Effective January 1, Medicare no longer recognizes office and other outpatient consultation CPT codes and inpatient consultation CPT codes. The decision was handed down for two reasons: First, the Centers for Medicare & Medicaid Services claimed that the codes were not being used correctly in most cases. Second, the CMS claimed that there was no significant difference between the major components of the services (history, examinations and medical decision making) that was required between a visit and a consultation. In short, the CMS claimed the only difference was that specialists were required to report back to the referring physician on a course of action, for example, a discovery, recommendation or transfer of patient care.

As with any change-and especially those involving Medicare-physician concerns are numerous. Specialists are concerned that their reimbursement rates from Medicare will decrease even further since they will need to spend the same amount of time with patients but for lower reimbursement. Primary care physicians are concerned that they will have an even more difficult time getting their Medicare patients in to see specialists.

General concerns center around the issue of communication, for one. With the elimination of the requirement for a specialist to report back to a referring physician, there is a danger that this transfer if information will simply stop occurring, especially since the specialist is no longer compensated for the reporting time. And, of course, there is the deep-seated fear that many specialists will simply drop out of Medicare, making access to quality health care even more difficult for the elderly or disadvantaged.

The reality is that no one yet knows for sure the long-term effects the changes will have. Certainly, super-specialists such as neurosurgeons will take a greater financial hit than, say, endocrinologists since these specialists may only see a patient once or twice rather than regularly over the course of the person’s condition. Yes, unless new federal legislation is brought to bear, physicians and patients must learn to cope with the current landscape. In this article, the California Medical Association- an organization that vehemently opposed the changes-helps clarify the basics of what you need to know to weather the change.

**New Rules**

Medicare no longer recognizes office and other outpatient consultation CPT codes (99241-99245) and inpatient consultation codes (99251-99255) for payment. The new rules provides minor increases in relative value units for some inpatient and outpatient evaluation and management visits in an attempt to offset losses that will result from the elimination of these codes. Nonetheless, physicians should be aware that some specialties may suffer significant financial losses.

According to the new CMS rules, instead of billing for consultation services physicians may bill using evaluation and management codes from the Office and Other Outpatient Services, Initial Hospital Care and Initial Nursing Facility sections of the 2010 American Medical Association CPT coding guidelines.

Physicians using electronic medical and health records software and practice management and other coding systems should contact their vendors for any program updates. Further, it is strongly recommended that physicians contact outside billing companies to ensure that they are coding and billing consultative services according to the new rules. Submitting claims incorrectly will lead to costly denials and significant delays in payment for those not prepared for the change in coding requirements.

**Office And Other Outpatient Services**

For consultative services provided in physician offices or other outpatient settings, physicians may report the level of care provided based on MA CPT coding requirements for evaluation and managementservices (for example, history and exam, medical decision making and contributory factors presenting problem [severity], counseling, coordination of care and typical face-to-face time). For example, instead of using criteria...
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McAllen or the Mayo?

By John Hoff, MD
SMCMA President

In early February, the SMCMA invited the membership to a private forum with Congresswoman Jackie Speier to review the current status of healthcare reform legislation in Congress. After a brief review of the two major bills she answered questions and received comments. The goal of both bills is to expand healthcare coverage and control health care costs, but they differ in their approaches. And after the Massachusetts election, the way forward is not clear.

One option is to pass the Senate bill unchanged in the House, but there are major problems with the Senate bill, especially for California: 1) With a proportionally high number of HMOs, California has an inordinate number of so-called Cadillac Plans, which are attacked in the Senate bill; 2) There is no fix for the GPCI included; 3) the introduction of interstate compacts eliminates many of the consumer protections already in place in California; and 4) There is a cap on Federal assistance for families with annual income levels at and above $40,000.

Besides the California issues, the Senate Bill is replete with unacceptable earmarks including special deals for Florida, Louisiana and Nebraska. There is also less support for primary care; there is no increase in Medicaid reimbursement and no fix for the SGR. These factors, among others, make the passage of the Senate bill in the House unlikely. Too many members of the House find the bill objectionable.

