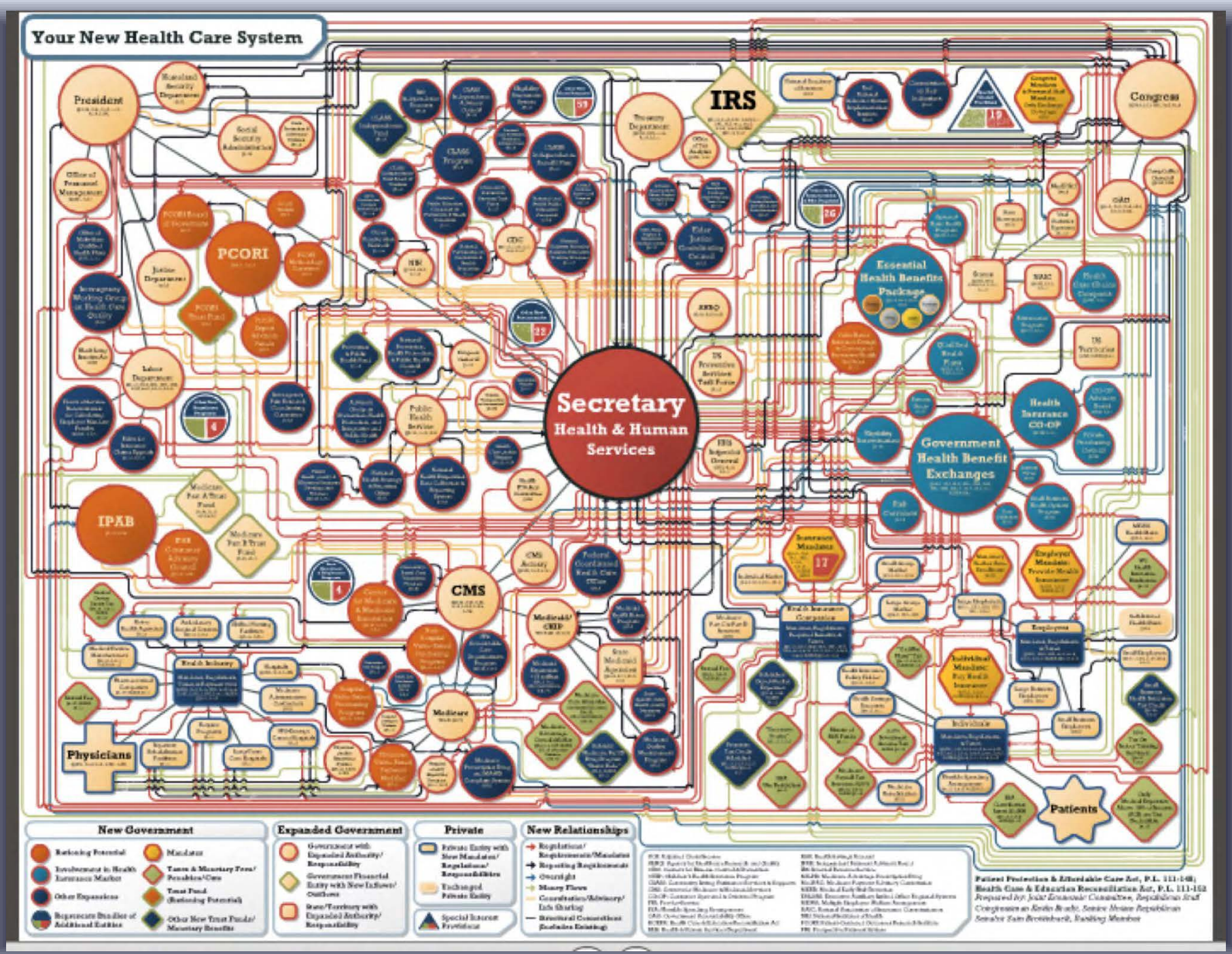
The Future of Health Reform:
The Supreme Court has Ruled
Now What?

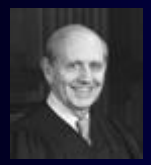
Michael W. Groff, MD

Spine Summit Meeting

August 2012


Your New Health Care System
President
IRS
Congress
PCORI
Secretary
Health & Human Services
Essential Health Benefits Package
Government Health Benefit Exchanges
Health Insurance CO-OP
IPAB
CMS
Medicare
Physicians
Patients
New Government
Expanded Government
Private
New Relationships
Patient Protection & Affordable Care Act, P.L. 111-148;
Health Care & Education Reconciliation Act, P.L. 111-152
Prepared by: Joint Economic Committee, Republican Staff
Congressman Kevin Brady, Senior Senate Republican
Senator Jim Bunning, Ranking Member

Supreme Court Upholds ACA
(basically)


(Slip Opinion) OCTOBER TERM, 2011 1

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

NATIONAL FEDERATION OF INDEPENDENT BUSINESS ET AL. *v.* SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 11–393. Argued March 26, 27, 28, 2012—Decided June 28, 2012*

In 2010, Congress enacted the Patient Protection and Affordable Care Act in order to increase the number of Americans covered by health insurance and decrease the cost of health care. One key provision is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. 26 U. S. C. §5000A.




