



Vascular Society of New Jersey

Monthly Report- October 2011

From the President

Paul B. Haser, MD

Oct 27th is fast approaching - the Fall meeting is set and the response has been positive, so in case you haven't made your reservation, please do so soon. Remember spouses/significant others are invited and there's a real discount for members who's dues are up to date. Besides the chance to rub elbows with a Nobel laureate, it is a great opportunity to see old friends, meet new members and have a great view of Manhattan.

Below you will find some legal and State House highlights. There has been a reported overpayment in of \$6.8 million over 3 years for Medicare in NJ and the surrounding states. Make sure your documentation is up to date. Your society is looking into a database system which will provide you with automated field fill-ins to both monitor your own quality improvement as well as ensure adequate and easier documentation. You will need to revalidate Medicare enrollment - (March 23, 2013) is the deadline. The federal government working on an insurance exchange policies - +/- good news/bad news for us as presently planned. Let's see if Congress even takes care of the budget first. Also, there is a regulation so that facilities can make health care decisions for patients who cannot do for themselves. Also, a violence protection program policy established.

Additionally, the cosmetic tax repeal effort makes gains, which would impact the cosmetic varicose vein work from our Society. Also, Sen. Vitale has been working on a physician loan redemption program for those willing to work in underserved areas. Through the Society we met with several ranking politicians, including the former Gov. Codey and Sen Tom Kean, Jr. Both expressed an interest in working for tort reform, but much of this will depend on the outcomes in November. We remain hopeful. See you soon!

REGISTER NOW

www.vascularsocietynj.org

Vascular Society of New Jersey Annual Meeting

October 27, 2011

New Location

LIBERTY HOUSE RESTAURANT

Jersey City, NJ

with keynote speaker:

Martin Chalfie

Nobel Laureate, Chemistry 2008

William R. Kenan, Jr. Professor of Biological Sciences at Columbia University

Chair of the Department of Biological Sciences

Cosmetic Tax Repeal Passes Upper House

On September 26, the NJ State Senate approved by a vote of 39-0 S1988, which phases out the cosmetic medical procedure gross receipts tax over three steps. Under the bill, as amended, the six percent rate of tax currently imposed on the gross receipts from cosmetic medical procedures is reduced to a 4% rate starting with the first calendar quarter beginning after the date of enactment; reduced to a 2% rate from July 1, 2012 until July 1, 2013, and starting July 1, 2013 the rate of tax will be 0%, effectively ending the tax.

Senators made political points in the lead-up to the vote, with Republicans emphasizing what they felt was the long-overdue nature of such legislation, arguing such a tax increase should never have been implemented in the first place.

"We did discourage business in New Jersey because of this tax," said Sen. Kevin O'Toole, driving business out of state. He wanted to repeal it in one shot instead of phasing it out. Sen. Paul Sarlo said they are opting for the phasing out because it does represent a loss of millions of dollars. He said "We wasted a year," and wished that similar bills had not drawn vetoes from the governor earlier. "Let's pass the bill."

The Office of Legislative Services reported that there will be an estimated revenue loss of \$1.8 million during fiscal year 2012, and an accumulated revenue loss of \$7.2 million during fiscal year 2013, with the elimination of the tax resulting in lost revenue of \$10.8 million.

The bill requires Assembly consideration, as well as support from the Governor's office.

LEGISLATION CREATING PHYSICIAN LOAN REDEMPTION PROGRAM ADVANCES

In an effort to address a current and worsening physician shortage in New Jersey, a bill (S-1774, Vitale) which would establish a Physician Loan Redemption Program for both primary care and specialty physicians who pledge to work in underserved and physician shortage areas was approved by the Senate Education Committee.

The bill is in direct response to the New Jersey Council of Teaching Hospitals report that within 10 years New Jersey will have a shortage of more than 2,800 physicians and specialists. This bill would create the Physician Loan Redemption Program which would pay off the cost of student loans for doctors working in underserved areas. Under the bill, doctors would receive a graduated percentage of the cost of their loans for each of ten years of which they commit to working in an underserved area. If a doctor continues to work in the community for ten years, their student loans would be 100 percent forgiven.