To Congresswoman Speier, the most likely way to pass healthcare reform is in pieces. She seemed to feel that a universal plan with catastrophic coverage and preventative care would be acceptable in combination with adequate insurance company reforms.

During the discussion, the Congresswoman agreed with many of the physicians who brought up some of the bare-minimum issues that need addressing, such as catastrophic coverage, exclusions for pre-existing conditions, rescission of insurance and portability. But the issue was cost.

As far as bending the curve on rising healthcare costs, the Senate goes further. In the Senate Bill, Medicare Payment Advisory Committee (MedPAC) has been given real teeth to cut expenses. There is nothing similar in the House bill. Cost control in the House bill is limited to eliminating Medicare Advantage, reducing physician ownership of facilities and reducing the expense of advanced imaging. To some extent, the president tied their hands in his negotiations with big Pharma and the insurance companies.

The Congresswoman mentioned McAllen, Texas, pointing out that the president had passed out Atul Gawande’s article published in the New Yorker to attendees of his healthcare team and declared that this issue alone would go a long way to controlling costs. Most of us have read the article. Atul Gawande went to McAllen Texas to find out why the costs there were twice as high as El Paso, which is very similar demographically. After talking to a handful of physicians, a hospital administrator and the owner of a home healthcare agency, he came to the conclusion that “a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers.” Both the administrator and the agency owner described being approached for kickbacks, though they had never succumbed to the requests. To put the situation in perspective, Gawande noted that at the Mayo and Grand Junction, CO, financial incentives were nonexistent or at least well controlled.

Congress appears to have a belief in the value of primary care. The Congresswoman pointed out that there were provisions for workforce investments in both bills, although the House bill went much further in supporting primary care, for example, through improvements and reimbursement in Medicaid.

With the widespread disgust over the earmarks and special deals, it is worth noting that on her arrival in Congress, the Congresswoman initially refused to participate in this system. However, after realizing that this position left her constituents at a disadvantage, she formed a citizen committee to review earmark requests in an open process for their relevance to the welfare of all the citizens in her district before moving any of these forward. All in all, the physicians that attended this meeting were impressed with the Congresswoman’s dedication to improving healthcare.

The physicians in attendance were appreciative of the opportunity to meet with Congresswoman Speier, impressed with her knowledge of the issues, and her appreciation of other viewpoints and her willingness to work with others to improve healthcare for all.
POLITICAL REALITY:

YOU’RE EITHER
AT THE
TABLE

OR

ON THE
MENU

WE’RE AT THE TABLE EVERY DAY

By choosing to join the San Mateo County Medical Association (SMCMA), physicians in San Mateo County have given voice to our patients and to our communities in the healthcare reform discussions and in every single healthcare issue being debated locally, in Sacramento and in Washington D.C.

ASK YOUR COLLEAGUES: “ARE YOU A MEMBER OF SMCMA?”
Local and State Physicians Share Their Views on Health Reform Legislation

By Sue U. Malone
SMCMA Executive Director

Recently the CMA retained the services of a public affairs company to conduct a survey of CMA members reflecting a proportionate sample of its members by type of practice, medical specialty, and gender. The objective of the survey was to gauge member attitudes towards health system reform, measure attitudes towards the healthcare legislation being debated in Congress; and testing support and opposition to the specific proposals being considered in the legislation.

You may recall that this past October, SMCMA conducted a similar electronic poll. Interestingly, both surveys found that physicians are divided on the overall state of the healthcare system. San Mateo County physicians felt that the current system of competing private health plans should be preserved, while a significant number of respondents to the statewide survey expressed the view that the system is broken and needs to be reformed. On the question of a government run single-payer system there was also a division. Our local physicians’ views were slightly weighted to a mix of government and private payers, but there was also strong support for a single-payer system. In the state physicians were more strongly behind the pluralistic system with less than 20% of the statewide respondents favoring single-payer.

