CNS e-news

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President's Message

Dear California Neurologist,

The California Neurology Society (**CNS**) Board of Directors and Consultants are pleased to announce the new name of your state neurology society (formerly the Association of California Neurologists - ACN).

The CNS mission is to stimulate and foster improvements in all aspects of the health care of patients with disorders of the nervous system, to encourage the association of professional neurologists and advancement in the practice of neurology in the state of California, and to promote continuing education and advancement in scientific and clinical techniques and methods of neurological medicine.

Given the recent political climate in the nation and significant plans for changes in health care delivery anticipated in the next few years, the Board also believes, as does the American Academy of Neurology that our mission must be expanded to include vigorous advocacy so that neurologists can continue to provide the best quality care to their patients. Advocacy can help ensure that adequate financial resources are directed toward this care. We are convinced that without an effective voice in Sacramento and Washington, neurologists and their patients will lose out and that it is the responsibility of the **CNS** to try and make sure that this does not happen.

Because these issues affect all the neurologists in the state, the Board has decided to automatically include all of California's neurologists in our membership regardless of their practice setting. Under the new guidelines, a neurologist can also opt out of being a member of the **CNS.** The **CNS** dues have not changed. Dues are still $95 for an active neurologist and $25 for a senior membership. Without this financial support the only California organization solely focused on the interests of neurologists and their patients will atrophy and disappear.

As part of the reorganization of the **CNS** we have created committees targeting specific important issues including legislation, electronic health records, coding and strong patient advocacy. For example, a recent survey of our membership identified three priority legislative issues to consider: AB25 (Hayashi) – Athletics Concussion & Head Injury, AB 310 (Ma) Fair Specialty Drug Payments and Mandatory reporting of lapses of consciousness. Although the **CNS** is currently focusing on these three items, other legislative issues will continually be identified and addressed.

In addition, the **CNS** is planning a two day annual meeting in 2012 in southern California that will address practice-related concerns, provide CME and address novel current topics including neurological disasters and "neuro-terrorism". Details will be soon announced.

Currently less than a third of the state's neurologists are dues paying members. Please consider being an active member of your California Neurology Society and providing us with the financial support we need to pursue our mission.

Adversity creates opportunity. If the neurologists of California remain united, organized, focused and motivated, we can achieve our goals and create a satisfying environment in which to practice and most of all, ensure the welfare of our patients.

Steven J. Holtz, M.D.

President, California Neurology Society
S. J. Holtz, MD, FAAN
CNS President

Deadline Nears to Avoid Electronic Prescribing Penalty

June 30 is the deadline for neurologists to avoid penalties and increase their incomes by prescribing electronically.

The Medicare Electronic Prescribing Incentive Program is 1 percent in 2011 and a 1-percentpenalty based on 2011 activity is in effect for 2012.

Eligible providers must provide 10 electronic prescriptions for Medicare patients during qualified clinical encounters (i.e., evaluation and management visits) by June 30, 2011, In order to avoid the 1-percent penalty on 2012 Medicare reimbursements. Medicare requires claims-based submission of electronic prescriptions.

By December 31, 2011, eligible providers must complete 25 electronic prescriptions for Medicare patients during qualified clinical encounters in order to avoid a 1.5-percent penalty in 2013. Electronic prescriptions performed during non-clinical encounters (e.g., refills provided for a patient when they are not in the office) do not count toward the number counted by the Medicare program.

For more information, visit *www.aan.com/view/erxhelp*.

Editor's Message: California Physician Supply: Crisis and Opportunity

Michael Stein, MD, CNS Newsletter Editor

Your editor had the opportunity to attend the recent meeting of the CMA's Council on Legislation up in Sacramento. The meeting began with a presentation of the **CMA Issue Brief: California Physician Workforce**.

I have attached it to this article; it bears careful and considered reading. The report highlights the many problems our profession faces in the coming decades and offers various approaches to dealing with the coming crisis. Many of us are nearing retirement age and the number of new neurologists entering the workplace simply will not keep up with the demand for neurological services. We have to start thinking creatively now, not 10 or 20 years from now, about how to meet these challenges.