The program would require participants to be a New Jersey resident; graduate from a medical school approved by the State Board of Medical Examiners; complete an accredited residency training program; and agree to participate in a full-time clinical practice in the State for the first four of the ten-year commitment at an approved site in an underserved area. The bill now heads to the Senate Budget and Appropriations Committee before going to the full Senate for review.

OIG Identifies \$6.8 Million in Overpayments to New Jersey and Surrounding States

On August 17, 2011, the U.S. Department of Health & Human Services Office of Inspector General ("OIG") released an [audit](#) report detailing Highmark Medicare Services overpayments. According to the OIG, providers were overpaid by approximately \$6.8 million from January 1, 2006 through June 30, 2009.

The OIG found that 68% of 1,507 selected claims processed by Highmark, the Medicare Administrative Contractor for Pennsylvania, Delaware, Maryland, New Jersey and the District of Columbia metro area, were incorrectly paid for outpatient services. Moreover, the OIG reported that providers failed to refund any of the overpayments by the start of the OIG's investigation.

Additional billing issues highlighted in the report include the following:

- Incorrect units of service
- Packaged services billed separately
- Healthcare Common Procedure Coding System (HCPCS) codes that did not reflect the procedures performed
- Unallowable services
- Unlabeled use of a drug/biological
- A lack of supporting documentation
- A combination of incorrect units of service and incorrect HCPCS codes
- Incorrectly calculated payments

The OIG recommended that Highmark recover the identified overpayments, implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and utilize the results of the audit report in its provider education activities.

OIG: Pay-for-Performance Payments Disbursed by Medical Home Program Administrator Will Not Implicate Anti-Kickback Statute

The U.S. Department of Health & Human Services Office of Inspector General ("OIG") recently issued Advisory Opinion 11-10, concluding that an arrangement whereby a provider of administrative services (the "Requestor") disburses pay-for-performance payments to physicians and dentists participating in a state's Medical Home Program on behalf of the state does not implicate the federal anti-kickback statute ("AKS").

The Requestor sells a variety of health care management services, including behavioral health administrative services and disease management and care services, and was selected through a competitive bidding process to provide administrative services to a state's Medical Home Program. The Medical Home Program was designed and approved by CMS to include a pay-for-performance component that uses payments by the state's Medicaid program to induce physicians and dentists to arrange for, order or recommend certain healthcare services in order to reduce medical costs and improve patient care. The Requestor disburses these payments via its own bank account. The payments are funded by the state's Medicaid program and the Requestor has no discretion or control over the payments. The state and the Medical Home Program are clearly identified as the source of the payments and the checks issued identify the Requestor as the administrator of the Program.

The OIG addressed only the narrow question of whether the Requestor's role as administrator and distributor of the payments implicates the AKS. The OIG opined that it does not because: (1) the payments are funded by the state's Medicaid program; (2) the Requestor is acting as an agent of the state and has no control or discretion over the payments; (3) steps have been taken to reduce misimpression by clearly identifying the state as the payor and the Requestor as the administrator; and (4) the state supervises all payments and has the ability to audit Requestor's performance as administrator of the Medical Home Program.

Plan to Sell Supplies below Cost to Nursing Home Rejected by OIG

The U.S. Department of Health & Human Services Office of Inspector General ("OIG") recently issued

Advisory Opinion 11-11, in which it declined to approve a supplier's proposal to enter into an agreement with a skilled nursing home to provide supplies and equipment below cost for its non-Medicare business.

The supplier furnishes medical supplies and equipment to skilled nursing facilities. In connection with furnishing the medical supplies and equipment, the supplier also provides related services, including emergency delivery, inventory control, frequent visits from customer service representatives, customized resident-specific packaging and simple returns of products for credit.