Supreme Court Ruling Summary

NFIB v. Sebelius

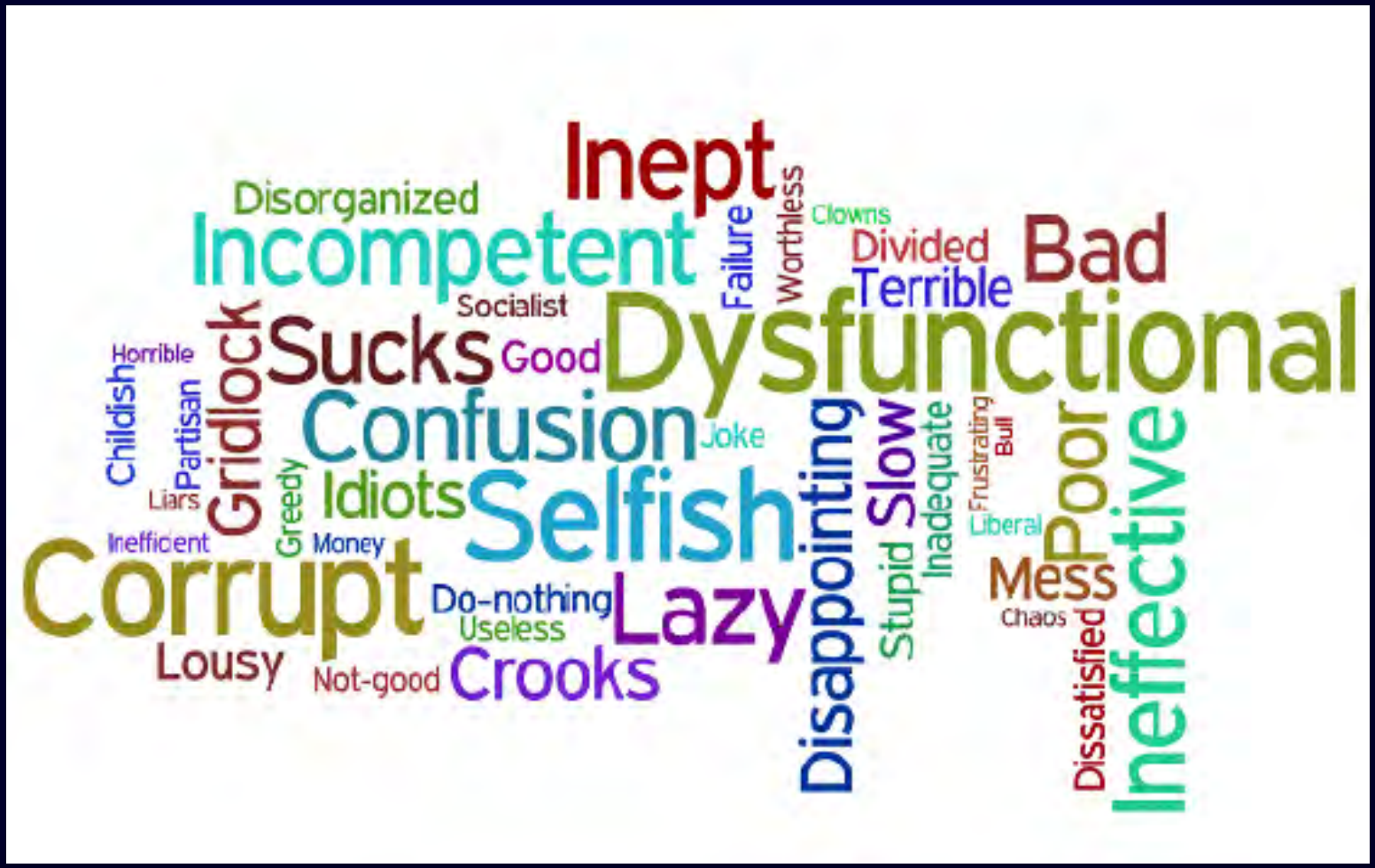
Outcome	For	Against
Court has jurisdiction to hear the case now.	9	0
Individual insurance mandate is unconstitutional under commerce and necessary & proper clauses	5	4
Individual insurance mandate ***is*** constitutional under Congress' power to tax	5	4
Medicaid expansion violates Congress' spending clause power as unconstitutionally coercive of states because all existing Medicaid funds at risk and states not given adequate notice to voluntarily consent	7	2
Remedy is to limit HHS Secretary's power to withhold existing federal funds for state non-compliance with Medicaid expansion	5	4

Did not need to address "severability" issues since mandate was upheld

So Now What?

Ball Remains in Congress' Court

The Bad News:
Your Government at Work



Modifying Affordable Care Act: Priority Issues

- Repeal IPAB
- Repeal SGR & adopt Medicare private contracting
- Repeal PQRS, eRx, EHR penalties & valued based payment modifier
- Adopt federal medical liability reform

The Independent Payment Advisory Board (IPAB)

- What is the IPAB?
  - 15 member, government board
  - Sole purpose: cut Medicare
  - Limited Congressional oversight
  - No judicial review
  - Hospitals exempt from cuts until 2020
  - Cuts on top of SGR and other Medicare cuts

IPAB cuts begin in 2015

Efforts to Repeal IPAB

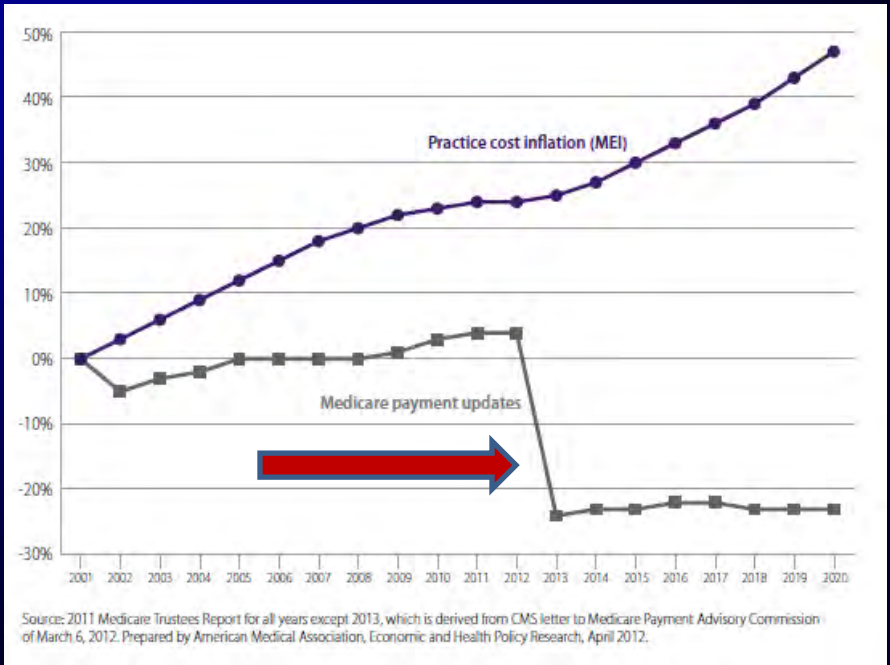
- *House of Representatives*
  - Passed H.R. 5, the "Protecting Access to Healthcare Act"
  - Bipartisan Vote: 223-181
- *Senate*
  - Introduced S. 668, the "Health Care Bureaucrats Elimination Act"
  - 32 cosponsors (all republicans)

The *Un*sustainable Growth Rate (SGR)

- House/Senate continue w/short-term "patches" to fix Medicare's SGR

→ 27% pay cut on Jan. 1, 2013

→ Cost of Repeal = $300+ billion



Problem Continues to Grow

Progress to Date

Options for SGR Reform "very" appealing:

- **MedPAC**
  - 10 yr pay freeze for PCPs; 18% pay cut for specialists + 7 yr pay freeze
  - RVUs based on efficient practice
  - Reduce overpriced procedures for 5 yrs; give $ to PCPs
  - Accelerate ACOs, bundled payments, etc.
- **Rep. Allyson Schwartz** (D-PA)
  - Eliminate fee-for-service
  - Force docs into ACOs other large systems

Medicare Private Contracting

House/Senate introduced Medicare Patient Empowerment Act (MPEA) – H.R. 1700/S. 1042

