

Upcoming Events

October 23, 2009

Inpatient and Outpatient Medicine
SEP Modules; Patient-Centered
Medical Home Interactive
Workshop

October 24-25, 2009

Southern California Regions I and
III/SGIM Annual Scientific Meeting
Hyatt Grand Champions Resort
and Spa, Indian Wells, CA

January, 13, 2010

Annual Associate's Dinner, UCSD
Faculty Club

March 2-3, 2010

Sacramento Leadership Day

April 22-24, 2010

IM 2010
Toronto Canada

In This Issue

From Your Governor	1
The 2009 ACP Regions I and III Scientific Meeting	2
Recruit-a-Colleague Program	2
Kudos Corner	2
Thank You, Dr. Parthemore!	3
Leadership Enhancement and Development	3
Fellowship	4
Healthcare Reform	5
Region III Chapter Officers	8
RAC Audits Are Here!	10
Physicians Urged to Pre-Register for H1N1 Vaccine	10



From Your Governor

Greetings!

It has been five months since I've assume the role as the new Governor of the Southern California Region III Chapter. I feel privileged to be your Governor and have several ideas for rejuvenating our Chapter and creating opportunities for our membership to become more involved in local, state and national issues.

These are very tumultuous times in medicine and Internists need to have a voice in the decisions being made about the direction that health-care will take. There are many opportunities for you to become involved our Chapter's efforts to make our voices heard. Those opportunities include:

- Becoming a member of the Governor's Council for our Chapter. We are seeking to expand our Governor's Council in order to develop more activities that will benefit our Chapter members and potential new members from our local medical programs. We would like establish more committees to develop activities such as a medical student mentoring program, input for educational programs, and community outreach. Council duties include those normally performed by a Board of Directors of a corporation. The Council manages the business affairs of the chapter, including chapter finances and is also responsible for setting the goals of the chapter and addressing policy issues as needed. The Council also oversees all activities of the local committees.
- Chapter Committee Chairs – We need strong and committed leaders to chair the various committees we hope to establish. By growing the Governor's Council, we hope to attract members who want to make a difference and assume leadership roles.
- State and National Advocacy - Now, more than ever, internists need to have their voices heard loud and clear in Sacramento and Washington D.C. We need to be proactive in helping to develop and support policies that will preserve primary care and our practices. Therefore, I would like to invite any of you who are interested to take part in our advocacy efforts. The California State Chapter has an active Health and Public Policy Committee (HPPC) which is very involved in advocating for our interests with lawmakers and policymakers. I would like to resurrect our local HPPC to represent Region III at the State and National levels. This would include attending lobbying sessions in Sacramento and Washington D.C. I have found that attending those sessions and meeting with the legislators is an incredible experience

and very productive. Some Council or HPPC Members are sponsored to attend these advocacy sessions, however all Members, Associates and Medical Students who are interested in participating in these advocacy efforts are encouraged to do so.

If you are interested in participating in any of the opportunities listed above, please contact me at acpcarla@gmail.com or (619) 299-2570. Or you may contact **Natalie Kaczur**, our Chapter Administrator, at CalifACP@aol.com or (760) 747-0014.

I would like to remind our members that now is a great time to apply for ACP Fellowship. The application process has been significantly streamlined and there are several pathways to Fellowship, which makes more of our members eligible for advancement to FACP.

For more information on membership, advancement to Fellowship or if you have questions or concerns about our Chapter, please feel welcome to contact either me or **Natalie** anytime. ■

The 2009 ACP Regions I and III Scientific Meeting

Our Annual Southern California Regional Meeting is right around the corner – October 23-25, 2009 at the Hyatt Resort and Spa in beautiful Indian Wells. This year, Regions I and III joined with the California Society of General Internal Medicine (SGIM) and developed an outstanding program addressing essential updates in general and subspecialty medicine. Speakers from throughout California will be sharing their expertise in areas such as Pulmonary and Critical Care Medicine, Cardiovascular Disease, Cancer Screening in the Elderly, Preoperative Medicine and much more. There will also be skills workshops and the keynote address focuses on a very timely topic: The Policies of Healthcare Reform. On Friday, SEP modules on inpatient and outpatient medicine are available as well as an interactive workshop on the Patient-Centered Medical Home (PCMH). Dr. Carole Warde and the California ACP PCMH Committee are working hard to develop a PCMH pilot program for California. Physicians interested in learning more about the PCMH should attend this interactive workshop.

