will have a Practice Management Session on Friday afternoon from 1:30 to 3:30 during our Annual Meeting.

The CSP continues its efforts to build a database of individual pathology practice managers. If you would like to have your group manager become involved as an Associate Member

simply call the CSP office or go the CSP website at www.calpath.org. The membership information is available on the website under the membership section.

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