- HR 1700 = 41 cosponsors
- S. 1042 = 1 cosponsor

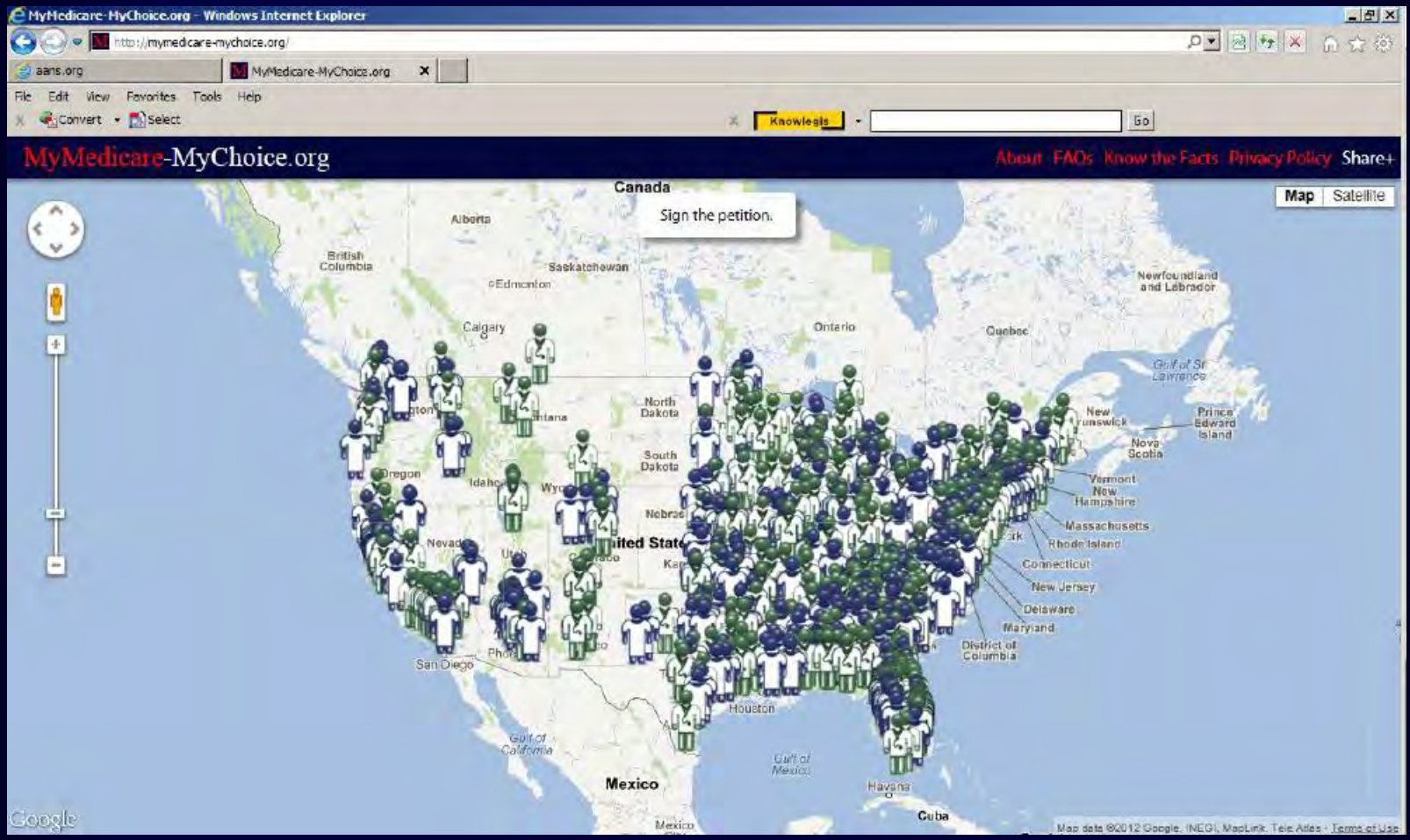
→ Allows docs and patients to privately contract on case-by-case basis

→ No Medicare opt-out

→ Hospital other fees still paid

www.MyMedicare-MyChoice.org

Sign the Petition

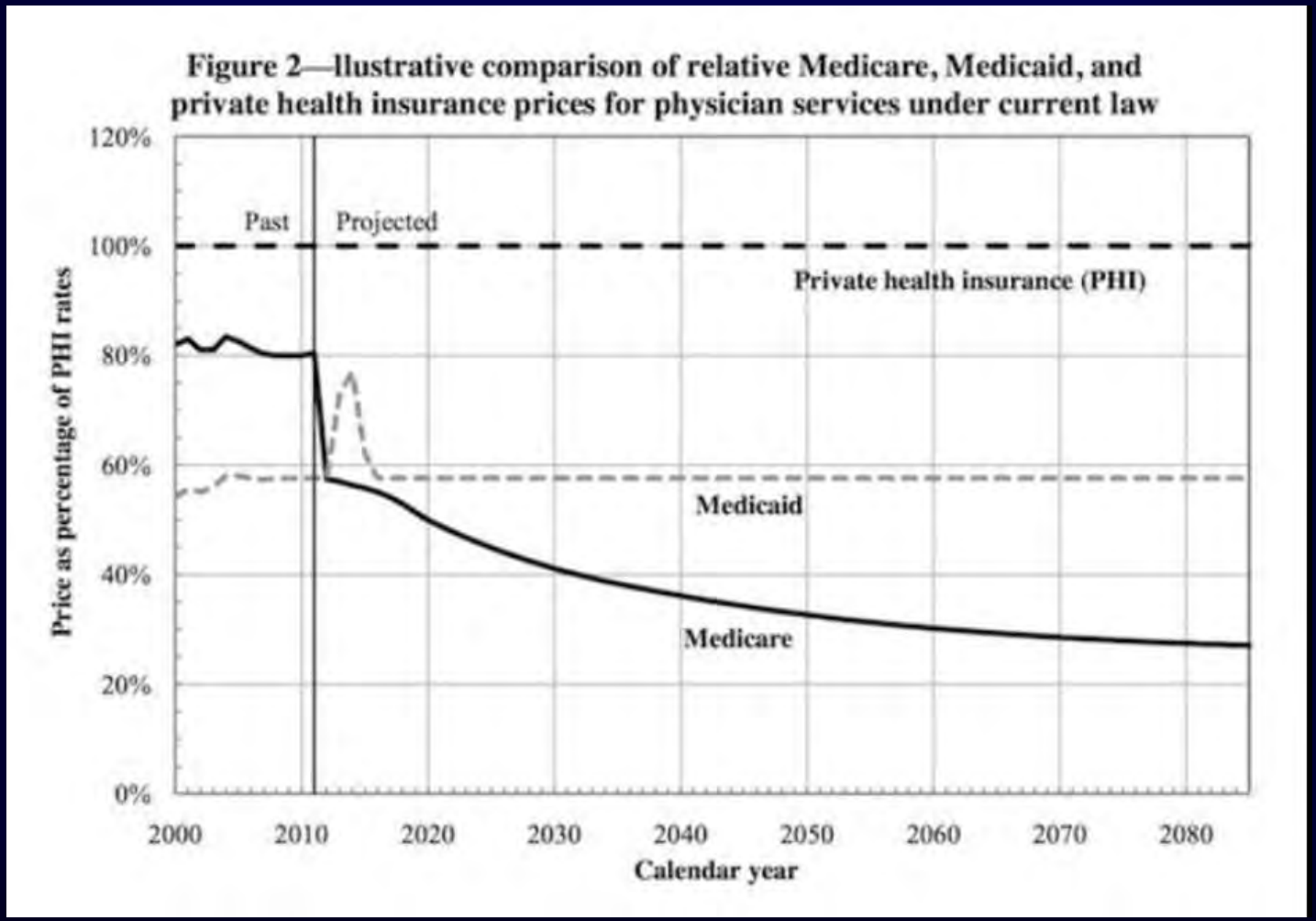


www.MyMedicare-MyChoice.org

Medicare Payment Reform

- **Next steps**
  - SGR will **NOT** be permanently repealed this year due to cost and lace of consensus on "replacement" policy
  - Congress will revisit issue in "lame-duck" post-election session, passing another short term "fix" (duration unknown)
  - Key Congressional committees developing options for "replacement" policy once SGR is repealed

Failure to Act: Medicaid rates HIGHER than Medicare



The Penalties are Coming!
The Penalties are Coming!