For more information on this meeting or to register, go to www.acponline.org/chapters/ca. You may view the entire program and learn more about the PCMH workshop by accessing this site. Questions? Call **Natalie Kaczur** at 760-747-0014. See you in October!

Strengthen Our Chapter: Participate in ACP's Recruit-a-Colleague Program!

The American College of Physicians and the Southern California Region III Chapter encourages all members to help strengthen the voice of internal medicine by recommending ACP Membership to colleagues. By joining the College, your colleagues will enrich their clinical knowledge and skills and have access to all of the ACP member benefits that you enjoy.

To thank you for your dedication to our organization, ACP offers dues incentives to members that recruit new members through the Recruit-a-Colleague Program. In addition, successful recruiters have the chance to win a trip to the annual Internal Medicine meeting that includes registration, airfare (up to \$500), and hotel accommodations.

To learn more about the Recruit-a-Colleague Program, please visit www.acponline.org/recruitacolleague.

Kudos Corner

New Members and Fellows

Region III welcomes the following new members to our Chapter:

Paolo Abada, M.D.

Mary Ann Arndt, M.D.

Amy Chang, M.D.

Michele DeKorte, M.D.

Kevin Antonio, M.D.

Josef Bauer, M.D.

Jason Davis, M.D.

Michael El Sonbaty

Margo Girardi
John Hippen
Jenna Lavina
Caroline Lin
Herman Lyle
George Maloof
Soyoung McFarland
Miguel Pena Ruiz
Priya Shah
Timothy Strouse
Natalie Voskanian

Alshafie Hassan
Karin Kordas
Ni-Cheng Liang
Cuong Luu
Haleh Mahdavi
Kimberly Maxon
Richard Nguyen
Michael Richardson
Mohammed Siddiqi
Nicole Tremain
Farah Yousif

New Fellows

Roya Kohani, MD FACP	La Jolla	92037-6205	09/01/2009
George J Rodriguez, MD FACP	San Diego	92130	09/01/2009
Susan E Trompeter, MD FACP	Rancho Santa Fe	92067	04/01/2009

Thank You, Dr. Parthemore!



A huge thank you to **Dr. Jackie Parthemore**, our immediate past Governor, for the wonderful job she did managing our chapter. Her tenure as Governor ended in April 2009. Dr. Parthemore will continue to serve on the Governor’s Council and is Chairperson of the Fellowship Recruitment Committee.

Additionally, congratulations to Dr. Parthemore on her recent retirement from the VA Hospital where worked since 1972 and served as Chief of Staff for the past 25 years! In “*retirement*,” she will continue to volunteer as a clinical attending physician in Endocrinology at the VA, participate on two Veterans Medical Research Foundation Committees, serve on the Leadership Council of UCSD’s National Center for Leadership in Academic Medicine and participate in house staff interviews and selection processes for the Department of Medicine at UCSD. In her spare time, she has joined a gym and spa and signed up for an adult education course in Adobe Photoshop. She and her husband, **Alan** (who is an avid photographer) are planning a photo workshop trip to Morocco. What retirement???

The Southern California Region 3 Chapter has won the 2008 Chapter Excellence Award. The Chapter Excellence Award recognizes those chapters that excel in reaching the standards for managing a chapter, such as communicating to members, instituting Medical Students’ and Associates’ activities and advancing and recruiting members. Congratulations to Dr. Parthemore and the 2008 Governor’s Council for their efforts in achieving this recognition.

LEADERSHIP ENHANCEMENT AND DEVELOPMENT

ACP is trying to help develop its young physicians into our next leaders. To do this, the College offers a Leadership Development pre-course prior to IM 2010.

