



Vascular Society of New Jersey

Monthly Report- January 2011

From the President

Theresa Impeduglia, MD

Dear Colleagues,

I hope that each of you have enjoyed the Holiday season... concurrently, regulations threatening our reimbursement and scope of practice were under consideration.

On December 15, 2010, under the direction of Michael T. Kornett, CEO, of the Medical Society NJ hosted a meeting of the presidents and lobbyists of New Jersey medical specialty societies to hear their concerns and issues affecting their specialties.

It appears that some medical legislation regulations have their initial exposure in the State of New Jersey. The climate of how they are received may dictate how those regulations become enforced, modified or squelched in New Jersey and in other states. Our voice matters. Collectively, and alongside other vascular specialists nationally, we are comparable in numbers to other medical and surgical specialties that may appear larger, but are simply more vocal.

As you know, Assemblyman Gary Schaer (D-Passaic), Chairman of the Assembly Financial Institutions and Insurance Committee, introduced legislation to regulate the OON insurance market in New Jersey. The provisions of this bill with some modifications include that OON providers would be required to make a "good faith and timely effort" to collect each patient's co-insurance, co-payment or deductible. A waiver for "medical or financial" hardship may be placed under scrutiny and may lead to licensure sanctions. At least the language previously used regarding the practice of frequent waivers as a criminal violation has been assuaged. (see the legal report below for more information)

Another issue confronting our specialty and all surgical specialties was brought into light by Dr. Gary Smotrich, president of the New Jersey Society of Plastic Surgeons. New technology and devices have made it possible for non-surgeons without any training in invasive surgical procedures to pass through credentialing committees for Hospital based procedures. Physicians may avoid scrutiny altogether and purchase equipment to perform these same procedures in an office based setting under local anesthesia. This choice of anesthesia avoids the regulation imposed on an environment that provides a deeper level of sedation and thus obscures the definition of qualifications to perform the procedure.

In November, Congress returned for a Lame Duck session ruling and enacting an extension on the Medicare physician fee schedule. The threat of reverting back to the Sustainable Growth rate formula approximating a negative 21.3 percent physician payment update still lingers. The one-year freeze on Medicare reimbursement does not include an update and does not include the Medicare Geographic Cost Price Index (GPCI) payment locality update. The next step is to repeal the Sustainable Growth Rate (SGR) formula once and for all.

Our lobbyist Beverly Lynch and her associates have kept us up-to-date regarding these issues via these newsletters and mailings. Occasionally you will be asked to contact your local leaders as well as House of Representatives and Senators to make your voice heard.

In regard to VSNJ activities, the fall dinner meeting was a great success with many new faces in attendance. The Program Chairman Joseph Lombardi, MD is organizing our 33rd Annual Scientific Meeting scheduled for March 9, 2011 which is to be held at Nanina's in The Park, Belleville, NJ. Instructions to submit abstracts can be found at the VSNJ website at <http://www.vascularsocietynj.org>.

The most important action for your practice and specialty is to stay informed and stay involved. I hope 2011 and beyond holds positive changes for all.

Attention: Vascular Surgeons Call for Scientific Abstracts

*The 33rd Annual Scientific Meeting of the Vascular Society of New Jersey will be held on
Wednesday, March 9, 2011
at Nanina's In The Park, Belleville, NJ.*

Winning presentation will receive

4th Annual Robert W. Hobson, II, MD Award

Engraved plaque and \$500

Abstracts are due by January 25, 2011.

There will be two types of presentations again this year:

(1) **Paper Session:** All types of submissions - clinical, research or basic science -- are encouraged. Participation by residents and fellows with member sponsorship are encouraged. (Note - Papers remain eligible for submission to the Eastern Vascular Society or other major scientific meetings.)

(2) **Case Presentation:** Members are requested to submit interesting and educational cases for audience participation and discussion. Case material with pertinent laboratory and radiological data should be submitted by the above deadline.

Submissions should be sent by email to the society offices at:

lmyers@blynchassociates.com

Presenters will be responsible to provide the society with their presentation in advance of the meeting, to minimize audiovisual delays.

Registration materials will be forwarded in February outlining the entire program. For more information or if you have questions, please contact VSNJ at (609) 392-7553.

***Mark your calendar for March 9
and
Submit your Paper/Case Presentation Today!***

*Joseph Lombardi, MD
Program Chairman*

LEGAL REPORT

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Out-of-Network Bill Update

In November, drastic changes were made to the bill that made it far worse than the October version. After pushback on the revised bill, Chairman Schaer went back to his original bill with some modifications. This bill was released from committee earlier in December. Key provisions of the released bill include:

- OON providers would be required to make a "good faith and timely effort" to collect each patient's co-insurance, co-payment or deductible. If a provider makes three (3) good faith and timely attempts to collect from a patient, such provider will be deemed to have made a "good faith and timely effort." The bill also contains a requirement that the provider retain all records relating to any "good faith and timely effort" to collect a patient's payment for seven (7) years and make them available to DOBI for inspection upon request.
- Providers may waive a patient's payment if the provider determines that the patient has a "medical or financial" hardship so long as (i) waivers are not granted "routinely or excessively" and (ii) providers must notify the carriers in the event that they grant such hardship waivers.
- At the time of scheduling OON doctors and facilities would be required to inform patients whether the health care services they seek are in-network or OON and the provider must: (i) explain to the patient his or her financial responsibility, including deductibles, co-

payments and co-insurance; and (ii) provide the patient with a description of any non-emergency services or elective procedures; and (iii) provide an estimation of the costs in the patient's primary language. Physicians in violation of this provision may be subject to licensure sanctions by the BME.