2015

BUT **CMS will start the clock in 2013!**

PQRS, eRx, EHR Oh My!
The Alphabet Soup of Quality

- Medicare's Quality Programs for MDs
  - Physician Quality Reporting System (PQRS)
  - Electronic Prescribing (eRx)
  - Electronic Health Records (EHR)
  - Value-Based Payment Modifier (VBPM)
- Future Penalties for Non-Compliance

Under Scrutiny: Resource Reports

PART I. QUALITY OF CARE

Quality Measures Derived from Medicare Claims

Exhibit 1 shows how many of the[#] Medicare patients for whom you filed at least one claim in 2010 received specific recommended clinical services, based on all Medicare claims from **all physicians treating them** (including you). If the number of patients is small (fewer than 30), please use caution in making comparisons.

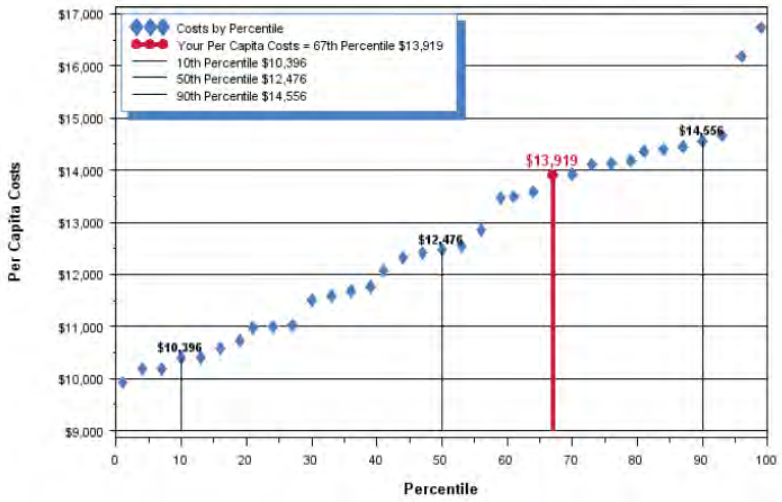
Exhibit 1. Physician Performance on Medicare Claims–Based Quality Measures for All Patients for Whom the Physician Filed at Least One Medicare Claim in 2010

Clinical Condition and Measure	Physician Performance for All Medicare Patients			
	YOU		Physicians in Iowa, Kansas, Missouri, and Nebraska	
Specifications for these clinical measures are posted at http://www.cms.gov/PhysicianFeedbackProgram/Downloads/claims_based_measures_with_descriptions_num_denom_excl.pdf	Number of Medicare Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service	Number of Physicians	Percentage of Medicare Patients Who Received the

CMS will be using non-risk adjusted claims data do determine quality for VPBM & *Physician Compare*

High volume = bad quality

Exhibit 6. Distribution of the 2010 Total Per Capita Costs of Patients Whose Care Was Directed by Physicians in Your Specialty in Iowa, Kansas, Missouri, and Nebraska



Quality-Related Penalties

- **Future cuts phased-in to:**
  - PQRS = 2% (2016-beyond)
  - eRx = 2% (2014)
  - EHR = 5% (2019-beyond)
  - ***Budget Neutral*** Value-based Payment Modifier = ????(some docs 2015; all 2017-beyond)

And of course this is on top of SGR and IPAB cuts

Going Forward

- Seeking legislative to repeal, modify and/or delay quality-related penalties
- Meeting w/CMS and commenting on proposed regulations
- But if you can't beat them, join them:
  - Developing specialty-specific measures and measures groups for PQRS
  - Gain approval of clinical data registries and allow docs to qualify for quality programs by participating in registries

Total Cuts (worst case scenario)

	SGR Update[1]	Deficit Reduction Sequester	PQRS	e-Rx	EHR	Value Based Payment Modifier	IPAB
2013	-30.9	-2		-1.5			
2014	0.9	-2		-2			
2015	1.2	-2	-1.5		-1	-1	?
2016	1.4	-2	-2		-2	?	?
2017	0.7	-2	-2		-3	?	?
2018	0.1	-2	-2		-3	?	?
2019	-0.1	-2	-2		-4	?	?
2020	0	-2	-2		-5	?	?
2021	0.2	-2	-2		-5	?	?

[1] 2012 Medicare Trustees Report

TOTAL: 86%!

Medical Liability Reform

Status of Traditional Tort Reforms:

- *House of Representatives*
  - Passed H.R. 5, the "Protecting Access to Healthcare Act"; Bipartisan Vote: 223-181
  - Bill includes:
    - MICRA-style reforms, including $250,000 cap on non-economic damages; and
    - Protections for MDs providing EMTALA-mandated care and volunteers in national disasters
- *Senate*
  - Introduced S. 1099, the "HEALTH Act"; 32 cosponsors (all republicans)
  - Bill includes: MICRA-style reforms, including $250,000 cap on non-economic damages

Medical Liability Reform

Exploring Other Options:

- Liability protections for MDs who follow specialty's clinical practice guidelines
- Early offer/settlement
- Pre-trial screening
- Expert witness reform
- Health courts

In Summary: Progress to Date

- House repealed ObamaCare…
  → **STALLED** in Senate

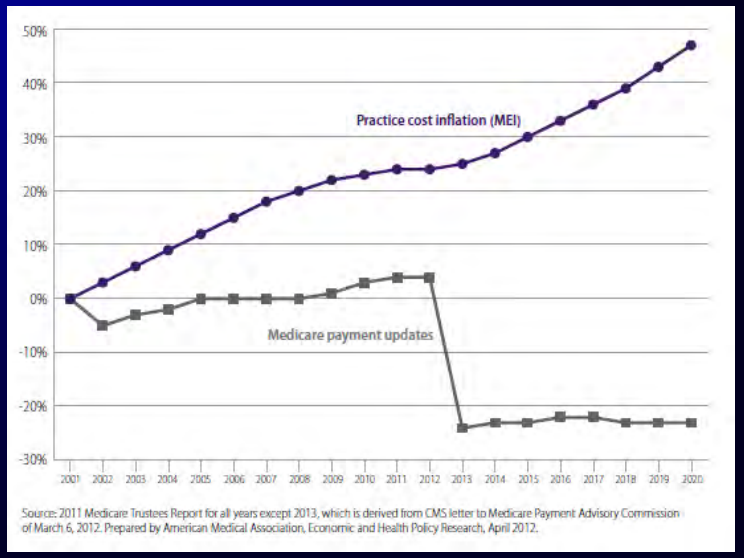
- House repealed IPAB…
  → **STALLED** in Senate