A LEAD Certificate can be awarded to any ACP member who has completed at least five out of seven of the leadership development activities within a 3-year time frame:

- 1) Attained or maintained active Fellowship status within the College (LEAD activities are designed to help non-Fellows achieve Fellowship status)

- 2) Attended at least 7 hours of CME focused on leadership competencies, at least 3 of which are sponsored by ACP at the local or national level
- 3) Took a leadership role in the local chapter
- 4) Served on a national workgroup, committee, or council of ACP
- 5) Served as a mentor/facilitator in at least one ACP-sponsored mentoring event or program
- 6) Participated in Leadership Day on Capitol Hill or similar state legislative activity
- 7) Demonstrated leadership competencies in the community setting, such as chairing a hospital committee or council; serving on a steering committee for a church, synagogue, or temple; serving on a Board of Directors for a local youth, sports, or arts group.

Fellowship

Fellowship is an honor achieved by those recognized by their peers for personal integrity, superior competence in internal medicine, professional accomplishment, and demonstrated scholarship. It may be achieved by either advancement from ACP Membership or, in exceptional cases, by direct election.

Honorary Fellowships are granted to presidents or their equivalents of medical societies abroad who attend ACP's annual Internal Medicine meeting.

Fellows are authorized to use the letters FACP (Fellow of the American College of Physicians) in connection with their professional activities for as long as their membership remains current. They have the right to vote, hold office, and sponsor applicants for Membership and Fellowship. Fellows are inducted at a Convocation ceremony held during ACP's annual Internal Medicine meeting.

If you are interested in becoming a Fellow, the following are the basic requirements:

- Certification in internal medicine or neurology
- Professional activity in internal medicine, a combined internal medicine specialty, the subspecialties of internal medicine, or neurology
- Experience in practice or in an academic position for two years since the completion of residency
- An active medical license in good standing (if in clinical practice)
- ACP membership in good standing for two years with ACP activities
- Continuing professional development and scholarly activities, including continuing medical education as a student or teacher
- Teaching (institutional and community-based), hospital committee work, and/or volunteer and community service, especially in the voluntary provision of medical care

In addition to the basic eligibility requirements, there are four ways to qualify for Fellowship. These are not mutually exclusive, and are provided only as guidelines to the types of activities necessary to attain Fellowship. Some candidates will be accepted for Fellowship based upon a combination of activities.

- Pathway 1 — The Published Academician
- Pathway 2 — The Physician with Multiple Certifications or Advanced Degrees
- Pathway 3 — The Active ACP Member
- Pathway 4 — The Senior Physician

Direct election to Fellowship without prior ACP Membership is a singular honor, conferred upon only a few outstanding physicians each year. All applicants must meet the eligibility requirements, summarized below and detailed in the Membership Information Booklet accessible at <http://www.acponline.org/membership/mib.pdf>

The following are basic requirements for Direct Fellowship:

- Certification in internal medicine or neurology
- Professional activity in internal medicine, a combined internal medicine specialty, the subspecialties of internal medicine, or neurology
- Experience in practice or in an academic position for two years since completion of training
- Ten years post graduation from medical school
- An active medical license in good standing (if in clinical practice)
- Continuing professional development and scholarly activities, including continuing medical education as a student or teacher
- Teaching (institutional and community-based), hospital committee work, and/or volunteer and community service, especially in the voluntary provision of medical care

In addition to the basic eligibility requirements, there are additional qualifications of excellence that candidates must meet for election to Direct Fellowship:

- Substantial published scientific contributions to prominent peer-reviewed journals
- Extraordinary scholarly achievement and professional excellence in several areas, including:
 - Teaching
 - Medical education
 - Scientific presentations at national and international meetings
- Significant involvement in a hospital, an appropriate medical institution, or in clinical or scientific research
- Community activities, either medically or non-medically related, with special consideration given to the voluntary provision of medical care

You can learn more about Fellowship by visiting <http://www.acponline.org/membership/join/fellowship> where you can also download a Fellowship application. Or you may contact our Chapter Administrator, **Natalie Kaczur**, at CalifACP@aol.com or 760-747-0014 and she will be happy to send you an application packet.

Questions about eligibility requirements should be directed to the Credentialing Department at 800-523-1546, ext. 2709, or can be e-mailed to mbrservices@acponline.org.