At the meeting, discussion groups worked on 3 possible ways to address the future shortage of physicians:

1. Considering that one of the deterrents to entering the profession is the amount of time it takes to become a physician, should the amount of years to finish medical school be shortened?

2. How can the physician community help to ensure that telemedicine evolves in a way that best serves the profession and patients?

3. Other than changing the federal formulas California receives for Graduate Medical Education funding, how can we increase GME for our state?

But these are only 3 questions and many others need to be addressed:

*How do we attract and retain physicians in California? California born physicians who undergo training out-of-state do not return in appreciable numbers.

*How do we address the disparity in primary and specialty physicians? In every area of the state, specialists outnumber primary care physicians, even in areas that are considered medically underserved.

*How do we develop a more diverse medical workforce? Latinos constitute 37% of the state population (and growing), but only 5% of physicians are Latino.

I found the discussion of telemedicine to be the most interesting. The winds of change are blowing most vigorously in this area and we have to deal with some thorny issues, such as care/advice being provided by out-of-state physicians, interoperability of electronic medical records, payment issues, liability issues and so forth. Telemedicine has the promise of being one way to address the shortage of physicians, but an unintended consequence of telemedicine, as I see it, is the perpetuation of the maldistribution of specialists in urban areas. If you can provide advice to a practitioner in a rural area while sitting comfortably in your office in San Francisco, who is going to move to one of these communities? Maybe a lifestyle choice, but one that I see made by only a few neurologists.

The Workforce Report ends with 5 recommendations; I'm sure that more can be thought of and the CNS Newsletter should be a forum where ideas and suggestions can be discussed. Let's start thinking of solutions. Who knows, some of your ideas may translate into a program which ultimately helps increase the number of neurologists in our state.

Medi-Cal HER Incentive Program Update

The state would like to remind Medi-Cal eligible providers and hospitals that although this delay may affect the timing of their payments,

The state has met with key stakeholders on several occasions and is making progress with the prequalification formulas for eligible providers and clinics. The state, with the help of stakeholders, has also developed a prequalification methodology for managed care providers. Last week the state met with its Region II counterparts in the State of New York, and with CMS Region II and IV to discuss similarities of approaches to prequalification formulas. DHCS has submitted a draft proposal to CMS for review.

The Office of Health Information Technology is working closely with its contractor, ACS and the department's Information Technology Services Division to address State Level Registry (SLR) defects identified by ACS during the final phase of User Acceptance Testing for the Eligible Hospital Component of the SLR. In addition, system requirements are being updated to reflect user recommendations for enhancing the SLR, as well as making necessary changes to address CMS requirements. It is anticipated that requirements updates will be completed and Level of Effort determined the first week of June. This will result in the state receiving an updated work plan and timeline to determine a firm California EHR Incentive Program launch date. The state would like to remind Medi-Cal eligible providers and hospitals that although this delay may affect the timing of their payments, it will not affect the total amount of their payments.

Thank you,
Genevieve Stevens
Department of Health Care Services – OHIT

Electronic Health Records: From Selecting a System to Demonstrating Meaningful Use

CMA and CMAF Publish a Resource to Help Physicians at Every Step of the Process

The 2009 federal economic stimulus package provides funding to promote the adoption of health information technology (HIT), the vast majority of which will be directed to physicians to subsidize the purchase and usage of electronic health records (EHR) systems. Beginning in 2011, qualifying Medicare providers stand to receive up to $44,000 and qualifying Medi-Cal providers stand to receive as much as $63,750.

The promise of the federal EHR incentives is causing a wide range of reactions among California physicians. There is excitement about the financial benefits available both through the incentives and practice efficiency. There is also confusion about issues such as how to get started, how to select the right system, and what does "meaningful use" mean?

To help physicians through this process, the California Medical Association (CMA) and the CMA Foundation have published a comprehensive EHR guide called the *EHR Desk Reference*. The

reference was funded by a generous contribution from the Physicians Foundation. Due to the foundation's support, the *Reference* is available free-of-charge to any physician.