In the statewide poll respondents were equally split between favoring or opposing the legislation currently being debated in Congress. 43.5% in favor and 43.8% opposed; if physicians are divided on the legislation being debated, perhaps it is not surprising that our Congressional representatives are as well. On the other hand, physicians are united in support of many aspects of healthcare reform including protecting MICRA (94%), prohibiting denial of health coverage for pre-existing conditions (89%), providing tax credits and subsidies to low-income families and small sized employers (88%), incentivizing prevention and wellness programs (86%), increasing Medicaid reimbursements for E&M services to Medicare levels (83%), increasing Medicare rates for primary care (81%) and requiring medium and large sized employers to provide health insurance to their employees (81%). One finding that surprised me is that while 64% of the CMA members supported repealing the Medicare SGR formula that automatically cuts payments to physicians each year, including 21% this year and another projected 40% cut over the next four years (SGR), there were 33% who opposed the SGR repeal! I guess if you don’t accept Medicare reimbursement one might cast their vote against repeal, but who are the others?

A large majority of physicians believe that the healthcare reform bills over-promise without providing necessary funding, but views are divided on what impact the healthcare reform proposals would have on quality and whether the reform proposals will result in too much government interference in medical treatment decisions.

The SMCMA survey asked physicians who are Medicare providers whether they will continue to see Medicare patients at the current reimbursement rates and whether they would continue to see patients if there was a 21% cut in the reimbursement rate. Although the respondents acknowledged that the reimbursement rates were poor, the majority stated they would continue to see their Medicare patients, and 38% responded that they would continue to see their Medicare patients even if there is a 21% rate cut though physicians did note that they would reduce their Medicare patient load. In this survey 90% of the respondents accept Medicare patients, with a substantial majority stating that Medicare patients made up a significant portion of their practice.

The Kaiser Family Foundation just released a poll conducts of the Democrats, Independents and Republicans to determine what areas of agreement the three parties have on health reform legislation. The results were not all that dissimilar from that of physicians: Each of the three parties supported reforming the way health insurance works; providing tax credits to small businesses; creating a health insurance exchange; helping close the Medicare “doughnut hold”, and expanding high risk insurance pools.

It is interesting to compare the views of physicians and the public and it is necessary to do so in order to create a solution that works for everyone. This is why we are at the table, every day. We bring your opinions and positions to the table and make sure that your voices are heard.
According to the AMA, CPT Prolonged Service Codes 99354-99355 for that date of service.

The descriptors for the levels of evaluation and management services recognize seven components, six of which are used in defining the levels of evaluation and management services. The first three components (history, examination, and medical decision making) are considered the key components and are required in selecting the appropriate level of evaluation and management services. The next three components (counseling, coordination of care, and the nature of the presenting problem(s)) are considered contributory factors and while important, they are not required to be provided during each patient encounter.

It is important to note that there is a significant time variance between consultation codes and office visit codes that the physician typically spends face-to-face with the patient according to AMA CPT coding guidelines. Time descriptors in CPT evaluation and management guidelines are averages and, therefore, coding should depend on the actual clinical circumstances. “The use of time may be considered the key or controlling factor to quality for a particular level of evaluation and management services.”

As noted, the AMA has determined through extensive survey and analysis that consultative services require more physician work, including extensive documentation, testing, and written communication back to the referring physician of the patient’s health status. Further, it is common for coordination of services and counseling to dominate the consultative patient encounter (services provided in outpatient, a hospital floor or unit, and nursing facility settings). Therefore, physicians should familiarize themselves with AMA CPT coding guidelines for using “time” when 50 percent or more of the visit is spent on counseling or coordination of care.

Given the new rules, physicians may also find it necessary to report face-to-face patient evaluation and management contact that is beyond the usual service provided in either an outpatient or inpatient setting. Also known as add-ons, they are used to report the first hour and additional half-hour increments of time beyond the time descriptors assigned to each E&M service CPT code on a given day.

All Prolonged Service codes must be reported in conjunction with the appropriate level of evaluation and management code regardless of the level of evaluation and management. For example, if a patient service is a 99204 (45 minutes) yet the physician spent a total of 105 minutes with the patient, the physician may bill 99204 plus Prolonged Service CPT code 99354. If the total time spent with the patient was a total of 135 minutes the physician may bill CPT codes 99204, 99354 and 99355 for that date of service.