- House passed medical liability reform…
  → **STALLED** in Senate

One more note of Gloom and Doom…

… the Budget Train Wreck is Approaching

- Pay-roll tax holiday *expires*
- So-called Bush tax cuts *expire*
- Unemployment benefit extension *expires*
- 30% SGR physician pay cut
- 1.2% trillion budget cuts/sequestration
  - Medicare, NIH, Public Health



SCOPE OF PRACTICE

JEFF SUMMERS, MD

VICE PRESIDENT

INTERNATIONAL SPINE INTERVENTION SOCIETY (ISIS)

Scope of Practice

Scope of practice battles touch almost every specialty:

- OB/GYN and Midwives
- Orthopedic Surgery and Podiatry
- Ophthalmology and Optometry
- Anesthesiology and CRNAs
- Maxillofacial Surgery D.M.D and Dentistry
- PMR and PT

Today's discussion will concentrate on

Interventional Pain Management

ISSUE: UNQUALIFIED PROVIDERS AND INTERVENTIONAL PAIN MANAGEMENT

Nursing community: years of efforts on federal and state legislative, regulatory and legal front to allow non-physicians to practice what we define as the “practice of medicine”

State and Regional Issues and Updates

STATE BATTLES OUTLINED AT THE SPINE SUMMIT IN PREVIOUS YEARS

Multiple State battles were already described at the Spine Summit Meetings in previous years:

Louisiana, New Hampshire, Minnesota, Nebraska, Alabama, Oklahoma, Iowa, etc.

IOWA - UPDATE

2009

Board of Nursing: pain management is part of the practice of nursing + advanced practice nurses are qualified to supervise fluoroscopy

2010:

Iowa Department of Public Health (IDPH), Agreed with Board of Nursing

IOWA - UPDATE

Iowa Advanced Nurse Association (IANA) admitted during the rulemaking process that training CRNAs receive… is insufficient to make CRNAs competent to utilize fluoroscopy in practice.

November 2011:

The Court held the regulations to be:

" invalid, illegal, void and of no effect"

Federal Trade Commission (FTC)

Federal Influence on a State Level

Federal Trade Commission (FTC)

Tennessee & Alabama

FTC weighed in commenting on proposed bills to regulate providers of interventional pain management procedures

Federal Trade Commission (FTC)

Alabama

Alabama Board of Medical Examiners (ABME):

IPM procedures constituted the practice of medicine, and therefore, should be so regulated.

FTC implied that the ABME was engaging in anticompetitive behavior and may be subject to further FTC inquiry.

The effect of the FTC letter was that the ABME immediately ceased its activity on the proposed rule.

Tennessee-Bill Passed

No physicians other than board certified anesthesiologists, radiologists physiatrists, orthopedic/neurosurgeons and neurologists can perform these procedures unless they have ABMS pain fellowship training.

Only the above are entitled to supervise nurse anesthetists.

NORIDIAN

(Medicare Administrative Contractor)

AUGUST/SEPTEMBER 2011

STATEMENT ON CRNA Practice and Chronic Pain Management

NORIDIAN

(Medicare Administrative Contractor)

“Chronic pain is a disease state in and of itself

Reasonable treatment of a chronic pain disorder begins with a detailed medical assessment aimed at developing a diagnosis or diagnostic evaluation plan which will then lead to an appropriate and comprehensive therapeutic plan. “

NORIDIAN

(Medicare Administrative Contractor)

The assessment skills required for the evaluation of the chronic pain state and consequent therapy are not part of the CRNA training curricula.

Noridian

Noridian Medical Director to the Council of Pain Physician Societies on a conference call:

Review of Society Websites (except ASA):

No statement of chronic pain as a disease nor that chronic pain interventions are the practice of medicine

Multi-specialty position statement would be helpful

From State and Regional to National Level…

National Concerns

PPACA already contains a provision stating that health plans may not discriminate against any health care provider, acting within the state scope-of-practice laws, that wants to participate in the plan

Chronic Pain Management Services
CMS PROPOSED RULE JULY 2012

Medicare Administrative Contractors (MACs)

[ie. Noridian]

have reached different conclusions as to whether the statutory description of 'anesthesia services and related care' encompasses the chronic pain management services delivered by CRNAs.

MEDICARE PROPOSED RULE

"Anesthesia and related care includes medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the State in which the services are furnished."

WHAT DOES THIS MEAN?

CRNAs to be paid full Medicare price for Chronic Pain Management Services that they are allowed to perform in their state.

MEDICARE PROPOSED RULE

Despite CMS' proposed regulation, in the very same proposed rule, CMS states:

"Simply because the State allows a certain type of health care professional to furnish certain services does not mean that all members of that profession are adequately trained to provide the service."

Comments on the Proposed Rule are Due September 4

WHERE DO WE STAND?

ASA Response

"The American Society of Anesthesiologists (ASA) strongly opposes the Centers for Medicare and Medicaid Services' (CMS) ill-advised proposal to create a new national policy to pay for chronic pain service delivered by providers who have no formal education or training in this *specialized area of medicine."*

ASA Points

Nurse anesthetists have neither the education nor the training to perform chronic pain services.

Medicare's data shows that physicians are the overwhelming providers of pain services, even in underserved areas, delivering over 99.8% of all services.

AANA Letter to FTC

The ASA letter holds that all physicians, regardless of subspecialty, education, or experience, have authority to perform interventional pain management services. While it advocates that all doctors should be able to perform interventional pain management services, it also advocates that all CRNAs, who are anesthesia experts, should not be able to perform *any* of these services under *any* circumstances. The only clear distinction is the type of license possessed by the healthcare professional – medical or advanced practice registered nursing. This arbitrary distinction fails to take into account the healthcare professional's education, training, experience, and expertise.

That's NOT What the ASA Said

"The (ASA) strongly opposes…a new national policy to pay for chronic pain service delivered by providers who have no formal education or training in this *specialized* area of medicine."

AMA POLICY

(…) interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians

(D-35.984)

NASS, ASA, AAPMR, ISIS, AAPM, Radiology and more – all on record supporting this policy

AMA

Developed a multidisciplinary Task Force on invasive procedures (Anesthesiology, Surgery, etc.,)

Interventional Pain Management

Do we all agree that it is within the scope of practice of MEDICINE?

If we can agree that interventional pain management is the practice of medicine…

Can we have a multi-society position statement to communicate that?

So There are Two Questions:

Is this about turf?

Are we being hypocritical?

Medicine's Ultimate Position:

That non-physician practitioners lack the education and *training* needed to practice medicine

Scope of practice arguments supported only by statute or regulatory law that does not allocate responsibilities could be accused of being turf battles

ISIS

Only members who are board certified/eligible in the following specialties:

Anesthesiology, PM&R, Radiology,

Neurology, Orthopedic Surgery and Neurosurgery

have appropriate background education/training to be eligible to take ISIS spine intervention courses.

