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News and Notes from the Legislative and Practice Affairs Division

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Hospital Contracts that Demand the Right to Fire Anesthesiologists

By David E. Willett, Esq., CSA Legal Counsel

Perhaps because a particular law firm advising hospitals has a fondness for the provision, anesthesiology groups seem to be confronting provisions in contracts proffered by hospitals which require the group to terminate an anesthesiologist upon the hospital's demand. There may be nominal "protections" or conditions in the language, but the bottom line is that the group is obligated to terminate any anesthesiologist targeted by the hospital.

When challenged, hospital representatives say that these provisions are essential, because no hospital can permit an anesthesiologist to remain in the facility under various scenarios, citing the possibility of violent crimes, psychopathic tendencies, or gross disregard for patients. While that is true, the fact is that medical staff bylaws, as well as other commonplace provisions in medical group contracts with hospitals, adequately address such contingencies. The real purpose of the provision requiring termination upon demand is to evade obstacles to termination posed by bylaw and statutory requirements for due process or a fair procedure, as well as National Practitioner Data Bank and Medical Board reporting requirements. However, the result is to make the medical group potentially liable to the terminated physician, for action taken to deprive the physician of exactly the rights this device means to deny. Myriad reasons may drive the demand for discharge. Some are unlawful. Objections based on race, religion or sex are obvious. Equally unlawful may be action taken to avoid compliance with the Americans with Disabilities Act, or similar statutes. Particularly as hospitals challenge physician involvement with competing entities, antitrust issues can arise, perhaps when a physician is terminated because the physician or a family member is involved in a disfavored enterprise.

Anesthesiology groups have responsibilities to members and employees. Termination is a serious matter. To allow the hospital to make the decision and leave the anesthesiology group with the liabilities that may result is nonsensical and unnecessary.

Federal Requirements for On-call Services Softened

By David E. Willett, Esq., CSA Legal Counsel

On September 9, the Centers for Medicare and Medicaid Services (CMS) issued new regulations governing Emergency Medical Treatment and Labor Act (EMTALA) requirements imposed on hospitals, governing the availability of emergency services. In addition to other changes, CMS has made it clear that hospitals will have more discretion than was thought to exist under prior regulations, particularly with regard to on-call coverage.

Requirements for on-call coverage have always applied to hospitals, not to physicians. However, the EMTALA requirements have been cited by hospitals in seeking or enforcing on-call service requirements, particularly when those requirements are found in medical staff bylaws which limit physician discretion.

CMS says that a hospital is not required to provide 24/7 coverage, even if it has three or more physicians in a particular specialty on staff. Rather, the hospital is free to adopt an arrangement which maintains the mandated on-call list in a manner which best meets patient need for emergency care, taking into account available resources. CMS has acknowledged that more stringent interpretation of CMS rules actually can be counter-productive, discouraging membership on multiple medical staffs, for example. Physicians may be on call simultaneously in two different hospitals, and can schedule elective surgery while on call, if allowing such latitude is likely to generally ensure availability of on-call services, even if coverage may not be available under specific circumstances. Hospitals are directed to consider how care can be provided or found under those circumstances, and develop appropriate procedures.

Other changes limit the scope within which EMTALA rules apply. Inpatients, for example, no longer will be regarded as persons who are the subject of EMTALA rules when emergencies occur during their admission. CMS points out that existing law apart from EMTALA ensures that emergencies will be addressed in the course of inpatient care.

The new regulations, which became effective on November 10, 2003, benefit hospitals by adopting a more rational approach to EMTALA requirements, eliminating overreaching and purely bureaucratic impositions on the provision of emergency care. Physicians benefit because they should no longer be hostage to such interpretations. Medical staffs which want to discuss changes in on-call requirements, particularly when rules were adopted under very different

circumstances than now exist, can do so in an environment where even the regulators have realized that something has to give.

A New Era at the State Capitol

By William E. Barnaby, Sr., CSA Legislative Counsel, and William E. Barnaby, Jr., CSA Legislative Advocate

Newly elected Governor Arnold Schwarzenegger has only been in office for a few weeks, as of this writing, but it is obvious that California's Capitol is a much different place. Even though Democrats outnumber Republicans in the Legislature, the new Governor's star power has clearly shifted the balance of power. Most Democratic legislators have pledged their cooperation in general, but have found the few available detailed proposals of his administration very troubling.

Already proposed are serious payment cutbacks for those physicians who render service to Medi-Cal patients and injured workers under the Workers' Compensation Program. These reductions are in addition to those enacted earlier this year. Detailed hearings on these cuts have only barely begun. What the impact will be in terms of physician participation in these programs, and the effect upon patient access, can only be a matter of speculation at this point.

Taking center stage initially were the Governor's proposed ballot propositions for a $15 billion bond issue and a spending limit for the future. While those subjects seem relatively simple in concept, their details and implications are being found to be highly complex and controversial.

As with any new administration, there is a learning curve for new officials to come to grips with how state government works let alone how it can be made to work better.