According to the AMA, CPT Prolonged Service Codes 99354-99355 may be used in conjunction with the appropriate level of 99201-99215 outpatient codes. CPT Prolonged Service codes 99356-99357 may be used in conjunction with 99221-99223 (initial inpatient services) and 99304-99310 (nursing facility services). For further instructions on the use of these add-on codes, physicians should refer to AMA CPT coding guidelines under Prolonged Services.

Finally, it is critical that total time be referenced in your documentation that supports the extended period of time that was necessary in each case. Be aware that Medicare and other payors often request supporting documentation when billing Prolonged Services and you must comply with any reasonable request.

Inpatient Hospital Services
According to the new rules physicians cannot use AMA CPT codes 99251-99255 for reporting consultative services provided to patients in inpatient hospital or skilled nursing facility settings. Instead physicians may report these services by selecting the appropriate AMA CPT Initial Hospital Care codes (99221-99223) or nursing facility care codes (99304-99306). As a result of this change, multiple billings of initial hospital and nursing home visit codes could occur even in a single day.

Another important change is that the Modifier “-AI,” defined as “Principal Physician of Record,” must be used by the admitting or attending physician who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care. The principal physician of record must append modifier “-AI” in addition to the initial visit code. All other physicians who perform an initial evaluation on this patient shall bill only the evaluation and management code for the complexity level performed.

Rural Health Clinics
Rural Health Clinics and Federally Qualified Health Clinics shall discontinue use of AMA consultation codes 99241-99245 and 99251-99255. As with other office and other outpatient services physicians may report the level of services provided under codes 99201-99215 and 99304-99306.

Other Services
Physicians who see patients in the emergency department, observation unit, or other location must report the appropriate code for the location and level of services provided in those locations. Physicians may also consider the use of Prolonged Service codes (99354-99355 for outpatient and 99356-99357 for inpatient) when appropriate documentation supports the billing for these codes.

Coding For Consultative Services
In the charts are the evaluation and management codes that physicians may bill based upon where the visit occurs and the complexity of the service(s) performed. There is no “official” CMS-published guide that links former consultation codes to the evaluation and management codes for 2010. In the July 2009 notice of its proposal, CMS published a guide, but it was only to demonstrate the budget impact, not to dictate the specific codes physicians should report instead of the consultation codes. Instead, CMS has indicated that physicians may report consultation services for Medicare patients using the most applicable inpatient, outpatient, or skilled nursing codes from
Recognized Body Areas and Organ Systems

<table>
<thead>
<tr>
<th>Type of Examination</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including face</td>
<td>- Eyes</td>
</tr>
<tr>
<td>Neck</td>
<td>- Cardiovascular</td>
</tr>
<tr>
<td>Chest, including breasts and axilla</td>
<td>- Gastrointestinal</td>
</tr>
<tr>
<td>Abdomen</td>
<td>- Musculoskeletal</td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td>- Neurologic</td>
</tr>
<tr>
<td>Back</td>
<td>- Psychiatric</td>
</tr>
<tr>
<td>Each extremity</td>
<td>- Ears, nose &amp; throat</td>
</tr>
<tr>
<td></td>
<td>- Respiratory</td>
</tr>
<tr>
<td></td>
<td>- Genitourinary</td>
</tr>
<tr>
<td></td>
<td>- Hematologic/ Lymphatic/ Immunologic</td>
</tr>
</tbody>
</table>

E&M Codes for Services Performed in an Office or Other Outpatient Setting

<table>
<thead>
<tr>
<th>Coding Guidance New Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires all 3 key components</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>New Patient Description</th>
<th>Typical face-to-face time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Problem focused history</td>
<td>10 minutes</td>
</tr>
<tr>
<td>99202</td>
<td>Expanded problem focused history</td>
<td>20 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>Detailed history detailed examination</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>Comprehensive history comprehensive examination</td>
<td>45 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive history comprehensive examination</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

E&M Codes for Services Performed in a Skilled Nursing Setting

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>New Patient Description</th>
<th>Typical face-to-face time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Problem focused history</td>
<td>10 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Expanded problem focused history</td>
<td>15 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Detailed history detailed examination</td>
<td>25 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Comprehensive examination</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>