The *EHR Desk Reference* brings together information, tools, and resources from many sources into one comprehensive tool to help physicians and their practices make the transition to EHR. It includes information from CMA, the American Medical Association, the California Academy of Family Physicians, the Texas Medical Association, and many others.

The *Desk Reference* can help both specialists and primary care physicians in all modes of practice. It is designed to help physicians at any stage of the EHR implementation process. Some of the topics covered in the book include:

- Understanding the Federal Incentive Programs
- Selecting the Right EHR for Your Practice
- Talking to Your Patients about Your EHR
- HIPAA Compliance
- Meaningful Use

In conjunction with the release of the *Desk Reference*, CMA staff and physicians will be traveling the state distributing copies and speaking about EHR adoption. Watch your county medical society publications for a seminar taking place in your area. Or, if you would like to schedule a speaker at your hospital medical staff meeting, medical group, or other gathering, please contact the CMA member helpline at 800-786-4262.To download a copy of the *Desk Reference*, or to view CMA's collection of tools and resources around HIT, please visit the CMA HIT Resource Center at www.cmanet.org/hit.

Report of the Medicare Carrier Advisory Committee San Francisco – April 20, 2011

LCD - Local Coverage Determination Report

A new LCD has been published in draft form and covers four botulinum products, Botox, Dysport, Xeomin, and Myobloc.

For a list of covered diagnoses, see the draft LCD on Palmetto's website.

Botox is now covered for prophylaxis of patients with chronic migraine (more than 15 days per month with headache lasting four hours a day or longer). Current diagnostic codes which can be used are 346.70-346.73. A specific CPT for migraine is to be determined in the future.

Xeomin is the newest and has a temporary CPT code of Q2040. On January 1, 2012, CMS is anticipated to release a J code.

Please pay attention to how you bill for these products as the rules are different for each product.

The coverage states "this A/B MAC has determined that the separate accepted indications for the four boxes will be combined into a single list of covered indications in this Local Coverage Determination (LCD) policy. However, it is the responsibility of providers to use each drug in accordance with the FDA approved indications that there are valid and documented reasons stating why the unapproved form is used".

Electronic prescribing: you have certainly received numerous publications from all sides. You must submit 10 prescriptions electronically before June 30 provided you have at least 100 "qualifying encounters" with Medicare beneficiaries in the first six months of the year. Qualifying encounters consist, amongst others, of office visits. People who have very few Medicare patients may not be affected.

Microvascular Therapy for neuropathy: this procedure consists of electrical stimulations. No studies or scientific evidence was found and it is therefore considered "investigational" and not covered.

Signature Required on Records: California is the highest in the country on the list of delinquencies under the CERT program (.. error rate). The main reason is not that the care delivered was poor or inappropriate, but because physicians did not respond to requests for records. Therefore, because of a technicality, California comes out poorly. The other reason is that the records are not signed. If you send records and your signature is not legible, it is suggested that you add a sample signature page to the records. You are urged to speak with your staff and designate a particular person in the office to handle such requests.

Partnership for Patients was just launched recently. The Obama Administration has launched the Partnership for Patients: Better Care, Lower Costs, a new public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans. The Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. For more information see:
http://www.healthcare.gov/center/programs/partnership/index.html

Billing for physician services for hospice patients: if a Hospice patient is admitted to a hospital, special attention needs to be paid when submitting a claim for services. If the physician has a contractual relationship with the Hospice, the Hospice should pay. If the physician has no contract, and the services are not related to the reason why the patient is in Hospice, a GW modifier should be added to the claim. If the services are related to Hospice care, a modifier GV should be added. These issues were discussed at some length but were very complex. If you receive a denial, it may be because of one of the above reasons and you should explore it further.

Respectfully submitted,
Eric H. Denys, M.D., CNS Secretary Treasurer

Are You Coding Observation Services Correctly?