Because of the many uncertainties, this column will be short. One thing is certain, however, and that is health care programs are being targeted for change. Future columns likely will have much more to offer on this subject.

Escape from Armageddon: The Battle Against RBRVS in Workers' Compensation

By Donald J. Prolo, M.D., F.A.C.S., Neurosurgeon, CMA Specialty Delegation

What is the value-equivalent to a patient of operatively relieving the pain, weakness, numbness, functional disability and suffering of a herniated L_5-S_1 disc:

1. a used BMV ($25,000)?
2. a used Buick ($3,000)?
3. a used Volkswagen ($900)?

Centers for Medicare and Medicaid Services (CMS), using the Resource Based Relative Value Scale (RBRVS) choose entry #3.

The Official Medical Fee Schedule (OMFS) of California's Division of Workers' Compensation (DWC) by law must be revised biennially. The OMFS is based on the California Relative Value Studies (CRVS) developed, published and utilized by the California Medical Association (CMA) until the Federal Trade Commission (FTC) prohibited it in the 1970s. Since that time the OMFS has not been updated in a systematic fashion. The CRVS was charge-based with relative values computed from analyzing billing practices of physicians in California.

Because the OMFS updates represented a patchwork of fees with a number of codes without established fees and allegedly lacked relativity among fees, the Industrial Medical Council (IMC, representing various providers) of the DWC held 25 hearings in 1998 to adopt a "resource-based scale that would provide fair reimbursement, preserve access and would provide biennial revisions." The UCLA Center for Health Policy Research under the supervision of Gerald F. Kominski, Ph.D., concluded a resource-based Relative Value System (RVS) had the potential to improve fairness of payments. Twenty states and the U.S. Department of Labor (USDOL) use relative value systems: USDOL and 10 states use the Federal RBRVS Relative Value Units (RVUs) methodology; the other 10 states use RVS approaches that were charge-based, most commonly Relative Values for Physicians (RVP, published by St. Anthony's Press). In 1999 Kominski and co-workers recommended to the DWC the use of the Federal RBRVS because it had undergone public development, review and scrutiny; was updated annually by the AMA's Relative Value Scale Update Committee (RUC) at a cost of $18,000,000 paid yearly to the AMA; and it was to be completely "resource-based."

In 2001, the Lewin Group was commissioned by the IMC to analyze the economic impact on physician specialists adopting the Federal RBRVS. The 4.1 million medical claims in California Workers' Compensation (WC) in the year 2000 had a value of $215 million in the aggregate. The conversion factor was equivalent to Medicare + 10% or computed to $44.73. The total paid neurosurgeons in 2000 was $1,345,492. Using the computed conversion factor ($44.73) for all claims would have reduced neurosurgical reimbursement to $916,941 or a 25.5% cut. Diagnostic radiology would have been cut 46% and orthopedic surgery 5.1%. [**Editor's note:** *If the WC fee schedule that has been legislated to take place in 2006 remains at 120% of Medicare, then anesthesiology reimbursement will be reduced by about 38%! This will represent a drastic cut from the already pitifully low conversion factor of $34.50 that has been unchanged (until the recently mandated 5% cuts) for a decade.*] In 2002, the Lewin Group determined physician work requirements with WC patients is 28% higher than with non-WC patients, practice expenses are 33% higher and that E&M codes would require a 28% increase over budget neutral values to cover the higher costs and additional work in caring for WC patients.

California has the fifth lowest fee schedule for WC in the United States and has not changed since 1984. **In 2001, total expenditures in the WC system were $9.974 billion, only 9% of which went to M.D.s—an equal amount, 9%, went to chiropractors!** Targeting M.D.s for lowering costs to the WC system is a mug's game.

The Administrative Director of the DWC (Dick Gannon) planned to convert the OMFS to the Federal RBRVS. If so enacted, the practices of many neurosurgeons in California stood to be seriously—in some instances fatally—impacted by the DWC. The California state legislature's adoption of the bill gaining greatest traction (SB 228 Alarcon) would fix maximal reimbursement at 120% of Medicare RBRVS.

In the spring of 2002 the CMA Committee on WC proposed adoption of RBRVS methodology for WC, but the CMA Board of Trustees rejected the RBRVS Medicare Fee Schedule. The California Association of Neurologic Surgeons (CANS), the California Orthopedic Association (COA), the Association of California Neurologists (ACN) and the California Society of Industrial Medicine and Surgery (CSIMS) formed a powerful block that resisted adoption of RBRVS and reimbursement at 120% Medicare RBRVS. Note that in states where federal RBRVS methodology was adopted, physician participation dropped and patient access fell, except where rates were at least 200% of

Medicare. Multiple meetings in 2002 and 2003 of an OMFS Advisory Panel were convened under the auspices of the CMA. In March 2003 a CANS resolution was adopted by the CMA House of Delegates (HoD) to reject the federal RBRVS methodology as the sole template for developing a revised OMFS. In multiple meetings of the OMFS Advisory Panel proposals by neurosurgeon Bob Florin, neurologist Steve Levine and the California Orthopedic Association (COA) were rejected by physician groups in primary care and occupational medicine, who advocated for adoption of the RBRVS. Their reimbursement would have immediately risen at the expense of other specialties. Concurrently 59 bills on WC were passing through the state legislature to control costs that were crippling business; premiums had risen 400% over three years.