E&M Codes for Services Performed in a Hospital Inpatient Setting

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>New Patient Description</th>
<th>Typical face-to-face time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>Straightforward or Low</td>
<td>15 minutes</td>
</tr>
<tr>
<td>99232</td>
<td>Moderate</td>
<td>25 minutes</td>
</tr>
<tr>
<td>99233</td>
<td>High</td>
<td>35 minutes</td>
</tr>
</tbody>
</table>

Elements Required for Each Type of Examination

<table>
<thead>
<tr>
<th>Type of Examination</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>A limited examination of the affected body area or organ system.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).</td>
</tr>
<tr>
<td>Detailed</td>
<td>An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>A general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).</td>
</tr>
</tbody>
</table>
**Suck It Up, America**

“We have become a nation of whining hypochondriacs”

By Thomas A. Doyle, MD

Emergency departments are distilleries that boil complex blends of trauma, stress and emotion down to the essence of immediacy: What needs to be done, right now, to fix the problem. Working the past 20 years in such environments has shown me with great clarity what is wrong (and right) with our nation’s medical system.

It’s obvious to me that despite all the furor and rancor, what is being debated in Washington currently is not health-care reform. It’s only health-care insurance reform. It addresses the undeniably important issues of who is going to pay and how, but completely misses the point of why.

Health care costs too much in our country because we deliver too much health care. We deliver too much because we demand too much. And we demand it for all the wrong reasons. We’re turning into a nation of anxious wimps.

I still love my job; very few things are as emotionally rewarding as relieving true pain and suffering, sharing compassionate care and actually saving lives. Illness and injury will always require the best efforts our medical system can provide. But emergency departments nationwide are being overwhelmed by the non-emergent, and doctors in general are asked to treat what doesn’t need treatment.

In a single night I had patients come in to our emergency department, most brought by ambulance, for the following complaints: I smoked marijuana and got dizzy; I got stung by a bee and it hurts; I got drunk and have a hangover; I sat out in the sun and got sunburn; I ate Mexican food and threw up; I picked my nose and it bled, but now it stopped; I just had sex and want to know if I’m pregnant.

Since all my colleagues and I have worked our shifts while suffering from worse symptoms than these (well, not the marijuana, I hope), we have understandably lost some of our natural empathy for such patients. When working with a cold, flu or headache, I often feel I am like one of those cute little animal signs in amusement parks that say ‘you must be taller than me to ride this ride’ only mine should read ‘you must be sicker than me to come to our emergency department.’

At a time when we have an unprecedented obsession with health (Dr. Oz, “The Doctors,” Oprah and a host of daytime talk shows make the smallest issues seem like apocalyptic pandemics) we have substandard national wellness. This is largely because the media focuses on the exotic and the sensational and ignores the mundane.

Our society has warped our perception of true risk. We are taught to fear vaccinations, mold, shark attacks, airplanes and breast implants when we really should worry about smoking, drug abuse, obesity, cars and basic hygiene. If you go by pharmaceutical advertisement budgets, our most critical health needs are to have sex and fall asleep.

Somehow we have developed an expectation that our health should always be perfect, and if it isn’t, there should be a pill to fix it. With every ache and sniffle we run to the doctor or purchase useless quackery such as the dietary supplement Airborne or homeopathic cures (to the tune of tens of billions of dollars a year). We demand unnecessary diagnostic testing, narcotics for bruises and sprains, antibiotics for our viruses (which do absolutely no good). And due to time constraints on physicians, fear of lawsuits and the pressure to keep patients satisfied, we usually get them.

Yet the great secret of medicine is that almost everything we see will get better (or worse) no matter how we treat it. Usually better.

The human body is exquisitely talented at healing. If bodies didn’t heal by themselves, we’d be up the creek. Even in an intensive care unit, with our most advanced techniques applied, all we’re really doing is optimizing the conditions under which natural healing can occur. We give oxygen and fluids in the right proportions, raise or lower the blood pressure as needed and allow the natural healing mechanisms time to do their work. It’s as if you could put your car in the service garage, make sure you give it plenty of gas, oil and brake fluid and that transmission should fix itself in no time.

