December 2012

The Official Publication of the Dade County Medical Association

Happy Holidays

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Twenty-seventh Annual

Sanford H. Cole, M.D. Memorial Ob/Gyn Symposium

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Continuing Medical Education
DCMA AND THE FMA LEGISLATIVE AGENDA

by Elizabeth Etkin-Kramer, M.D.

A long with being president of the DCMA, I am privileged to serve on the FMA Council on Legislation.

The Council met recently to review the legislative recommendations from the 2012 House of Delegates and the results of previous legislative sessions, specifically the 2012 Florida Legislative Session. The Council developed a draft legislative agenda and presented their recommendations to the FMA Board of Governors at their October Board meeting.

During their meeting, the Board of Governors finalized our legislative agenda for the 2013 Legislative Session, and I am happy to report that many of the issues that have long concerned us in South Florida have made the cut! As a result, DCMA and FMA will continue to work together on issues affecting the practice of medicine and patient care in Miami-Dade County.

The DCMA and FMA plan to support:

• **Real Time Eligibility For Medical Coverage:** Despite existing legislation designed to protect proper reimbursement, there is a loop hole often used by managed care companies in denying physician reimbursement. Managed care organizations sometimes claim that despite appropriate preauthorization for services or medical devices, a patient's insurance was not really “active” when care was provided or that the patient's policy didn’t cover the service. As a result, even though the service was approved and even completed, the provider is denied payment. The DCMA and FMA will seek legislation requiring managed care organizations to provide real time subscriber eligibility and reimburse providers for patient services assuming subscriber eligibility has been appropriately confirmed prior to the delivery of care.

• **Tort Reform:** The DCMA and FMA will support legislation permitting defendant providers in a medical liability suit to discuss the case with plaintiff’s other treating providers.

• **Medicaid to Medicare:** The DCMA and FMA will support legislation to increase the Medicaid reimbursement rate to that of Medicare, and will seek to ensure that physicians have the opportunity to control the disbursement of Medicaid funds in any type of capitated system.

• **CAT fund:** Current laws that exclude the taxing of medical liability insurance premiums to provide monies for the Florida Hurricane Catastrophe Fund are “sun-setting” and set to expire in 2013. Unless the exclusion is extended, liability insurance premiums will increase because of the increased tax. The DCMA and FMA will seek a permanent exemption for medical malpractice insurance premiums from any CAT fund assessment.

• **Appropriate Payments for Vaccines and Vaccine administration:** The DCMA and FMA support physician reimbursement for vaccines and vaccine administration to be above the average cost of the vaccine plus an additional percentage amount. The DCMA and FMA plan to oppose:

• **Medicaid Pilot Project Expansion:** The DCMA and FMA oppose the statewide expansion of the Medicaid Pilot Project that would effectively move almost every Medicaid patient into a Medicaid HMO. The DCMA and FMA will also oppose any effort to mandate Medicaid participation as a condition for physician licensure.

• **Balanced Billing:** The DCMA and FMA oppose imposition of any new restrictions on the ability of a physician to bill patients directly for the costs of care that are not fully covered by their insurance policy.

• **Protect The Right To Self- Insure:** Current laws allow physicians to self- insure. The DCMA and FMA will oppose any legislation that will limit or otherwise restrict a physician’s right to self-insure or that would make it more difficult for a physician to satisfy financial responsibility requirements for licensure.

• **Mandatory Participation In Health Networks:** The DCMA and FMA will oppose legislation that would require participation in a health care delivery system in order to maintain physician licensure.

• **Limits On Physician / Patient Conversations:** Last year, we watched as the legislature tried to censure communications with our patients and prohibit questions regarding gun ownership. The DCMA and FMA oppose any legislation that interferes or restricts the types of conversations that a physician can have with their patients or patient’s guardian.

These are just some of the issues that that have made it onto the 2013 DCMA and FMA legislative agenda. Additional information can be obtained on the DCMA website: Miamimed.com. As you read the agenda, many of you will nod your head and you will be pleased that the DCMA is working with the FMA to tackle issues that affect the quality of care that you provide and your ability to practice medicine.