- The recently enacted assignment of benefits legislation ("AOB Law") would be modified by the proposed bill. The existing requirement under the AOB Law that forces a carrier to pay a provider directly (or pay the provider and patient jointly) was expanded to include self-funded health benefit plans. However, under the bill, OON providers may be excluded from the direct pay benefit of the AOB Law for a one (1) year in the event a carrier or insurance entity determines that a provider engaged in a "pattern of violations" of the obligation to collect co-insurance, co-payments and/or deductibles, as set forth above, for a period of at least six (6) months. Providers would have the right to appeal such determination to the Office of the Insurance Claims Ombudsman in DOBI in accordance with procedures outlined in the bill.
- Carriers would be prohibited from terminating a provider from a managed care panel on the basis that the provider referred to an OON provider. Additionally, the bill would restrict carriers from making unilateral changes to participating provider agreements more than once a calendar year and requires them to provide thirty (30) days advance written notice of any such changes to practitioners.
- The bill also requires carriers and entities offering managed care plans or self-funded health benefits plans to maintain a website making available so called "quality rankings" of health care providers and other information deemed necessary by DOBI.

In order to become law, the bill must be approved by the entire Assembly, go through the Senate committee structure and a full vote of the Senate, and then signed by the Governor.

House and Senate Pass Legislation Delaying MPFS Cut Until January 1, 2012

The House and Senate recently approved House Bill H.R. 4994, "The Medicare and Medicaid Extenders Act of 2010" (the "Act"), legislation that will stop the 24.9% Medicare Physician Fee Schedule ("MPFS") cut that was scheduled to go into effect on January 1, 2011 under the 2011 Sustainable Growth Rate ("SGR") formula.

President Barack Obama is expected to sign the Act into law. On November 30, 2010, President Obama signed into law "The Physician Payment and Therapy Relief Act of 2010" which delayed the application of the 2010 SGR formula, which would have resulted in a temporary average 21.3% cut and also continued the 2.2% update to the Medicare Physician Fee Schedule ("MPFS"), until January 1, 2011.

In addition to stopping the 24.9% MPFS reduction and extending the current MPFS rates through December 31, 2011, the Act also extends the Medicare work geographic adjustment floor for physician work relative value units until December 31, 2011, extends payment for the technical component of certain physician pathology services, and also allocates funding for the Centers for Medicare & Medicaid Services to reprocess Medicare claims back to January 1, 2010.

Red Flags Rule Update

On November 30, 2010, the Senate approved Senate Bill S3987, legislation that would exempt small businesses, which includes physician practices, from the Federal Trade Commission's ("FTC") Red Flags Rule.

During discussion of the legislation, Senator Christopher Dodd, stated that the legislation "makes clear that lawyers, doctors, dentists, orthodontists, pharmacists, veterinarians, accountants, nurse practitioners, social workers, other types of healthcare providers and other service providers will no longer be classified as 'creditors' for the purposes of the Red Flags Rule just because they do not receive payment in full from their clients at the time they provide their services, when they don't offer or maintain accounts that pose a reasonably foreseeable risk of identity theft." Under the legislation, creditors that must comply with the rule would no longer include those who "advance funds on behalf of a person for expenses incidental to a service provided by the creditor to that person." The House approved the bill on December 9, 2010. President Obama is expected to sign the legislation into law.

On June 25, 2010, Federal District Court Judge Reggie B. Walton of the United States District Court for the District of Columbia entered a stipulated court order directing the FTC to delay enforcement of the FTC's Red Flags Rule against doctors and medical practices. The FTC and AMA agreed to this delay in a Joint Stipulation filed in the lawsuit initiated by the AMA and other medical associations to exclude doctors and other medical professionals from the application of the Red Flags Rule.

By way of background, the Red Flags Rule, as it currently stands, requires creditors that hold consumer accounts (which includes most, if not all health care providers), or other accounts for which there is a reasonably foreseeable risk of identity theft, to develop and implement an identity theft prevention program ("Identity Theft Prevention Program") for combating identity theft in connection with new and existing accounts. The Identity Theft Prevention Program must include reasonable policies and procedures which enable the party to (1) identify relevant patterns, practices and specific forms of activity that are "Red Flags" signaling possible identity theft, and incorporate those Red Flags into the Identity Theft Prevention Program; (2) detect Red Flags that have been incorporated into the Identity Theft Prevention Program; (3) respond appropriately to any Red Flags that are detected to prevent and mitigate identity theft; and (4) ensure the Identity Theft Prevention Program is updated periodically to reflect changes in risks from identity theft.