The bottom line is that most conditions are self-limited. This doesn’t mesh well with our immediate-gratification, instant-action society. But usually that bronchitis or back ache or poison ivy or stomach flu just needs time to get better. Take two aspirin...
and call me in the morning wasn’t your doctor being lazy in the middle of the night; it was sound medical practice. As a wise pediatrician colleague of mine once told me, “Our best medicines are Tincture of Time and Elixir of Neglect.” Taking drugs for things that go away on their own is rarely helpful and often harmful.

We’ve become a nation of hypochondriacs. Every sneeze is swine flu, every headache a tumor. And at great expense, we deliver fantastically prompt, thorough and largely unnecessary care.

There is tremendous financial pressure on physicians to keep patients happy. But unlike business, in medicine the customer isn’t always right. Sometimes a doctor needs to show tough love and deny patients the quick fix.

A good physician needs to have the guts to stand up to people and tell them that their baby gets ear infections because they smoke cigarettes. That it’s time to admit they are alcoholics. That they need to suck it up and deal with discomfort because narcotics will just make everything worse. That what’s really wrong with them is that they are just too damned fat. Unfortunately, this type of advice rarely leads to high patient satisfaction scores.

Modern medicine is a blessing which improves all our lives. But until we start educating the general populace about what really affects health and what a doctor is capable (and more importantly, incapable) of fixing, we will continue to waste a large portion of our health-care dollar on treatments which just don’t make any difference. Ω

Dr. Thomas A. Doyle is a specialist in emergency medicine who practices in Sewickley, Pennsylvania. This is an excerpt from a book he is writing called “Suck It Up, America: The Tough Choices Needed for Real Health-Care Reform.” Dr. Doyle can be reached at tomdoy@aol.com.
Kids Shoes and Death Panels

By Philip R. Alper, MD

Only in medicine do we pretend that costs don’t count. The nation has concurred by adopting a legal and moral standard that patients should not be deprived of anything that is medically beneficial no matter how minimal the benefit and how great the cost. Under existing law, Medicare cannot even consider cost in determining whether to approve a test or procedure for payment.

That’s what is at the core of the health care reform dilemma and what guarantees that all the plans under consideration from Republicans and Democrats will have only a marginal impact on the rising cost of health care.

Consider how abnormal this “spare no expense” thinking really is. Every family faces innumerable decisions that involve trade-offs in the use of money. Should we buy new shoes for the kids or, instead, use the money toward a weekend at Disneyland? One of those choices might be viewed as an essential and the other as nonessential. So perhaps the better question to ask would be whether to buy new shoes for the kids or first spend the money on pants, dresses and jackets. Only when the supply of money is unlimited can we gratify all spending impulses promptly and independently.

Of course, the reality in medicine is quite different. Costs do matter, and Medicare and Medicaid as well as private insurers use some form of “utilization review” to decide whether to pay for specific tests, procedures and operations. What they do not do is acknowledge that cost is the driving force in the decisions. Instead, their verdicts speak to “medical necessity” and “evidence-based guidelines” — suggesting that it would be wrong to pay for care that isn’t necessary or that hasn’t been documented adequately in the scientific literature to be of benefit. It is an open secret, however, that the more costly the claim, the more intense the scrutiny.

But what if the flagship payer — Medicare — were to explicitly include cost as a reason for approving or disapproving a medical service? That was a major change that was quietly embedded in the Senate health care reform bill, which established an “independent Medicare commission” to determine what services would be covered by Medicare in the future. Two questions immediately present themselves: Is the service worth the money? And are you worth what Medicare would be spending?

Both questions are vexing. The first one blends highly precise medical science that defines the effectiveness of a procedure, a drug or an operation with economic considerations that are far less precise and nonobjective because they are value-laden.

The results are endlessly arguable. Reasonable people differ in their perception of worth.

And amidst this spectrum of opinion, should a program like Medicare that is designed to cover the entire population of elderly and, to a lesser extent, the disabled, set spending limits that will pit the individual who disagrees against the government?