Observation is a 24-48 hour outpatient stay in a hospital building. An Observation patient is not an inpatient. Neurologists might use Observation Status for their own patients who present to an Emergency Department for a new onset seizure, syncope, or a TIA, or for any other reason in which the stay is likely to be only 24-48 hours.

The physician caring for the patient uses Observation Status Care codes:

On the initial day, use codes Observation Status Care 99218, 99219, or 99220 for levels of service similar to hospital admission codes 99221, 99222 or 99223. The Observation Status codes can be used even if you have seen the patient previously.

On a follow up day, use Observation Status Care codes 99224, 99225 or 99226 for levels of service similar to hospital subsequent day codes 99231, 99232 or 99233.

For a consultation on an Observation Status Care patient, use the outpatient consultation codes. For most carriers, those are the traditional outpatient consult codes 99241-99245. Of course, Medicare and some other carriers now use the outpatient office visit codes in those circumstances, codes 99201-99215.

Coding the service status as Observation is important too for the billing forms.

Note that an Observation Status patient might be physically anywhere in the building - Emergency Department, a formal Observation Unit, or on one of the hospital floor units. Location is not relevant.

If an Observation Status Care patient needs to stay longer than 48 hours for medical reasons, a simple order can be written to change status to inpatient. Observation Status usually should not be used longer than 48 hours.

Marc Nuwer, MD, PhD
CNS Consultant

New Guidance On Responding to Requests For Non-Beneficial Care

Occasionally, a patient or his or her care decision maker will request one or more medical treatments that the physician determines to be medically ineffective for the patient's particular medical condition and goals of care. To help physicians and medical institutions deal with this difficult issue, CMA has created medical-legal guidance that discusses the principles of medical ethics, legal immunities and CMA policy that supports physician and medical institution decisions to decline non-beneficial treatment request from patients or their health care decision makers. The document also offers guidance on how to handle conflicts that arise after a determination that a requested treatment would be medically ineffective or non-beneficial.

The article can be read in its entirety by clicking on the link "CMA On Call" in the index at the beginning of the CNS newsletter. This article is provided free to CNS members with the kind permission of the CMA. For those of you who are not members of the CMA, this and a wealth of similar articles are available without charge; if you're not a member, the articles can be purchased for a nominal fee.

California Neurology Society – 2011 Legislative Issues

1. **AB310 (Assembly Member Ma)** – This bill prohibits "specialty drug pricing" or "tiered pricing" of new (and usually expensive) medications. As stated in the bill, "a health insurance policy issued, amended or renewed on or after January 1, 2012, shall not require an insured to pay a co-payment for outpatient prescription drugs in excess $150 for a one month supply of a prescription or its equivalent for a prescription for a longer period as adjusted for inflation."

2. **AB369 (Assembly Member Huffman) -** This bill prohibits "step therapy" of pain medications. This bill would impose specified requirements on health care service plans or health insurers that restrict medications for the treatment of pain pursuant to step therapy or fail first protocol. The bill would authorize the duration of any step therapy or fail first protocol to be determined by the prescribing physician and would prohibit a health care service plan or health insurer from requiring that a patient try and fail on more than two pain medications before allowing the patient access to other pain medication prescribed by the physician, as specified.

3. **AB25 (Assembly Member Hayashi) -** This bill would require student athletes (essentially ages 12-18) who are suspected of sustaining a concussion to be taken out of practice or competition and not allowed to return to play until they get a written release from a "licensed health care provider". This issue is gaining support in California; a similar bill has been enacted by 10 states and is being considered by 20 states.

4. **Mandatory reporting of lapse of consciousness -** There is no current legislative proposal which removes the requirement that physicians report lapse of consciousness. Assembly bill **AB1389 (Assembly Member Allen)** requires that all new or renewal applicants for a driver's license report whether they have had a lapse of consciousness or confusion in the past 3 years. Five states have physician reporting requirements similar to California. It is unlikely there will be any significant legislation modifying the reporting requirements this session; the California Neurology Society should, however, let legislators know this law needs to be changed.

5. **Scope of practice issues -** This issue is not being addressed during this current legislative session. Physical Therapists have tried but failed to allow Medicare to cover physical therapists doing both the performance and interpretation of EMG.