But remember, the success of this agenda requires all of our participation. Don’t be a silent beneficiary of the hard work of others. The DCMA needs your membership and your help. We are one unified voice. Make sure you are a member of the DCMA. Participate in committees. Help us voice our issues in Tallahassee. If we work together we can make a difference!
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More Questions from Our Electronic Mailbox

By: Robert J. Conroy, Esq.1 & Denise Sanders, Esq.2

Every day we are asked a number of questions. We thought we would address some of the more recent and interesting ones in this article. The selection is admittedly somewhat eclectic. If you have a question, you would like to see addressed in a future article please email me at rconroy@drlaw.com.

Are Repayments to a Payor Tax-deductible?

Question: I have been sued by a third party payor for billing fraud. We are about to enter into a settlement which will require me to repay over $300,000 to this insurer. Is there a way that I can deduct these payments on my income taxes?

Answer: Yes, it is possible to deduct these payments. However, there are a number of conditions that must be met. It is extremely important during settlement negotiations that your counsel consults with a tax attorney to review the tax consequences of the agreement and to craft language that will make it more likely that the IRS will allow a deduction. Generally, the IRS will not allow a deduction for criminal or civil fines and penalties but may allow deductions for restitution paid to third party payors, including Medicare and Medicaid. Most recently, our tax department obtained a ruling allowing a $4 million deduction for a client.

Remember, the tax consequences of any settlement agreement should be reviewed during the negotiation of the agreement or, if a judgment is obtained from the court, counsel should ask for language that will provide the best tax result for the physician.

OIG “Work Plan,” Who Cares?

Question: Why should the OIG’s annual “work plan” matter to me?

Answer: The Office of Inspector General (OIG) of the U.S. Department of Health & Human Services (HHS) releases its Work Plan for each upcoming fiscal year and recently released its FY2013 Work Plan: http://ow.ly/eJeY2. The Work Plan provides “brief descriptions of new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations during the next 12 months and beyond.” In other words, it is a guidebook for determining what service areas the OIG is currently reviewing for audit and enforcement purposes, and where the OIG is focused for future oversight. When a service you typically provide is in the Work Plan, you should make sure your practice is abiding by Medicare’s requirements for the provision and billing of that service. This year, there is something for everyone:

- Medical Review of Part A and Part B Claims Submitted by Top Error-Prone Providers – review Medicare Part A and Part B claims submitted by error-prone providers to determine their validity, project our results to each provider’s population of claims, and recommend that CMS request refunds on projected overpayments
- Improper Use of Commercial Mailboxes - determine the extent to which Medicare Part B providers and suppliers had practice locations that matched commercial mailbox addresses
- Payments to Providers Subject to Debt Collection - review providers and suppliers that received Medicare payments after CMS referred them to the Department of the Treasury for failure to refund overpayments and the extent to which they ceased billing under one Medicare provider number but billed Medicare under a different number after being referred to Treasury
- Physician-Owned Distributors--High Utilization of Orthopedic Implant Devices Used in Spinal Fusion Procedures - determine the extent to which physician-owned distributors (POD) provide spinal implants purchased by hospitals and are associated with high utilization of such implants
- Anesthesia Services--Payments forPersonally Performed Services - review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare rules and whether Medicare payments for anesthesiologist services reported on a claim with the “AA” service code modifier met Medicare requirements
- Ophthalmological Services--Questionable Billing – identify questionable billing for ophthalmological services during 2011 and review the geographic locations of providers exhibiting questionable billing for ophthalmological services in 2011
- ASCs--Payment System - review the appropriateness of Medicare’s methodology for setting ASC payment rates under the revised payment system and whether a payment disparity exists between the ASC and hospital outpatient department payment rates for similar surgical procedures provided in both settings
- ASCs and Hospital Outpatient Department--Safety and Quality of Surgery and Procedures – review the safety and quality of care for Medicare beneficiaries having surgeries and procedures in ASCs and hospital outpatient departments
- Electrodiagnostic Testing--Questionable Billing – review Medicare claims data to identify questionable billing for electrodiagnostic testing and determine the extent to which Medicare utilization rates differ by provider specialty, diagnosis, and geographic area for these services

1Mr. Conroy is a member of the bar in Florida, New Jersey, New York, California, Pennsylvania, Massachusetts and the District of Columbia.
2Ms. Sanders is a member of the bar in New Jersey and Pennsylvania.
• Diagnostic Radiology--Medical Necessity of High-Cost Tests - review Medicare payments for high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialists for the same treatment