ABMS Board Certification (AQ) in Pain Medicine Requirements

ABMS: Boards of Anesthesiology, Psychiatry/Neurology

Diplomates must apply through their primary board +

Complete one-year of ACGME Accredited Pain Medicine fellowship program

ABPMR

Diplomates of any other ABMS Member Boards +

1 Year of ACGME Pain Subspecialty Fellowship + ABMS Examination

The training curriculum must be compatible with the program requirements in PM&R

Should any statement on Interventional Pain Management have a statement regarding minimum *physician* qualifications?

If Not, How Do You Counter the AANA Letter to FTC?

The ASA letter holds that all physicians, regardless of subspecialty, education, or experience, have authority to perform interventional pain management services. While it advocates that all doctors should be able to perform interventional pain management services, it also advocates that all CRNAs, who are anesthesia experts, should not be able to perform *any* of these services under *any* circumstances. The only clear distinction is the type of license possessed by the healthcare professional – medical or advanced practice registered nursing. This arbitrary distinction fails to take into account the healthcare professional's education, training, experience, and expertise.

Why is Everyone Doing (or trying to do) Interventional Pain?

ANSWER:

Because They Can!

"Surgeon" is defined as a licensed physician performing any procedure included within the definition of surgery

The difference is CREDENTIALLING

If we don't do it, who will?

AAOS 2012

AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

HR 1409: Correcting the Imbalance between Health Care Professionals and Health Plans

Christopher P. Kauffman, MD

NASS Spine Summit

August 10, 2012

Sherman Anti-Trust Act 1890

- Sherman -"To protect the consumers by preventing arrangements designed, or which tend, to advance the cost of goods to the consumer”

Sherman Anti-Trust Act 1890

- Supreme court 1993
- "The purpose of the [Sherman] Act is not to protect businesses from the working of the market; it is to protect the public from the failure of the market."

Background

- The McCarran-Ferguson Act of 1945
  - Came as a result of a Supreme court Ruling
  - *United States v. South-Eastern Underwriters Ass'n*

The McCarran-Ferguson Act of 1945

- partially exempts insurance companies from the federal anti-trust legislation that applies to most businesses[1]
- allows for the state regulation of insurance
- allows states to establish mandatory licensing requirements
- Preserves certain state laws of insurance.

The McCarran-Ferguson Act of 1945

- Overall Effects
  - Exempts health insurance issuers from federal antitrust laws
  - Allows a few select health care plans to dominate the market

Background

- The AMA's study, Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2010), found that in one year, the two largest insurers with a combined market share of 70 percent or more increased from 18 of 42 states to 24 of 43 states
- In Gadsden, Alabama, for example, BCBS AL holds a 94% share of the health insurance market

The Problems for Physicians

- Under current antitrust law, health care providers are prohibited from working together to pursue fair reimbursement rates
  - Physicians that come together to negotiate reimbursement rates are subject to investigation for collusion and antitrust violation by the DOJ and FTC

The Problems for Physicians

- These antitrust enforcement policies and recent healthcare industry consolidations have enabled health insurance issuers to capture significant market power sufficient to impose unilateral, non-negotiable contracts onto physicians

The Problems for Physicians

The AMA's report in 2007 found that "physicians across the country have virtually no bargaining power with dominant health insurers and that those heath insurers are in a position to exert monopsony power"

- This imbalance in negotiating power has forced an increasing number of private practitioners to close shop and join hospital systems

The Problems for Patients

- **Many private practitioners** can no longer afford to stay in private practice, and are often forced to merge with hospital systems creating unintended negative consequences for the patient:
  - Higher cost of care at hospitals is passed on to patients.
  - Patients experience reduced access to care as hospital systems dominate their region.

The Problems for Patients

- These contracts give insurers the power to deny patients access to timely care, and impose costly administrative burdens on physicians that further limit their ability to provide care to patients

The Solution

The "Quality Health Care Coalition Act of 2011" (H.R. 1409)

- "To ensure and foster continued patient safety and quality of care by clarifying the application of the antitrust laws to negotiations between groups of health care professionals and health plans and health care insurance issuers"

H.R. 1409

- Any health care professionals who are engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plan shall, in connection with such negotiations, be exempt from the Federal antitrust laws.

The Solution: HR 1409

- Protects health care professionals engaged in contractual negotiations with a health plan for the delivery of health care services from federal antitrust prosecution
- Enables health care professionals to negotiate meaningful contracts that deliver high-quality health services and protect patient safety, while also bending the cost curve by cutting wasteful spending

The Solution: HR 1409

- Employs open negotiations between insurers, physicians, and patients that foster the development of transparent contracts
- Reverses the current trend of physician departures from the practice of medicine
- Reverses the current migration of private practice physicians to hospital employment.
- Allows healthcare providers to emerge as patient advocates in future private ACOs without fear of antitrust prosecution.

HR 1409 Exemptions

- No collective cessation of services
- No change in National Labor Relations Act

- **No application to federal programs**

Quality Health Care Coalition Act of 2011

- A bipartisan bill co-sponsored by Representative John Conyers (D-MI), Congressman Ron Paul (R-TX)
  - Introduced in the House on April 7, 2011
  - Referred to the House Judiciary Committee
  - H.R. 1409 enjoys bipartisan co-sponsorship from:
    - Representative John Duncan (R-TN), Congresswoman Donna Edwards (D-MD), Representative Jeff Miller (R-FL), Congressman Tom Price, MD (R-GA), Representative Steve Southerland (R-FL), Congressman Dan Benishek (R-MI), Representative Ken Calvert (R-CA), Congressman Steven Palazzo (R-MS), and Representative Aaron Schock (R-IL)

Quality Health Care Coalition Act of 2011

AAOS' Office of Government Relations has been meeting with Senate offices to enlist Senate Champion(s) to introduce companion legislation to H.R. 1409 in the U.S. Senate.

AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Improving the Relationship between Professional Societies and Industry While Promoting an Ethical Relationship and Professionalism

John Finkenberg MD
NASS Advocacy Chairman

2012

Concern

Over the last 5 years a significant amount of negative press has surfaced regarding physician and professional society relationships with Industry.

There was the perception that both groups were prioritizing their professional relationship over patient benefit.