The supplier bills Medicare Part B for items that are covered by the Medicare program. When they are not covered, the supplier bills the nursing home directly. Normally, the supplier charges each nursing home a price that covers the cost of providing the related services, as well as the supplier's overhead and profit. The amount paid by Medicare also covers the costs of the related services, overhead and profit.

A nursing home has issued a request for proposals for a supplier to be its exclusive supplier of the supplies and equipment. The supplier wishes to submit a bid for non-Medicare covered supplies and services at a price that would be below its costs. The supplier stated that the amount it receives for Medicare Part B payments would more than offset any losses it would incur in furnishing the non-covered items and services at the below-cost pricing.

The OIG declined to approve of the arrangement because it was unable to conclude that the supplier would be offering improper discounts to the nursing home without the intent to induce referrals of the more lucrative federal business, stating that the arrangement poses a substantial risk of improper "swapping" of business that may run afoul of the federal anti-kickback statute.

Time to Revalidate Medicare Enrollment

Under the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services ("CMS") was required to implement new anti-fraud screening measures for providers and suppliers who enrolled in Medicare prior to March 25, 2011. These providers and suppliers must revalidate their Medicare enrollment information before March 23, 2013; otherwise, Medicare will suspend payment.

The New Jersey Medicare Administrative Contractor, Highmark Medicare Services, will be notifying the applicable providers and suppliers as to when they should revalidate enrollment information. Providers and suppliers should wait for their notice before revalidating, unless revalidation is necessary for other reasons, such as change of ownership. When notified, revalidation must be completed within 60 days by submitting the information online via the Provider Enrollment Chain Ownership System ("PECOS") or by submitting the applicable CMS-855 form by mail.

Revalidation will not be necessary for those providers or suppliers that have revalidated their Medicare enrollment information on or after March 25, 2011.

Insurance Exchanges - Credits to Some, Costs to Others

The U.S. Department of Health & Human Services ("DHHS") and the United States Treasury simultaneously released three proposed rules for the development of "affordable insurance exchanges" authorized by the Patient Protection and Affordable Care Act. These draft rules accompany previously released draft rules released by DHHS in July, setting forth the underlying framework for crafting state-run insurance exchanges in order to offer a competitive marketplace for consumers and small businesses to compare and purchase health insurance, effective in 2014. Comments to the proposed rules must be submitted by October 26, 2011.

The proposed rules are intended to guide insurance exchanges, employers and individuals enrolling in plans sold on these exchanges with regard to eligibility, affordability programs, coordination of coverage and premium tax credits. The proposed rules include cost parameters identifying that taxpayers who purchase qualified plans on an exchange would be eligible for a premium tax credit if they have household income between 100% and 400% of the federal poverty line, when taking into account family size. Employers could be subject to an assessment if at least one employee receives a tax credit because the employer-sponsored coverage either does not provide minimum value or is unaffordable to the employee. Safe harbors from this employer assessment will be set forth in future rule proposals.

New Jersey Bill Provides for Facilities to Make Health Care Decisions for Patients without Decision-Making Capacity

On June 13, 2011, a bill sponsored by Assemblyman Herb Conaway, Jr. and Assemblywoman Valerie Vainieri Huttle reported favorably out of the Assembly Health and Senior Services Committee (A4098). The impetus behind the bill is to facilitate the making of health care decisions for patients in a general or special hospital, nursing home or assisted living facility (health care facility) who have lost decision-making capacity, and to establish a demonstration program relating to the transfer of certain patients from inpatient care to post-acute care.