In mid-2003 CMA staff—in my opinion mistakenly—sided with occupational medicine/primary care specialists in supporting federal RBRVS: "The CMA believes that using the Medicare formula for determining practice expense and work related costs often referred to as the Resource Based Relative Value Scale (RBRVS) might be appropriate for the basis of a new physician fee schedule and can be easily applied by the DWC in overcoming the administrative burden in updating the formula for physician reimbursement." This was in violation of the House of Delegates Resolution 414-03.

As a result of what seemed to me to be a misguided CMA policy decision, in August 2003 prospects for neurosurgeons and other specialists looked grim in combating RBRVS. Reform measures swept through the California State Senate and Assembly leading to a Conference Committee where, fortunately, more sound judgments prevailed in maintaining access for patients as a consequence of strong advocacy by CSIMS and the COA. Results of the synthesis of bills by the Conference Committee, adopted by the legislature, and signed by former Governor Davis are detailed below. Of enormous importance to physicians was the determination that **physicians' fees would be reduced 5% for each of the next two years, rather than being set at 120% of a Medicare RBRVS** that is arbitrary and distorted yearly by CMS. We have dodged the RBRVS bullet for at least two years!

A decision to control physician payments by creating a national fee schedule passed the U.S. Congress in the mid-1980s along with a plan to impose price controls on medicine. The so-called "resource based" RVS conceived by social scientists at Harvard and anointed by the AMA was part and parcel of the federal government's effort to transfer payments from procedural to cognitive specialties and to fix prices. The RBRVS purports to establish the relative value

of services by considering components of physician work, practice and malpractice expenses. It is the initial product of about 30 physicians from each specialty (not all of whom performed the service) who decided on time factors and intensity in arriving at the value of one service in comparison with another. RBRVS promotes the aura of respectability, but it is a product of a pseudo-science long ago abandoned by most economists: the theory of comparable worth enunciated by Karl Marx in his labor theory of value. Physicians are deluded through the processes of the Relative Value Scale (RVS) Update Committee (RUC) of contributing to objective valuations of relative values that are then promptly distorted by CMS to maintain budget neutrality. Opportunity costs of education, training and duration of residency, variable among programs, were never factored into this bogus "relative value" system.

Consequent to the intense and effective lobbying of several of the specialties which were most at economic risk, a wise decision was made by the legislature and the former governor, their action now presents for the coalition-of-the-willing a golden opportunity to propose a unique California fee schedule reflecting market force valuation of physician services rather than a concocted "relative value" system easily corrupted by the federal government and potentially abused by the DWC. Will physicians be proactive following the request of the DWC to propose a transparent, publicly scrutinized relative value scale, or will the easier but treacherous choice be made for accepting what the federal government ordains is the relative value of services?

Worker's Compensation Reform Adopted by Legislature and Signed by the Governor September 2003

1. **Official Medical Fee Schedule:**
   Physicians are subject to a 5% reduction from current value for 2004 and 2005, except for Evaluation and Management codes and minor surgical procedures which will not be reduced. The Administrative Director (AD) of the DWC is to adopt and revise the fee schedule by January 1, 2006. [**Editor's Note:** *For anesthesia, this reduces the conversion factor from $34.50 to $32.78.*]

2. **Ban on Physician Self Referral:**
   Physicians may refer their patients to outpatient facilities in which they have a financial interest, provided they receive prior authorization for the service and notify the carrier of the financial interest.

3. **Outpatient Surgical Facilities Fee Schedule:**
   Reimbursement levels for both free-standing and hospital-owned outpatient facilities are set at 120% of Medicare's fee schedule for hospital-owned outpatient facilities.

4. **Caps on Physical Medicine Services:**
   Chiropractic and physical therapy are each capped at 24 visits per injury. Insurer may authorize additional visits.

5. **Pharmaceuticals:**
   Generic pharmaceuticals will be required to be dispensed when a "generic equivalent" is available, unless brand name is specified by the prescribing physician.

6. **Industrial Medical Council:**
   The Industrial Medical Council is abolished.

7. **Utilization Review:**
   Every employer must establish a utilization review process.

8. **Spine Procedures:**
   Spinal procedures are subject to a "second opinion."

9. **Electronic Submission of Claims:**
   The AD must adopt regulations for electronic submission of claims by July 1, 2006, with payment within 15 days.

10. **Vocational Rehabilitation:**
    Existing program is repealed with creation of a voucher system to provide $4,000-$10,000 worth of educational assistance to the injured worker.

11. **Direct Contracting:**
    Medical providers can continue to direct contract with carriers for care of injured workers.