6. **AB655 (Assembly Member Hayashi) -** Hospital Peer Reviews - This bill would require a peer review body to respond to another peer review body and produce a summary of specified information concerning a licentiate under review as specified. A similar bill was vetoed by the Governor in 2010.

7. **Defense of MICRA**. Trial lawyers have proposed a "spot" bill to modify MICRA (Medical Injury Compensation Reform Act of 1975). A formal bill has not been written or submitted to the Legislature.

8. SB810 (Senator Leno) - Single Payer Health Care Coverage for residents of this bill totally replaces the current health insurance system and would provide every California resident medical, dental, vision, hospitalization and prescription drug benefits.

9. Write in_____

Bill Information: http://www.leginfo.ca.gov/bilinfo.html

California Neurology Society – 2011 Legislative Survey Results

- Survey distributed via email:
  - April 6, 2011 - 1,805 AAN members in California
  - May 3, 2011 – 1,826 AAN members in California
- The two distributions resulted in a total of 114 respondents as of May 5, 2011. Responses will continue to be tracked throughout May.
- A copy of the survey can be viewed by following this link: http://tinyurl.com/3lbomsd

Results:
The respondents were asked to choose three priority issues from the list below:

Legislative Issue	**Yes, Make this a Priority (Number of Respondents)**
AB310 *(Assembly Member Ma)*	40
AB369 *(Assembly Member Huffman)*	39
* AB25 *(Assembly Member Hayashi)*	62
* Mandatory reporting of lapse of consciousness	55
Scope of practice issues	32
AB655 *(Assembly Member Hayashi)*	15
* Defense of MICRA	51
SB810 *(Senator Leno)*	32

* Top three priority issues

Federally Subsidized Services Are Available from "CALHIPSO" To Assist with HIT Adoption

by ACCMA Staff

Recognizing the significance of the challenge, part of the Federal "stimulus" legislation adopted in 2009 allocated funds to assist physicians with HIT adoption. This assistance was to be provided through "Regional Extension Centers" created throughout the country. When this funding opportunity became available the California Medical Association (CMA) formed a coalition with the California Primary Care Association and the California Association of Public Hospitals to establish an organization – California Health Information Partnership and Services Organization (CALHIPSO) – to serve as a Regional Extension Center in California.

CALHIPSO's mission is to help physicians meet the standards required to qualify for Federal incentive funds that are being offered to physicians for HIT adoption – up to $44,000 per physician from Medicare or up to $63,750 per physician from Medi-Cal program (provided at least 30% of patient volume in Medi-Cal; 20% for pediatricians). The incentive payments are available both to physicians who already have an EMR system and to physicians who purchase a new EMR system (see separate article on Federal incentives for HIT adoption), provided the EMR system is "certified" and the physician meets "meaningful use" requirements (see related article on meeting "meaningful use" standards).

For many physicians, adopting and implementing an EMR system or making changes to your current system can be a costly, complicated and time consuming task. Although many physicians report great benefits from using EMR, most also report considerable logistical and financial challenges along the way. The purpose of CALHIPSO is simply to assist physicians with this challenge. While CALHIPSO does not provide financial support for the purchase or upgrade of an EMR system, its consultative services, educational tools and products will help physicians make cost effective HIT investments and achieve "meaningful use" standards and thereby receive the Federal stimulus funds.

What services does CALHIPSO offer physicians? CALHIPSO services include preferred pricing on EMR package deals, educational services, "best practice" tools, and access to commercial service providers (i.e. IT consultants, technology vendors, etc.) that have been vetted by CALHIPSO and its local administrator for the Bay Area, Lumetra Healthcare Solutions. The following "core services" are specifically made available to CALHIPSO enrollees:

Assistance with Vendor Selection: "Vendor neutral" information will be provided to help with selecting an EMR that best meets the practice needs (including CALHIPSO-negotiated package deals); Note: CALHIPSO is prohibited from having financial relationships with HIT vendors that present conflicts of interest.