HEALTHCARE REFORM

by Joseph W. Stubbs, MD, FACP
President, American College of Physicians

Health care reform is moving at "light speed" by US Congressional standards. President Obama has made this reform his highest priority and both Houses of Congress have picked up the gauntlet. On the Senate side, the Senate Finance Committee and the Senate HELP committee are the principal drafters of legislation. On the House side, three committees, Ways and Means, Energy and Commerce, and Education and Labor are responsible for collectively drafting legislation. All of these committees have submitted legislation drafts which are undergoing extensive review and comment by all health care, business, insurance, and consumer organizations, and the actual legislative mark-up process has begun.. Congress's intent is to have legislation voted on by August and signed into law by October. The American College of Physicians has played a significant role in these deliberations because our members who are the experts in adult primary care and the management of chronic illnesses are key to reform of the delivery system and because the policy of our organization is considered by those in government to be some of the most reliable and comprehensive sources of information available. Important for our membership are four key areas, universal coverage, support of primary care, new models of reimbursement and delivery, and financing.

The College has long been committed to health care reform that provides all Americans with access to affordable health insurance. The legislation in both the House and Senate drafts strongly seek universal coverage through insurance market reforms, a health insurance exchange for those unable to get benefits through their employment, better coverage of preventive services, expansion of Medicaid to cover all of the poor, and shared responsibility for the funding (employer and individual mandates and federal subsidies). Insurance market reforms include things such as modified community rating, guaranteed issue and renewability, prohibition of exclusion of coverage for pre-existing illnesses, no cost sharing on preventive services, and no lifetime or annual limits on payments.

Controversial among the insurance market reforms is the "Public Plan" option. The College believes that arguments for or against "The Plan" are premature until the details are defined. Our

policy provides us with guidelines for evaluating proposals that would include a combination of public and qualified private health plans based on the degree to which they would advance other important policy objectives. Such objectives include reforming payments to better support primary care and the patient-centered medical home, promoting fair competition between plans on a level playing field, redesigning benefits to support prevention and wellness, ensuring adequate access to physicians within each plan, and ensuring that both patients and physicians can voluntarily choose the plans in which they participate.

The Senate Finance Committee did not explicitly call for a public plan option, but the House and Senate HELP drafts do. The College has expressed concern about the House version because it bases reimbursement on existing Medicare rates (Medicare + 5%) which are not competitive with the private sector and will not adequately recognize the value of care provided by primary care internists. Secondly, it leaves to the Secretary of HHS the power to decide about rules regarding physician participation in the plan and could force Medicare providers to accept the public plan enrollees. The HELP version of the public option requires competitive rate setting not based on Medicare and does not make participation of providers mandatory. Our view is that the HELP public plan option is more acceptable, but needs to more specifically increase reimbursement for primary care and better promote innovative models of care delivery such as the Patient Centered Medical Home (PCMH).

The College believes that the success of any reform effort to provide universal coverage is clearly dependent also on the need to expand the primary care workforce and improve the quality and capability of the primary care delivered to our patients. The evidence is clear that primary care is the best medicine for both high quality and low cost health care. Yet, reimbursement for primary care physicians is around half that of nonprimary care physicians. As a result, our physician work force is skewed far too greatly toward the nonprimary care physician pool leaving us with a critical shortage of primary care physicians, a problem that is worsening every year. To stabilize the situation, we have proposed a significant increase in payments to primary care physicians over five years that would make their salaries competitive with nonprimary care physicians. We believe this is essential if we are going to entice the needed increase in U.S. medical graduates to choose primary care specialties, and to dissuade those currently practicing from leaving.

The Senate Finance and HELP and the House Tri-Committee drafts reflect concern about primary care and are headed in the right direction, but in terms of some specifics do not go far enough. The House draft does call for the creation of a national advisory council to assess, evaluate, and advise on the appropriateness of the nation's health workforce and make recommendations on policies to ensure that such workforce is meeting the nation's needs. It provides for increased funding for National Health Services Corps and Title VII primary care health professions programs. It also provides scholarships and loan repayment to primary care physicians in areas of the country with an insufficient supply and high need for primary care. Further, it proposes to redistribute the graduate medical education training positions to increase the number of available primary care residency training positions. Lastly, the House draft raises Medicaid payments for primary care physicians to Medicare rates.