Rules Proposed to Address Cullen Act Requirements

On November 1, 2010, the New Jersey Division of Consumer Affairs published proposed new rules to implement the requirements of the Health Care Professional Responsibility and Reporting and Enhancement Act, also known as the Cullen Act (the Act), a law passed in 2005 which requires health care entities to report health care professionals who have demonstrated impairment or incompetence or who engaged in professional misconduct.

Health care entities include hospitals, ambulatory care facilities, and home health care agencies.

The proposed rules largely mirror the provisions of the Act that pertain to the reporting of individuals to the Division who may be impaired, incompetent or have engaged in professional misconduct. For example, health care entities must report, among other things, when it has suspended or revoked a health care professional's privileges, removes a health care professional from a staffing registry list, or terminates or rescinds a contract with a health care professional. The proposed rules also include definitions for such terms as "conduct relating to adversely to patient care or safety," "imminent danger," "impairment," and "remedial action or training."

There are two items in the proposed new rules worth noting. Under the proposed rules, it states that it is a reportable event when a health care professional resigns from the staff of a health care entity, or voluntarily relinquishes partial privileges, when the entity is investigating, among other things, the health care professional's patient care, conduct demonstrating impairment or incompetence relating to patient safety, whether or not the investigation is known to the health care professional. The Act does not specifically state this and it could therefore be interpreted that such resignations were only reportable if the health care professional knew of the investigation when he or she resigned or partially relinquished privileges.

In addition, under the Act, a health care entity is required, upon the inquiry of another health care entity, to report whether it had provided any notice to the Division with respect to a health care professional for the preceding seven year period.

Under the proposed rules, there is no time limitation when another health care entity makes an inquiry regarding a health care professional. While there is a provision in the proposed rules that a health care entity is only required to maintain records for seven years, and therefore it could be asserted that it is only obligated to report events from the past seven years, the time limitation under the Act is not present in the rules as they are currently written. As you may recall, Assemblyman Gary Schaer (D-Passaic), Chairman of the Assembly Financial Institutions and Insurance Committee, introduced legislation in October intended to further regulate the OON insurance market in New Jersey.

Happy New Year!

Calling all New Jersey political "junkies".... Enjoy!

<http://www.politickernj.com/43793/2010-year-review>

From the Statehouse

Beverly J. Lynch

NEW LAW ENACTED TO PROVIDE PHYSICIANS (& VETERINARIANS) WITH EDUCATION CREDITS FOR PROVIDING VOLUNTEER SERVICES

On December 10, 2010, Governor Christie signed legislation to allow physicians and veterinarians to earn continuing education credits for providing free medical and veterinary services.

This law requires the State Board of Medical Examiners to offset up to 10 of the required 100 credits, required biennially for continuing medical education by the number of hours

of volunteer medical services rendered by the licensee, at the rate of one half of one credit of continuing medical education for each hour of volunteer medical service rendered. "Volunteer medical services" is defined as medical care provided without charge to low-income patients for health care services for which the patient is not covered by any public or private third party payer, in accordance with such standards, procedures, requirements and limitations as are established by the board.

The bill also requires the State Board of Medical Examiners to establish any specific courses or topics which are to be required for continuing medical, as appropriate, and designate which are the core requirements for continuing medical education, including the number of required hours, subject matter and content of courses of study.

Asset Protection Updates: The Act

The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (The Act) was signed into law on 12/17/2010. In general, the Act extends several provisions of the 2001 Tax Act for an additional two years. Some of the most significant (albeit largely temporary) aspects of the Act include:

- Retroactive reinstatement of the federal estate tax for 2010 decedents with an exemption amount of \$5 million.
- Election out of estate tax, and into a modified carryover basis regime, for 2010 decedents.
- A zero Generation Skipping Tax (GST) for 2010.
- An increase in the estate tax exemption from \$3.5 million in 2009 to \$5 million.
- Reunification of the estate and gift tax in 2011 so that the gift tax exemption in 2011 and 2012 is \$5 million.
- An increase in the GST tax exemption from \$3.5 million to \$5 million.
- Starting in 2011, the ability to transfer a decedent's unused estate tax exemption to the decedent's surviving spouse, which is referred to as "portability".
- Extension of lower income tax rate with a top rate of 35%.
- Extension of lower capital gains and dividend tax rates, with a top rate of 15%.
- Ability to rollover directly from an IRA to a qualified public charity through 2011.
- Alternative Minimum Tax relief.
- A 2% reduction in the Social Security payroll tax rate for 2011.

As usual, when our government makes changes to the tax code, clarity on the implementation of said changes won't be available for awhile. I will share more details of the effects of the changes in future articles.

Have a safe, healthy, and happy New Year!

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