Meaningful Use Reporting: Help meeting the Federal "meaningful use" requirements (meeting measures and collecting required data) to ensure eligibility for Federal incentive payments.

Preferred Pricing on EMR Implementation Tools: Access to affordable technological tools, such as standard deployment, data aggregation tools, and best practice modules for achieving meaningful use.

Training and Education: Presentations and webinars; peer networks of physicians/office staff implementing the same or similar EMR systems; regional user groups to share best practices and lessons learned.

Readiness and Workflow Assessment: Lumetra Healthcare Solutions will assess resources – human, technical, capital – that can be leveraged for HIT adoption; gaps will be identified, and a snapshot of the physician's data exchange partners and unique needs will be made.

Project Planning, Monitoring and Management: A high-level project schedule will be developed for sequencing of events and to manage expectations

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CALHIPSO Services

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about roles and responsibilities for implementation; coaching will be provided regarding the implementation process; and EMR vendors' implementation activities will be monitored.

Application Training: EMR vendors will perform training. Lumetra Healthcare Solutions may offer additional expertise as a value-added service.

Workflow Redesign: Assistance in adapting and transitioning paper-based processes to technology-enabled processes.

In addition, the following services are available for CALHIPSO enrollees at preferred rates:

System Customization: Assistance creating specifications for any custom programming needs.
Infrastructure Development: Assistance to upgrade hardware, network and other devices to meet the requirements of the new systems.

Interface Development: Intermediary services between EMR vendor and lab, pharmacies, hospitals and other data exchange partners to develop, test and monitor interfaces.

EMR packages Offered Through CALHIPSO: CALHIPSO has negotiated packaged pricing and contract terms with some major national EMR vendors that are made available to physicians participating in CALHIPSO. Pricing of the products, interfaces, etc. represents, in most cases, "most favored nation" pricing. Essential contract terms include:

- Clarifying that patient data belongs to the physician, not the vendor
- Protecting the use of patient level data by the EMR vendor either through using a "opt-in" or "opt-out" process and clarifying how de-identified patient data will be used
- Holding the EHR meaningfully liable if there is a breach in the contract
- Requiring that the vendor enhance the product to provide for Stage 2 and Stage 3 Meaningful Use Criteria and limiting the cost of these upgrades to "most favored customer" rates
- Detailing specific service level agreements and training programs that the provider can rely on – and outlining additional fees, if any, for additional services provided
- Providing limits on the fees paid by providers for health information exchange and interfaces
- Providing for a detailed process that protects the provider, and patient data, in the event that a provider chooses to change EHR vendors

At press time, CalHIPSO had concluded negotiations on these package deals with: eClinicalWorks, e-MDs, NextGen, AthenaHealth, Allscripts, GE Centricity and McKesson.

What Does CALHIPSO Cost?
For primary care physicians (Certified in Internal Medicine, Family Practice, Pediatrics, Geriatrics, ObGyn, or Adolescent Medicine) in practices of 10 or fewer physicians or who practice in medically underserved areas, CALHIPSO's services, including the "core services" listed above, are offered free of charge for two years if you enroll before July.

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HIT Workforce Resources

Recognizing that physicians will need HIT-savvy personnel to assist them with their implementation and ongoing operation of an EHR, CALHIPSO has identified the following resources:

Educational programs for existing staff – www.calhipso.org (go to Education and Training) offers listings of of free, short, easily accessible trainings targeted towards providers and their staff, as well as longer term trainings such as the community college programs.

Accessing the HIT workforce of tomorrow - As part of CalHIPSO's work to support the development the HIT Workforce of the future, a section has been added to the website for students in the Community College HIT Certificate programs to post their resumes and brief descriptions of their experience. Go to http://www.calhipso.org/index.php?option=com_content&view=article&id=152&Itemid=38. Many of the students are mid-career professionals wanting to transfer existing healthcare experience into the HIT world, or IT professionals looking to apply their skills in healthcare. They have all completed an extensive six month certificate program. CalHIPSO is encouraging all its partners, including physicians and practice managers, to review this list of students who are looking for either short-term internships (limited paid engagements of 3 weeks to 3 months) or full time employment. If you need more information about how to structure an internship, or how much to pay an intern, etc., contact Caryn Rizell: crizell@cpca.org.