• Laboratory Tests--Questionable Billing in 2010 - identify questionable billing for Part B clinical laboratory tests in 2010

• Physicians and Other Suppliers--Noncompliance With Assignment Rules and Excessive Billing of Beneficiaries - review the extent to which physicians and other suppliers fail to comply with assignment rules and determine to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare

• Physicians--Error Rate for Incident-To Services Performed by Non-physicians - review physician billing for “incident-to” services to determine whether payment for such services had a higher error rate than for non-incident-to services

• Physicians--Place-of-Service Coding Errors - review physician coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the places of service

• E/M Services--Potentially Inappropriate Payments - determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations and review multiple E/M services for the same providers and beneficiaries to identify electronic health records documentation practices associated with potentially improper payments

• Evaluation and Management Services--Use of Modifiers during the Global Surgery Period - review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during such a period met Medicare requirements

• Chiropractors--Part B Payments for Non-covered Services - review Medicare Part B payments for chiropractic services to determine whether such payments met Medicare requirements

• Claims Processing Errors--Medicare Payments for Part B Claims With G Modifiers - determine the extent to which Medicare improperly paid claims from 2002 to 2011 in which providers entered GA, GX, GY, or GZ service code modifiers, indicating that Medicare denial was expected

• ESRD--Medicare’s Oversight of Dialysis Facilities - assess Medicare’s oversight of facilities providing outpatient maintenance dialysis services to Medicare beneficiaries with ESRD

• ESRD--Bundled Prospective Payment System for Renal Dialysis Services - review Medicare pricing and utilization related to renal dialysis services under the new bundled ESRD PPS for renal dialysis services and determine whether Medicare payments under the new ESRD PPS were made in accordance with Medicare requirements

• Patient Safety and Quality of Care--Off-Label Use of Medicare Part B Drugs - review off-label and off-compendia use of certain Medicare Part B prescription drugs and determine the extent to which specified compendia provide support for coverage

• Payments for Outpatient Drugs and Administration of the Drugs - review Medicare outpatient payments to providers for certain drugs and the administration of the drugs to determine whether Medicare overpaid providers because of incorrect coding or overbilling of units

Kern Augustine Conroy & Schoppmann, P.C., Attorneys to Health Professionals. For more than 30 years the firm’s practice has been solely devoted to the representation of health care professionals. The authors may be contacted at 800 445 0954 or via email – rconroy@drlaw.com. For more information log on to DrLaw.com

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It Hurts: The Patient with Noncancer Pain

By: Susan Shepard, MSN, RN, Director, Patient Safety Education, The Doctors Company. Updated by Howard Marcus, MD, FACP, Chair, Texas Alliance for Patient Access, and Chairman, The Doctors Company Texas Physician Advisory Board.

The patient’s pain started on an otherwise normal day—another day of hard work as a certified nurse assistant who frequently did more physically demanding work than she should. She awoke with excruciating pain in her back. When she called her family physician, she was told that she didn’t need to be seen, that she just needed to rest and use NSAIDs for a day or so.

Fast forward a few years. The patient, still in the same job, injures her back again, overexerting herself at work. This time, the pain doesn’t go away. The patient is seen by multiple physicians, none of whom alleviate the pain to the patient’s satisfaction, despite ever-increasing doses of opioids.

Does this patient seem familiar to you? She represents your patient in the emergency room, who hears the nurse say quietly, “There’s another drug seeker in bed two.” Or, he is the patient in the exam room who digs in his heels and insists that he has to take multiple doses of Vicodin just to get through the day. Or, she is the customer in the pharmacy being lectured about the dangers of addiction to narcotics. Treating the patient with chronic pain can be difficult, frustrating, and even dangerous—not only to the patient, but also to you.

Facts and Figures

Twenty percent of the general population is significantly affected by chronic nonmalignant pain (CNMP). According to Doris K. Cope, MD, a member of the American Society of Anesthesiologists’ Committee on Pain Medicine, the most common types of chronic pain include headaches, back pain, and joint pain.