Attention

- National and Local Media
- Professional Organizations
- FDA
- OIG (Office of Inspector General)
- Legislative Branch of US Government
  (Senate Finance Committee)
- State Government
  (Regulatory laws in Massachusetts, Vermont,
  New York and Minnesota)

Societies Effort to Develop Guidelines

- 2002 Medical Professionalism in the New Millennium
- 2004 Standards for Commercial Support
- 2008 Industry Funding of Medical Education
- 2009 PhRMA Code
- 2009 AdvaMed
- 2010 Code for Interactions with Companies

Guidelines and Codes

- Independence
- Transparency
- Appropriate Charitable Contributions
- General Medical Education / CME
- Research
- Practice Guidelines
- Societal Journals
- Defining Conflict of Interest

Federal Level

- 2009 Physician Payments Sunshine Act

  -Requiring pharmaceutical and medical device companies to disclose all payments to physicians

  (part of Affordable Care Act)

- Federal Anti-Kickback Statue

  -Fine and/or Imprisonment for offering remuneration for referral or recommendation of any item or service covered by federal healthcare program

  -Safe Harbor amendments were later added

Interesting Facts

- Industry funds more than 60% of biomedical research and 50% of clinical research
- Industry heavily supports our professional medical journals through advertising and paid supplemental issues
- In 2008, 24% of the operating budget for AAOS and 30% of AOA was funded by Industry (Note: 30-50% of all professional societies budgets are funded by Industry)

Reason for Discussion

- Some Industry members feel the pendulum has swung too far
- There is a perceived “adversarial” posture being taken by Societies toward Industry
- Societies expect continued support but are limiting access to physicians and meeting exposure
- Physicians are reluctant to interact with Industry due to concerns of being considered unethical and creating conflict of interest

- Industry is unable to work with physician “thought leaders” in developing innovative products even with full transparency and fair market reimbursement
- Physicians with expertise in specific areas are reluctant to participate in teaching labs
- Physicians with the most experience must make a choice between advancing quality healthcare through Industry interaction and Leadership positions

Potential Opportunities

- Publish clear Guidelines regarding Industry/Society relationships discussing positive appropriate interaction and not just the negative
- Promote Transparency on all Levels
- Publish Guidelines or Codes that encourage ethical physician/Industry interaction with reimbursement at fair market value

- Defining Professionalism and encouraging physician/Industry interaction that demonstrates how this can benefit patients and increase value/quality of healthcare

- Change the perception “back to” the concept that it should be considered an honor to be designated as a “thought leader”, asked to participate in required research and sought after to be a faculty member

- Define outstanding ethical behavior and professionalism from a Pro-Industry angle

- Continue to communicate with Industry to make sure we are working together to the benefit of our patients.

Multi-Society Leadership Survey

F. Todd Wetzel MD

Director, NASS Administration and Development Council

Survey results

- Goal: to increase background information as NASS proceeded with Leadership Development Program
- Societal Leadership Polled:
  - AAOS
  - AANS
  - AAPM&R
  - ISIS
  - NASS
  - CNS

Survey results

- Past Leaders
  - 35 polled
  - 14 responded (40%)
- Current Leaders
  - 17 polled
  - 6 responded (35%)

Survey results

- How and why did you get involved?
  - Past
    - General Interest: 50%
    - To make a difference: 29%
    - Recommended by others: 14%
    - Education: 7%
  - Current
    - Process in residency program and interest: 50%
    - Asked by other leaders: 50%

Survey results

- Why did you stay involved?
- Past
  - To serve/ give back/ make a difference: 44%
  - Belief in society goals and mission: 21%
  - Opportunities: 14%
  - Expand the field/ enjoyment/ people: 7%, each
- Current
  - Challenges/ opportunities: 50%
  - People: 33%
  - Satisfaction and giving back: 17%

Survey results

- Why did you accept a leadership role?
  - Current
    - Giving back: 83%
    - Essential to the practice of medicine: 17%

Survey results

- Past Leaders
  - Are you currently involved or hold any office?
    - Yes: 64%, No: 36%
  - How can potential leaders be identified?
    - Committee work/ early involvement in the society: 57%
    - LDPs: 22%
    - Networking with current and past leaders: 7%

Survey results

- Past leaders
  - How do you define leadership?
    - Lead groups to a common goal/ vision: 36%
    - Identify new visions/inspire those around you: 36%
    - Impressive knowledge and skills: 14%
    - Promoting those around you: 7%
    - Lead by example, make hard decisions, be respected and honest: 7%

Survey results

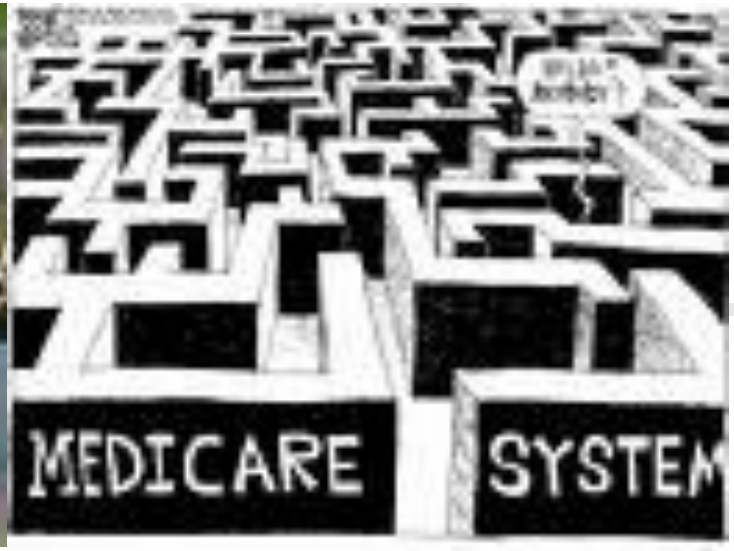
- Past leaders
  - What characteristics are essential for good leadership and what advice would you give those that follow?
    - Ongoing strength of any organization depends on who was promoted up and through the organization
    - Collaborate with others; accept you are not always right; accept constructive criticism
    - True leader gets satisfaction from the success of the organization
    - Good listening skills
    - Mentor
    - Clear vision and plan for implementation
    - Lead by example

Survey results

- Looking at the data
- Will be used in LDC, probably as background or why leadership development is important
- Recurrent themes
  - Give back to society
  - Identification by committee work, LDP
  - Skills consistent with leading the team

They're HERE!!!

Medicare Audits

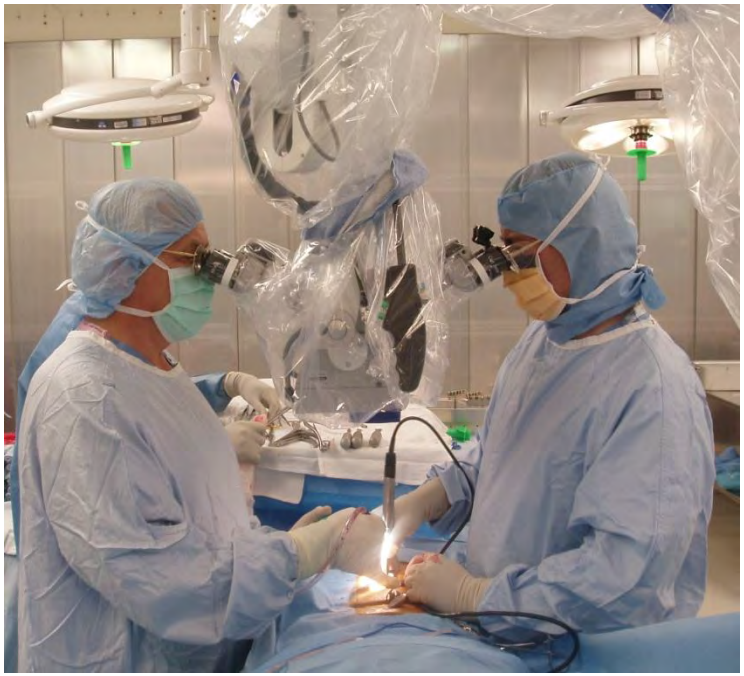


Not just hospitals-Now MD's at Risk of retrospective repayment

David A. Wong MD, MSc, FRCS(C)
Past President NASS
Member NASS Washington Committee