CALHIPSO Services

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ACCMA members who do not qualify for the primary care federal subsidy listed above – non-primary care physicians or physicians practicing in groups with more than 10 physicians – may enroll for a fee of $150 per provider per year (up to a maximum of $750 for up to 10 physicians) or $1500 per year for groups of more than 10 physicians. The "core services" are not offered free of charge to non-primary care physicians but it is believed that these services, which are generally required for any EMR installation, are priced at levels that compare favorably to those that physicians would otherwise have to purchase for an EMR installation.

If I decide to enroll with CALHIPSO, what will happen?

If you decide to take advantage of CALHIPSO services, you will be asked to complete an enrollment agreement. This agreement is quite straightforward and addresses: the services CALHIPSO will provide; any fees associated with the delivery of the services; the term of the agreement; provisions for the termination of the agreement, which can be initiated by either party without cause; agreement by the physician to use best efforts to cooperate with CALHIPSO to install the selected certified EMR and achieve "meaningful use" of the system; and, CALHIPSO's commitment to comply with HIPAA requirements to protect personal health information.

Upon receipt of the agreement, the physician will be contacted by a representative of Lumetra Health Services (the local representative of CALHIPSO) to schedule an in-depth practice assessment and to obtain any further information necessary to process the enrollment agreement. Upon completion of the practice assessment, Lumetra will provide a "Practice Service Plan" describing the services to be rendered and the costs the physician must assume to complete the process of HIT adoption (such as the EMR system cost, associated equipment, other services not covered by CALHIPSO) and achieve "meaningful use."

Lumetra or its contracted service partner will then commence working with the physician to select and implement an EMR and achieve "meaningful use" so the physician can begin to qualify for Federal incentive payments as soon as possible (assuming the physician is eligible for such incentive payments). Once the EMR system is selected, the EMR vendor will also work closely with the physician.

How do I enroll in CALHIPSO?

To enroll, physicians should obtain a Provider Enrollment Agreement online from www.calhipso.org or by contacting the ACCMA at 510-654-5383. The ACCMA promoted the creation of CALHIPSO to help busy physicians overcome the challenges of HIT adoption, and hopes physicians will take advantage of this program.

Are You Aware of Physician Profiling – and Ready to Take Action?

Physician profiling programs, designed to judge physician efficiency and quality of care, affect all physicians, including neurologists. Profiling has gradually evolved over the past few years to focus on cost more than quality. Recent studies on physician cost profiling evaluated the tools that are used by insurers and identified alarming flaws that result in inaccurate classification of physicians. The AAN's Payment Policy Subcommittee believes this is a significant issue for neurologists and encourages members to join the AMA and state efforts to introduce legislation to regulate profiling measures. Neurologists must be knowledgeable about the process and make certain that their profiling data accurately represent their performance. They should be ready to challenge their classification as well as educate their practices and patients. "As a practicing neurologist and member of the AAN, I recognize the value of efforts to identify opportunities to improve the cost, and efficiencies in health care, "said Marianna Spanaki, MD, PhD, MBA, a member of the Payment Policy Subcommittee. "In order to accomplish this goal, the development of tools such as profiling tools to measure quality, \cost and utilization of resources should be the product of partnership with all stakeholders and demonstrate accuracy and transparency in data collection, interpretation, and utilization."

What Is Physician Profiling?

In an effort to rein in rising health care costs, managed care organizations have focused on the relative cost of care delivered by physicians. Health plans have developed tools to assess physician practice patterns called cost profiles that identify physicians who provide lower cost services for a given medical condition. Some health plans give patients financial incentives (lower premiums or co-pays) to select lower-cost or "cost-efficient" physicians. The Premium Designation® Program from United Healthcare and the Aexcel® Program from Aetna are two examples of these profile programs. In 2007, the New York Attorney General raised concerns that physician profiling programs "have the potential to cause confusion if not conducted and communicated appropriately and could

result in a violation of law." A number of major private health plans agreed on accuracy and transparency in developing their ranking programs. By 2012, Medicare itself will begin providing physician cost profiles, called Relative Resource Reports.