The Dilemma

Patients want relief from pain while physicians are often concerned about longer-term issues concerning opioid abuse. Patients with untreated pain may feel that the physicians they consult are unfeeling, paternalistic, judgmental gatekeepers, while physicians must be alert to patients with a high potential for substance addiction. In addition, physicians deal with feedback from pharmacists about over-prescribing, pressure from reimbursement channels to hold down costs, bad experiences with other opioid patients, and the knowledge that some of their colleagues have been punished by state medical boards and even indicted for prescribing opiates.

Opioid Use Is Skyrocketing

In the past 10 years in the U.S., prescriptions for hydrocodone and Oxycodone have increased by approximately 300 percent, while the number of opioid-related deaths has increased fourfold. There are tragic reports of iatrogenic inpatient opioid-related deaths from opioid analgesics. Opioids are now number one on the list of drugs implicated in medical malpractice litigation.

Guidelines

Physicians who treat acute and chronic pain need to be comfortable and secure in their competency. Physicians need to be cognizant of correct dosing guidelines, which may have dramatically changed in the past decade. For example, current dosing recommendations for Dilaudid are much lower than previous recommendations. Before prescribing opioids, physicians need to obtain a patient’s history of any substance and alcohol abuse, his or her psychiatric history for anxiety or depression, and any comorbidities, such as obstructive sleep apnea.

References


The Doctors Company, the nation’s largest insurer of physician and surgeon medical liability, goes beyond a superior legal defense for members facing a claim. We created regional Litigation Education Retreats to help members who are involved in a malpractice claim.

Each retreat provides a safe and supportive environment for physicians and their spouses to become familiar with the litigation process and to learn constructive methods for alleviating stress and anxiety. It’s also a valuable opportunity for them to meet others experiencing a claim.

To learn more about our unique program and how attending a Litigation Education Retreat helped one physician, visit www.thedoctors.com/lere watch our six-minute video, or visit www.thedoctors.com. Participating physicians may also be eligible for up to 6.5 CME credits.

The struggling economy continues to put a strain on health care services, and serious issues involving the doctor-patient relationship can occur when patients don’t pay their co-pays or when they refuse to pay their physician charges. What is an appropriate response when an established patient comes in but is unable to pay?

It is always advisable to talk to the patient first. Investigate why the patient isn’t paying the bill; in other words, is he or she unhappy with the care? After that you can consider alternative financing options, including bill collection.

It is helpful to have a written policy summarizing the practice’s policy on financial matters that you give to each patient at the initial visit. A physician has the right to expect payment for services rendered. The practice should have a policy and apply it consistently in a nondiscriminatory fashion. When you can, “remind” a patient that he or she received a copy of your policy at the time of the first visit. It makes handling this type of difficult situation easier.

If a patient did not come to you as a result of a referral from an Emergency Department and you have an established policy of not accepting patients who cannot pay, you can refuse to establish the doctor-patient relationship. Potential patients should be given some indication of your practice’s financial requirements when they make an initial appointment for treatment. A process in which the biller checks the status of coverage before the patient comes in can expedite your decision on whether to accept him or her as your patient.

If you decide to terminate the doctor-patient relationship for nonpayment, you must follow a formal process that includes giving the patient proper notice and treating emergencies in the interim. For more information, please reference the article “Terminating Patient Relationships” under Practice Guidelines at www.thedoctors.com/patientsafety.
Medicare recovery audit contractors receive a contingency fee of 9% to 12.5% of any overpayment they find but must return that money when a determination is overturned on appeal. Physicians and hospitals have a record of success when appealing RAC overpayment decisions, according to an analysis by the Centers for Medicare & Medicaid Services for fiscal 2010. The Medicare agency reported that:

- 8,449 determinations, or 5% of all cases, were appealed by physicians and other health professionals in 2010.
- 3,902 cases were overturned in the doctor’s or other health professional’s favor, which represented a 46% success rate.
- $2.6 million in recoveries was returned to physicians or other health professionals as a result of appeals.

Source: “Implementation of recovery auditing at the centers for Medicare & Medicaid Services,” CMS
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Department of Health, Medical Quality Assurance will verify a practitioner's continuing education record in the electronic tracking system at the time of renewal. Practitioners will be able to view their course history in the continuing education tracking system free of charge. The course history will show all the courses that have been reported for the practitioner.