The second question touches on the issue of “medical futility.” How helpful does a treatment have to be to be to be authorized? Are terminal patients to be kept alive endlessly? Is a high likelihood of significant benefit to be the standard? Or should it be any benefit at all no matter how minimal and how unlikely to affect the ultimate prognosis? And what about non-terminal patients who are not fully normal to begin with — such as those with Down syndrome? Are they to be treated differently?

The proposed Medicare commission would have to grapple with and resolve such dilemmas. The decisions made would have life-and-death implications. Moral and financial considerations both would play a part in an ill-defined combination that could be manipulated easily. Should a mother of a child with Down syndrome (like Sarah Palin) be worried by such a prospect? Would it be irrational for her to see an all-powerful review board as a death panel? I think not. Might others who see themselves as medically “ordinary” be less concerned? Of course.

Here we see a political divide that only enlarges and hardens when powerful outside constituencies weigh in. Consider something far less complex — the commotion over new breast cancer screening guidelines issued by the U.S. Public Services Task Force in November. The task force, which is federally funded but operates independently, advised that women who do not have an increased risk for breast cancer should wait until age 50 (rather than age 40, as previously had been the standard) before beginning to get regular screening mammograms for early cancer detection.

A storm of protest erupted, led by the American Cancer Society, radiology and oncology organizations, lay groups and, of course, the manufacturers of mammography equipment. They were joined in their vehement opposition by breast cancer survivors.

Republicans called this the opening salvo in the Democratic administration’s plan to impose health care rationing as an integral part of health care reform. Democratic politicians

CONTINUED ON PAGE 12
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back-pedaled furiously, reassuring American women that their access to mammography would not be interfered with under health reform.

What are the facts? For every 1,300 mammograms taken on women older than 50, a new breast cancer is discovered. But for women between 40 and 50, it takes 50 percent more - 1,900 mammograms - to detect one new case of breast cancer. Because breast cancer is less frequent in the younger group and because there are many false positives and biopsies that turn out negative, the task force did not recommend them.

The media were quick to point out that even though there are fewer positive mammograms in younger women, a life saved is still a life saved, and that remains true even though it costs at least 50 percent more to detect them. The American Cancer Society and some medical specialists also made much of the presence of generalist physicians on the task force, implying that they knew less about the disease and perhaps weren’t qualified to give advice.

That criticism stung because generalist physicians are a small handful represented among the 112 medical specialty organizations designated by the American Medical Association that have any serious role in overall health spending. When I began my own practice of internal medicine in the 1960s, most patients were poorly insured, and I had to advise them on the most effective use of their limited funds. It wasn’t easy, and my advice was highly valued. Since then, insurance has improved, costs have soared, and by the 1990s, there was renewed interest in using primary physicians to prioritize the need for care. Only this time, it was on behalf of the insurance carriers and not the patients. Thus, the generalist physician went from adviser to “gatekeeper,” whose permission was needed for referrals to specialists and for tests. Naturally, patients hated this, and so did most of the physicians.

So we now find ourselves with a host of narrowly focused specialists, each vying to do the best and the most in his or her domain. They are closely allied with hospitals and medical and pharmaceutical manufacturers. There is no doubt that they do a great deal of good.

But there are underlying assumptions that cannot be ignored permanently. They are: (1) All services that provide any value to individual patients should be provided and (2) there is no trade-off between money and clinical usefulness in determining overall societal value. Perhaps a third assumption is that the money supply is infinite.

In other words, in health care, the kids can have it all — new shoes, new clothes and a weekend at Disneyland — because there is nobody to prioritize their needs. Patients want to be free. So do specialists. Primary physicians don’t want to fight everyone. And we are all rightfully wary of top-down decision-making by government.

The answer to infinite spending or the alternative — rationing — is to find new ways to lower medical costs so that budgetary pressure doesn’t force us into more and more difficult dilemmas. So far, no one has found that answer.

Reprinted with permissions from the author and the Washington Times, published February 10, 2010 on washingtontimes.com. Dr. Philip R. Alper is clinical professor of medicine emeritus at the University of California at San Francisco and former Robert Wesson Fellow at Stanford University’s Hoover Institution.

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