Some of the major highlights of the bill include:

- A health care facility will be required to establish policies and procedures to provide for the making of health care decisions by a surrogate, to be designated by the health care facility, for an adult patient who is determined to lack decision-making capacity, who does not have a patient's representative and who has not executed an advance directive
- The patient's attending physician will make an initial determination (subject to a concurring determination by a health or social service practitioner) that the patient lacks decision-making capacity to a reasonable degree of medical certainty, including an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain decision-making capacity
- A health care facility will be authorized to designate a surrogate to make health care decisions for an adult patient who has been determined to lack decision-making capacity, and is to provide prompt notice of that determination and designation to the patient, if the health care facility has any indication of the patient's ability to comprehend the information, and to designate at least one person on the "surrogate list," which will be set forth in the final law and which will designate individuals, by order of priority, to be named as surrogates when necessary
- A surrogate who is designated pursuant to the bill will, subject to the provisions to be included in the final law, have authority to make health care decisions on the adult patient's behalf
- A decision by a surrogate to withhold or withdraw life-sustaining treatment from the patient will be authorized if the attending physician determines, with the independent concurrence of another physician and to a reasonable degree of medical certainty and in accordance with accepted medical standards, that certain criteria to be set forth in the final law are met

If passed in its present form, the new law would establish a three-year transition authorization panel demonstration program, to be conducted at six program sites, two each in the northern, central and southern regions of the state, for the purpose of evaluating an approach to making decisions relating to the transition of eligible patients from inpatient care to post-acute care.

Safe Patient Handling and Violence Prevention Rules Adopted

The New Jersey Department of Health & Senior Services ("DHSS") recently approved for adoption, without change, previously proposed licensing rules governing safe patient handling and violence prevention in health care facilities. The final rules were published in the September 6, 2011 New Jersey Register.

DHSS approved for adoption N.J.A.C. 8:43E-11, which requires general hospitals, special hospitals, county and private psychiatric hospitals, and nursing homes licensed by DHSS to establish a workplace violence prevention program within three months of adoption of the rules.

N.J.A.C. 8:43E-12, which was also approved for adoption, establishes the requirements for these facilities to minimize unassisted patient handling in order to decrease the number of job-related musculoskeletal injuries suffered by health care workers and to improve the comfort, dignity, satisfaction and quality of care for patients.

In addition to the adopted new rules set forth at N.J.A.C. 8:43E-11 et seq. and N.J.A.C. 8:43E-12 et seq., DHSS is adopting an amendment at N.J.A.C. 8:43E-3.4 that establishes monetary penalties for violations of these rules.

MEDICAL MALPRACTICE RISK

The New England Journal of Medicine published a comprehensive report in their August edition regarding medical malpractice risk by specialty.

Click to view report:

http://www.protectpatientsnow.org/sites/default/files/NEJM_Medical_Malpractice_Risk_8-17-11.pdf

DI Marketplace for Physicians

It has taken awhile but we have finally entered into another doctor friendly disability insurance market. Carriers have been improving their contracts and increasing their limits for the last couple of years now.

You can actually purchase "True Own Occupation" coverage again. This definition of disability will allow you to collect on your benefits as long as you suffer a loss of income and are unable to perform the duties of your AMA approved specialty or sub-specialty. So if you are disabled and cannot earn a living as an Orthopaedic Surgeon, even though you could do IMEs, teach medicine, or do something else in the medical field, you will be paid your full monthly benefit. As a matter of fact, they will pay you even if you do earn an income in another career.

As recently as five years ago the most individual coverage that an Orthopaedic Surgeon could purchase, regardless of income, was \$10,000 per month. Over the last few years that limit has increased to \$12,500, then to \$15,000 per month. You can now purchase up to \$20,000 per month.

Currently there are also a couple of Group Disability providers that specialize in writing policies for doctors. Although not as strong as some of the individual disability providers their contracts are still pretty good. They have also increased their coverage limits to \$20,000 per month. So currently, you can actually purchase up to \$40,000 of combined total monthly coverage.

Want some more good news? Both Union Central and Standard offer exclusive discounts to society members. These discounts not only apply to individual disability policies but also business overhead and disability buy-out policies.

When is the last time you reviewed your disability policies? Given the expanded benefit limits and the discounts offered through your society, now might be a good time for a 2nd look.

If you have any questions or would like an insurance review please call me at (877)972-7900 or dvargo@varbeco.com.

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