If the practitioner's continuing education records are complete, they will be able to renew their license without interruption.

If the practitioner's continuing education records are not complete, they will be prompted to enter their remaining continuing education hours before proceeding with their license renewal.

**Why is continuing education being verified at renewal?**

Continuing Education is a requirement to renew a professional license.

Chapter 456.025(7) requires the Department to implement an electronic continuing education tracking system for each biennial renewal cycle and to integrate such system into the licensure and renewal system.

**When will this change become effective?**

Beginning with licenses expiring May 31, 2013, practitioners will be prompted to report continuing education credits during the renewal process.

**What will happen if I do not have the required continuing education for renewal?**

Beginning in 2015 you will not be able to renew a license without having your continuing education reported into the continuing education tracking system. If you do not have the hours to report, your license will move to a delinquent status at expiration. In order to renew a delinquent license you will be required to complete the continuing education requirements. Additional fees may apply.

**Do I have to wait until license renewal to report my continuing education credits to the electronic tracking system?**

No, you can report your hours free of charge anytime during the biennium. For more information please visit www.CEatRenewal.com. Please note, if you take a course from a Florida Board approved Provider they are required to report on your behalf. If you take a course from a National organization it is your responsibility to report completion.

**Do I have to subscribe to the electronic tracking system?**

No, subscriptions remain optional. There are a number of services you can receive by subscribing, however, it is optional.

You can always search for courses, report your hours, and view your course history free of charge by creating a Basic Account.

**How will I know what has been reported?**

You will be able to view your course history free of charge. Your course history will show all the courses that have been reported.

**What is the difference in viewing my course history for free or subscribing to the continuing education tracking system?**

With a free Basic Account you can view your basic course history, which will list the course name, educational provider name, date of completion and hours reported. It would then be up to you to determine whether all of the courses that have been reported will complete all of your specific continuing education requirements. You can also self-report any continuing education that may be missing.

A Professional Account (paid subscription) provides you with all of the tracking tools that CE Broker offers. Your transcript will display what your specific CE requirements are and will calculate what requirements have been met and what may still be outstanding. A Professional Account is a subscription service and is not a requirement but it can be a useful tool in managing your Florida continuing education requirements should you chose to subscribe.

For more information please visit www.CEatRenewal.com

If you have questions, you may contact the help desk toll free at 1-877-434-6323
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Credits (11 Cat. 1) MiamiNeuro@BaptistHealth.net

**Tenth Annual Pediatric Multispecialty Symposium**
Saturday, April 6, 2013
Miami Dadeland Marriott Hotel, Miami, Florida
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**Twenty-Seventh Annual Sanford H. Cole, M.D., Memorial OB/GYN Symposium**
January 25, 2013
Miami Dadeland Marriott, Miami, Florida
Credits (6 Cat. 1) ObstetricMiami@BaptistHealth.net

**Nephrology Symposium**
Saturday, April 13, 2013
Baptist Hospital of Miami Auditorium, Miami, Florida
Credits (5 Cat. 1)

**Eleventh Annual Cardiovascular Disease Prevention International Symposium**
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  2 AMA PRA Category 1 Credits™
  Credit available through June 30, 2013
- Good Clinical Practices Course
  4 AMA PRA Category 1 Credits™
  Credit available through June 30, 2013
- Health Information Privacy and Security Course
  1.5 AMA PRA Category 1 Credits™
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To obtain information or to register for upcoming conferences, go to www.cme.med.miami.edu and click on “Conferences” or call University of Miami Miller School of Medicine, Division of Continuing Medical Education at 305-243-6716 or email ucmcme@med.miami.edu.

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What does uncompromising protection look like? With 71,000 member physicians nationwide, we constantly monitor emerging trends and quickly respond with innovative solutions, like incorporating coverage for privacy breach and Medicare reviews into our core medical liability coverage.

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When it comes to your defense, don’t take half measures. Get protection on every front with The Doctors Company. This uncompromising approach, combined with our Tribute® Plan that has already earmarked over $30 million to Florida physicians, has made us the nation’s largest insurer of physician and surgeon medical liability.

To learn more, call our Jacksonville office at (800) 741-3742 or visit www.thedoctors.com/fpic.

We relentlessly defend, protect, and reward the practice of good medicine.