AAN Position Statement on Profiling
In a 2008 position statement, the AAN urged insurers to include national physician organizations in the development, implementation, and evaluation of physician profiling programs. The Academy emphasized the importance of transparency in collecting, analyzing, and compiling performance and ranking data in the development of performance measures and physician profile.

Research on Physician Profiling
Recent studies have questioned the reliability of the tools used to profile physicians and have raised concerns about the value of profiling programs in reducing health care costs.

1) A 2010 *New England Journal of Medicine* study funded partially by the Department of Labor and conducted by the nonprofit research organization RAND Corporation found that 22 percent of physicians would be misclassified in a two-tiered system (high cost/low cost). The overall rate of misclassification ranged from 16 percent (gastroenterology
2) and otolaryngology) to 36 percent (vascular surgery). In this study, researchers looked at commercial claims provided by four insurance companies in Massachusetts for 2004 and 2005. The plans followed the following steps in order to construct the cost profile of a physician:

1. Grouped claims for services related to the management of a medical condition into categories that are called "episodes." For instance, a year-long episode of care for a type-2 diabetic patient included office visit, glycated hemoglobulin, oral hypoglycemic drug for a year, lipid profile, ophthalmology evaluation, endocrinology consultation;
2. Calculated the observed cost of each episode;
3. Assigned the cost to the physician who had billed at least 30 percent of the professional costs; and
4. Calculated the expected cost that is the average cost of each episode type assigned to physicians in each specialty (i.e., diabetes episodes assigned to internists).

A physician's cost profile is the sum of the observed costs for all assigned episodes divided by the sum of the expected costs. A value <1 indicates that the physician's cost is lower than those of his peers. The researchers subsequently analyzed the reliability of physicians' classifications and found that the proportion of physicians who were not classified as lower cost but were actually lower cost ranged from 10 percent (OB-GYN) to 22 percent (vascular surgery and internal medicine). The majority of physicians in this study (59 percent) had low cost profiles. Based on this study, RAND urges that improvements of cost profiling methods be made and concludes that current methods used by insurers "are not ready for prime time."

2) In another recent study, researchers from University of Maine investigated whether two commercially available software packages currently used to determine physician cost efficiency rankings could produce consistent rankings across specialties. Researchers discovered that although there was some agreement between rankings for cardiology, general surgery and neurology,there was little agreement for family practice, internal medicine and gynecology. Also, if pharmacy data claims are not available, accurate rankings for family practitioners are not feasible. Thus,the researchers concluded "the use of inaccurate scores to reward or penalize physicians should be avoided."

AMA and Physician Profiling
On July 19, 2010, the American Medical Association sent a letter to the largest health insurance companies—co-signed by 47 state medical societies—pleading for accurate and reliable information on physician cost profiles and urging collaboration with the AMA and state medical societies to re-evaluate the use of physician profiling programs.

Resources
For more information, visit *www.aan.com/go/practice/policy*. The AAN provides several resources to help members, including:
- AAN Position on the Principles of Physician Profiling *(www.aan.com/globals/axon/assets/4250.pdf)*
- AAN Insurer Relations Toolkit *(www.aan.com/globals/axon/assets/7911.pdf)*
- Physician Profiling: How to Prepare Your Practice *(www.aan.com/globals/axon/assets/3454.pdf)*

Visit the AMA website at *www.ama-assn.org* and search for "physician profiling" to get more information on this subject, including "Terminology Used in Physician Profiling" and "A Comparison of Three Physician Profiling Programs."

"The development of tools such as profiling tools to measure quality, cost, and utilization of resources should be the product of partnership with all stakeholders and demonstrate accuracy and transparency in data collection, interpretation,and utilization."
—Marianna V. Spanaki, MD, PhD, MBA
Gregory J. Esper, MD

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