Both the House and Senate Finance proposals include a 5% bonus for designated services by primary care physicians. By itself, the College believes this is insufficient to significantly stimulate more medical graduates to enter primary care careers or stem the increasing numbers who are leaving. The ACP recommends that any

health care reform proposal provide at least a 10 percent increase in total Medicare payments for primary care physicians in 2010 followed by an additional 5 percent increase in the next four years. We believe all reforms aimed at improving primary care are important but making significant progress to reduce the compensation gap is needed to send a strong signal to physicians-in-training, and in practice, that primary care is a valued and viable option. Efforts on the part of Congressional committee members to achieve this aim are significantly hampered by the self-imposed "pay-as-you-go" rules which require them to find additional financial offsets to match this increase in spending. Nevertheless, the ACP will continue to vigorously lobby for the additional bonus payments.

Significantly, the administration has recently proposed regulatory changes that demonstrate its commitment to improve payments to general internists and primary care physicians. CMS has proposed rule changes in Medicare payment policies reflecting recognition of increased practice expense, physician work, and malpractice RVU's pertaining to primary care. Such increases largely result from the most recent AMA survey results. In aggregate, they represent a 6-8% increase reimbursement for primary care physicians. Unfortunately, by law, these RVU changes must be budget neutral. CMS has proposed significant cuts in payments for imaging procedures, which would result in cuts for cardiologists and radiologists. It also proposes the elimination of consultation codes, requiring the use of usual inpatient and outpatient visit codes in their place. ACP applauds administrative efforts to increase the reimbursement for primary care and to update RUV's to reflect more current and accurate survey data. However, we continue to advocate for increasing reimbursement for primary care physicians using a broader view of budget neutrality that incorporates the system wide savings resulting from the improved overall quality of care and reduced utilization of unnecessary services due to enhancing primary care. ACP staff and leaders are continuing to study the impact of these proposed regulatory changes on all our members and on the quality of care for our patients.

To control the unsustainable escalation in health care costs, ACP believes that innovative new models of health care delivery and reimbursement need to be implemented. Removing the onerous Medicare payment cuts dictated by the Sustainable Growth Rate (SGR) formula is a high priority of the ACP. The House Tri-committee draft goes the farthest in terms of not only removing the pending 21 percent Medicare payment cut for 2010, but also removing the accumulated billions in costs resulting from the failure of past Congresses to enact a long-term SGR solution. They replace the current SGR formula benchmarking growth in physician services against growth in gross domestic product (GDP) with two separate spending targets for physician services. One is for primary care and prevention which allows a spending growth target that is 2 percent over GDP (GDP+2). The second spending target for all other physician services allows a spending growth target that is 1 percent over GDP (GDP+1). Even with the additional percentage allowances, the College has expressed concern that continuing to benchmark physician updates on growth in the US economy as measured by GDP could lead to arbitrary physician cuts, especially in today's recessionary time. Nevertheless, such changes will be welcome reform for all physicians.

Further, CMS has recently proposed regulatory changes that remove physician-administered drugs, like chemotherapy, from the definition of physician services under the Sustainable Growth Rate (SGR) formula. This proposal helps to reduce the negative updates physicians face under the current SGR payment formula. More importantly, in finding a solution to the SGR payment formula, it reduces the budget cost that Congress must offset (remember "pay-as-you-go rules") if it wants to rebase to zero the cost of all the prior years' negative updates that it did not enforce.

The most widely discussed innovative model of care has been the Patient Centered Medical Home (PCMH). Costs and logistical challenges are major stumbling blocks in its wide spread implementation. Both the Senate and House drafts recognize the importance of the PCMH and provide substantial increased funding to support nationwide pilot testing and rapid implementation. The rapid dissemination of this model will greatly enhance the quality of primary care for patients. It also serves to enhance revenue for practices designated as a PCMH through a new reimbursement model that includes not only the traditional fee for service but also a care coordination and performance measurement fees, as well. The House draft also provides funding for pilot testing groups of physicians voluntarily organizing as "accountable care organizations" and receiving "bundled" rather than just traditional individual fee-for-service payments. This methodology incentivizes the physicians to work

together and rewards care that meets enhanced quality and efficiency targets. The ACP believes that these legislative efforts to promote new reimbursement and delivery models that incentivize value rather than volume of service are critical to the overall success of health care reform.