Disclosures
David A. Wong MD, MSc, FRCS(C)

- **Stockholder**
  - **Denver Integrated Imaging North**
  - **Colorado Ortho & Surgical Hospital**
  - **Neurotech/CervIOM Colorado**
  - **Huron Shores LLC**
- **Research Funding**
  - **Abbott/Anulex-Nuvasive/Cervitech/Stryker/ Zimmer/ Mesoblast**
- **Consultant**
  - **Anulex/DeRoyal/Allosource/ United Healthcare**



"RAC" Recovery Audit Contract

- Obamacare
  - $500 B red'n Medicare
- CMS Audits –"recover" $
  - Guise fraud and abuse
  - Documentation
    - Academic Medical Centers
    - OR note document staff surgeon present
    - Repayment of DRG
    - Jim Herndon
      - Penn - $20 M

"RAC" Recovery Audit Contract

- Who
  - CMS contractors
- What
  - Hospital Pre-payment audits
  - Hospital Post-payment audits-new
- Where – Pre payment
  - 7 high fraud/improper billing
    - FL,CA,MI,TX,NY,LA,IL
  - 4 high rate short stay inpatient
    - PA,OH,NC,MO

"RAC"
Recovery Audit Contract

- Hospital Pre-payment audits
  - Document Sx indications
  - Outpatient/Obs
  - No docs = No Pay
- Hospital Post-payment audits
  - Pilot
  - Retrospective review – 3 yrs
    - Document Sx indications
    - Outpatient/Obs
  - Repayment DRG – Hospital
  - ***Repayment Surgical Fee – MD***

Recourse/Due Process

- Request Review ALJ (Administrative Law Judge)
  - Hire attorney/review Co
  - Court costs
  - Time
- Accretive PAS (Physician Advisory Services)
  - Chicago
  - 70% cases overturned

Criteria

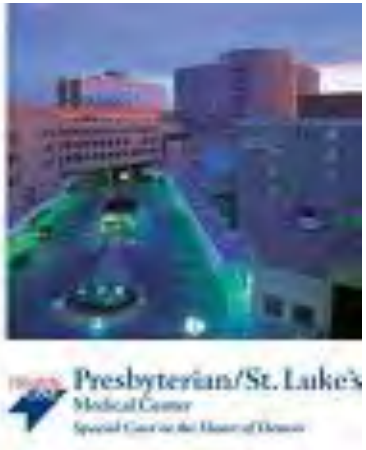
- **RAC Pre-Payment Fusion Criteria**
  - **Black Box**
  - **? Source?**
  - **? Application to other diagnoses**
- Documents
  - H&P/Progress notes
  - Consultations
  - PT/OT evaluations / notes
  - Radiographic reports
  - Therapeutic procedures-inj
- Documentation
  - HPI – Onset to present
  - Prior treatments/results
  - Current symp/func limits
  - Exam consistent with Hx

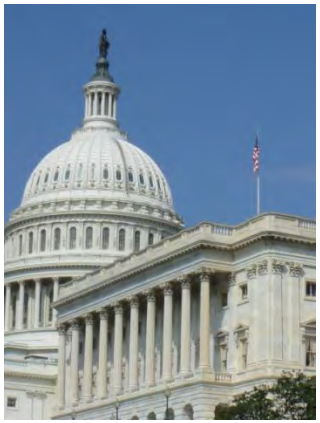
RAC Criteria

2) Spinal stenosis with associated spondylolisthesis for a single level (e.g., L4-L5), or other documented evidence of instability (e.g., facet joint instability (iatrogenic) related to decompression)	**ALL of the following MUST be documented:** **1) Back pain with symptoms of neurogenic claudication or radicular pain** **2) Radiographic evidence of spondylolisthesis when applicable. Classification of slippage in spondylolisthesis is defined as follows: Grade I = 1% - 25%, Grade II = 26% - 50%, Grade III = 51% - 75%, Grade IV = 76% - 100%, Grade V = spondyloptosis and occurs when the L5 vertebra completely slides over the top of the sacrum.** **3) Pain and significant functional impairment despite a history of 3 months of conservative/non-surgical therapy as clinically appropriate addressing the following: a) Anti-inflammatory medications, b) Analgesics, c) Daily exercise, d) Activity/ lifestyle modification, e) Weight reduction as appropriate, f) Supervised PT with ADLs diminished despite completing a plan of care** **4) If cognitive, behavioral, or addiction issues are identified, the documentation should support assessment and treatment prior to surgical management.**

Congress

- American Hospital Association-AHA
- HR 1543
  - Improving Access to Medicare Coverage Act of 2011
    - Joe Courtney (R) Connecticut
    - Tom Latham (R) Iowa
  - Outpt/Obs count to 3d inpt qualify SNF
    - Remove Observation status
  - In Committee
    - Ways and Means/Energy and Commerce





Congress

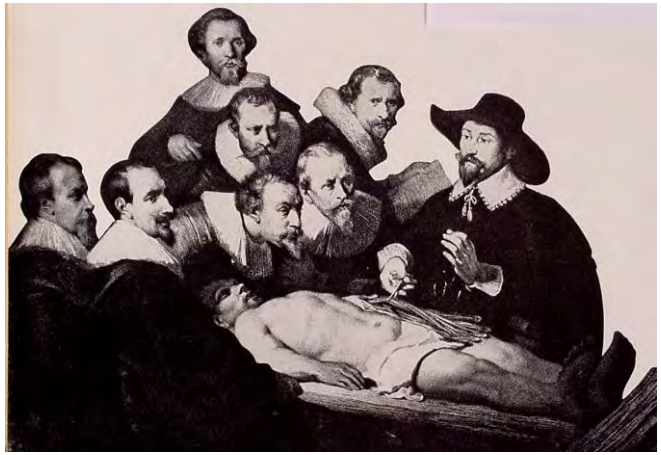
- 6-26-12 letter to Gene Dodaro -US Government Accountability Office (GAO)-Comptroller General of the US
- 11 Senators/Congressmen
  - Hatch R-UT,Baucus D-MO,Coburn R-OK, Carper, Grassley R-IA
  - Upton R-MI, Waxman D-CA, Stearns R-FL, DeGette D-CO, Boustany R-LA, Lewis D-GA
  - http://republicans.energycommerce.house.gov/Media/file/Letters/112th/062612GAOMedicare.pdf

Congressional Letter

- "determine whether the contractors audit criteria and methodologies are valid, clear and consistent"
- Prevent duplication/overlap
- What strategic plan to co-ordinate and oversee audits

Actions ?

- Voice
  - Congress
  - CMS
  - GAO
  - IOG
- Member Heads up/ Education
  - Uncertain criteria



MD's Take Grief