Finally, financing the health care reform legislative package has been a major issue both in the House and the Senate. Each reform proposal is seeking to cost no more than \$1 trillion dollars over 10 years, and according to pay-as-you-go rules, such spending must be offset by cuts elsewhere or by additional revenues. The ACP has strongly argued that enhancing and increasing the primary care workforce, changing reimbursement paradigms from volume to value, and promoting prevention and wellness will all create substantial savings to the system in the form of better management of patients with chronic diseases, reducing unnecessary hospitalizations and emergency room visits, reducing duplication of services, and improving the coordination of care. However, the Congressional Budget Office which is responsible for costing out the various proposals cannot score these provisions as true factual savings. On the other hand, it does score the increased payment for primary care and the increase funding for such things as the PCMH as true factual additional costs. Consequently, the committees must find other means of generating revenue or savings. The House and Senate drafts both rely on mandating individual health insurance coverage, the increase revenue from young healthy individuals will help to offset costs of those older and those with chronic diseases. They are also requiring employers to either provide health care coverage for their employees or pay a penalty that will be used to subsidize individual premium costs. Another source of revenue being considered is a cap on the tax-exemption for employer-sponsored health care benefits. Additional savings are being derived from reductions in cost of biologics by making generic biological drugs possible. Savings are also being considered through cuts in payments to hospitals. Savings will include not paying for "avoidable" readmissions, phasing out disproportionate indigent care payments, and applying productivity growth expenditure targets similar to those used for physician services. All of these financing options are generally in keeping with ACP policy as long as the mandates for patients and employers do not come into effect until market reforms and affordability credits are in effect.

The path to health care reform is long and circuitous; yet being traveled in a very short time frame. What is being proposed now will undoubtedly undergo substantial change before it is voted upon by Congress and signed into law. The four areas of universal coverage (including the public plan option), primary care workforce, innovative payment and delivery models, and financing options will continue to dominate the discussion. With a commitment of doing what is best for patient care, the ACP continues to be "at the table."

Note: Information within this article was accurate at the time of writing and submission, however as Dr. Stubbs has indicated, things are moving very quickly and may have changed prior to publication. For the latest, up to date information from the ACP, please visit: <http://www.acponline.org/advocacy>

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RAC Audits Are Here!

By: Glenn D. Littenberg, M.D., FACP
Chair, Medical Services Committee
California Chapter of the American College of Physicians Services

California internists probably took little notice of the Recovery Audit Contractor (RAC) pilot project CMS recently ran because it impacted few physicians directly. However, CMS found it provided a high rate of return (20:1 on cost, despite the bounty nature of the fee paid to the contractor). So now the RAC system is being rolled out nationally and comes to California NOW.

RACs are private firms contracted with CMS to data-mine and develop paid claims where they think that claims were paid in error or should have been paid at lower rates. They can do two types of reviews:

- Automated review - They can whiz through Part B payments made by Palmetto (our CMS contractor) and focus on aberrancies without requesting records to review.
- Complex reviews - These involve requests for chart documents (similar to what is sometimes received from Palmetto or from the CERT contractor, which analyzes accuracy of payment).

RACs can go back as far as October 2007 looking for overpayments. When they find them, they will require repayment. Physicians have the right, which should be exercised whenever feasible, to appeal RAC findings, but the entire process promises to add hassle and financial loss if practices haven't been carefully compliant with coding and claims submission.

CMS needs to approve issues that RACs can pursue and has, in fact, already approved some. Our local RAC has performed its required outreach and is "starting business." There are limits to how many physician claims can be requested based on the size of the practice, but this could amount to 15 or more per quarter, per physician.

Clearly, hospitals, durable medical equipment entities and others will be bigger targets than physicians. E&M services are NOT yet OK to pursue, EXCEPT when billed the same day as a procedure where they think that perhaps the E&M service was NOT separately identifiable.

So far, the targeted services shouldn't concern too many physicians. They are:

- IV hydration therapy, initial (96360 in 2009, 90760 in prior years) if more than one unit per patient, per date of service was billed.
- Bronchoscopy services especially 31625 (w/ biopsy) and 31628-29 (bronch with lung bx, each) - unless billed with modifier 59 (e.g. separate site, separate session same day, according to CPT rules for these), any unit more than one per date of service might get questioned.
- Once in a lifetime procedure. Few of these affect internists except perhaps welcome to Medicare physicals
- J2505 (injection, Pegfilgrastim 6mg) which should be billed one unit per patient, per date of service.
- Other targets are not pertinent to internal medicine unless the physician employs physical or occupational therapists, where some untimed codes may be targets. Again, one unit per service date.

The ACP Medical Services Committee and Contract Advisory Committee will be reviewing the RAC contractor's site regularly and keep you updated, but your practice manager can also do this. We predict that services billed same day as 99211 will become targets, since denial rates are high and in 2005 the HHS Office of the Inspector General found 35% error rates in payment, mostly for same day billing with injections and blood draws, which contractors are supposed to deny (i.e. deny the 99211; but can pay the higher level services if billed for other diagnoses). See Medicare Claims Processing Manual Ch 12 Sect. 30.6.7 for applicable regulations.

Note: Don't look at other RAC sites for lists of targets; these will become increasingly individualized as time goes on according to what appears to be the "low-hanging fruit" in each region. There is a recovery for underpayments the RAC finds, but this will more than likely be an exception. Additionally, they don't reimburse for photocopy/mailing costs, but you can also fax, scan/send, or encrypt a CD/DVD and send them.

References: The Region D RAC (Midwest, West Coast, Southwest states) is HealthDataInsights (HDI), at www.healthdatainsights.com/RAC.aspx

Open the portal, click on "California" on the map to get to "State's Issues" or click on "New Issues" in the banner at the top of the home page. The FAQ link also has some useful background information. Each issue has some background reference, e.g. CMS instructions, CPT or other. The public portal has links to CMS RAC information, Medicare claims manual, Palmetto's website etc.

HDI's Provider Portal offers information and communication on RAC activities in Region D. The information provided will assist with understanding the basics of the RAC program, review RAC Region D updates and view improper payment types. Once a provider logs-in to access the private side, they can review any medical record requests, check the status of a medical record review, and obtain practice specific information if they have claims pending. They can also obtain answers to questions on the RAC program.

Region D's RAC portal is now available to providers at: racinfo.healthdatainsights.com or www.racinfo.com

Email questions to racinfo@emailhdi.com or call their provider relations line at 702-240-5510.

The CMS site on RAC is www.cms.hhs.gov/RAC

Physicians Urged to Pre-Register for H1N1 Vaccine

The California Department of Public Health (CDPH) is urging physicians to preregister for the Influenza A (H1N1) vaccine, the first doses of which are expected to be available in mid to late-October. Even if you are not ready to place an order, you must register now to inform CDPH of your interest in being a vaccinator.

Unlike the seasonal flu vaccine, the H1N1 vaccine will not be distributed through regular suppliers. Due to the uncertainty of the supply and capacity, CDPH is serving as a central distribution point so that the vaccine is available to those who need it most.

Although the Centers for Disease Control and Prevention (CDC) does not expect that there will be a shortage of the H1N1 vaccine, availability and demand can be unpredictable. There is always the possibility that the vaccine will be available in limited quantities at least initially. California is expected to receive 8 million doses by late October, with an additional 2 million doses per week thereafter.

Physicians are being asked to register as vaccinators so that CDPH can get a realistic assessment of physician capacity and interest in vaccinating. When registering, be prepared to submit your National Provider Identification number, the projected number of doses of the vaccine your practice expects to use, and the number of patients your practice has that fit into the high risk groups. (See last issue of CMA Alert for information on who is at high-risk for H1N1-related complications.) By registering, you are not making a commitment to administer the same quantity of vaccine.

To register, or for more information, visit <http://www.CalPanFlu.org>. Physicians who are ready to order vaccine can also do so at that webpage. You should be aware, however, that vaccine will not be distributed on a first come, first served basis.

The H1N1 vaccine does not protect against the seasonal flu. Because of the dual flu threat and the impact of the increased patient volume is expected to have on physician practices, you are urged to start administering the seasonal flu vaccine as soon as possible before the arrival of the H1N1 vaccine in October.