LEE COUNTY MEDICAL SOCIETY

Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 21, NO. 7

Fort Myers, Florida
John W. Snead, M.D.

November, 1997

THE "BIG" WORD IN ATTENDANCE IS "ATTEND"
NOVEMBER MEETING

LEE COUNTY MEDICAL SOCIETY
GENERAL MEMBERSHIP MEETING
CME FOR RE-LICENSURE

November 17, 1997
Royal Palm Yacht Club
6:00 p.m. Social Time/Dinner

Continuing Medical Education Programs:

7:00 p.m. ~ 8:00 p.m.
Program: *HIV/AIDS Update*
Presenter: *Joseph W. Shands, Jr., M.D.*
Professor, Division of Infectious Diseases
Department of Medicine
University of Florida

8:00 p.m. ~ 9:15 p.m.
Program: *Domestic Violence Update*
Presenter: *Hugh E. Starnes*
Chief Judge of the 20th Judicial Circuit Court
Michael D. Gregory
Domestic Violence Family Law Investigator
20th Judicial Circuit Court
Nancy Walton
Domestic Violence Coordinator
20th Judicial Circuit Court

Question and Answer to follow on the topics presented.

- *You will receive your CME Certificate upon presentation of your evaluation form to our staff after each session.*
- *Cost of meal for non-members is $25.00 / Check payable to Lee County Medical Society, FAX 936-0533 or MAIL to P.O. Box 60041, Ft. Myers, FL 33906*
- *Reservations by November 10th / Cancellations a must or we will charge, as seating is limited. 936-1645.*

Lee Memorial Health System is accredited by the Florida Medical Association to sponsor Continuing Medical Education for physicians. LMHS designates this Continuing Medical Education activity for 2 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

In This Issue...

PRESIDENT'S MESSAGE
George C. Kalemeris, M.D.
"THANKS"

Stuart Harrison died on September 30, 1997. I was notified early that morning, and, like most of us, I went through the usual disbelief, anger and acceptance of loss of a gond friend and colleague. Stuart was only 58. His early death was a surprise. It seemed unfair that someone so young and active should be gone. I had reports on his patients to give him. I had just talked to him yesterday.

I first met Stuart on the Executive Committee at Lee Memorial Hospital. He was President of the Medical Staff at the time, having practiced in the community for many years. His tall, large frame and experienced presence intimidated this freshman member of the Executive Committee. His kind welcome to the Committee was much appreciated at the time. Although we occasionally disagreed, I always found him to be a student of the truth, protector of quality, and fair.

He also supported his medical profession. A faithful member and participant of the Lee County Medical Society, he served on the Board of Governors in 1979.

Most of us have had occasion to work with Stuart over the years. My experiences were full of this compulsive checking and rechecking of diagnoses, and his sincere effort to have a complete understanding of the disease affecting his patients prior to deciding what best therapy to provide. Others describe his kindness and sincere interest towards his patients. Others describe his lack of interest in the financial benefits of the practice of medicine, providing care without expectation of compensation. Still others describe his devotion as husband and father.

Scholar, physician, family man and humanitarian. This is the legacy that all of us looking back on our own lives would he deeply grateful to have.

I'm not sure that Stuart knew how much he touched those around him. He was not self-absorbed. Nevertheless, it is often the humble amongst us that touch the most people in the kindest way, their willingness to treat those around them with respect and kindness dispenses a magical touch that leaves a permanent mark behind.

Each of us, regardless of our years in the profession, has opportunities not only to satisfy the physical needs of our patients, but their emotional needs as well. Stuart, in his life and practice, was a model of the caring physician.

Thanks, Stuart.

Stuart S. Harrison, M.D. ~ 4/18/39 - 9/30/97

A member of the Lee County Medical Society for 25 years. Our deepest sympathy to his family: wife Gene and children Steven, Marc and Mindy. Donations can be made to Temple Judea in his honor.

WHY BELONG?

Every day in your office you help ease suffering, heal patients and save lives. Being a physician is a noble calling.

- We share your values.
- We speak out on behalf of patients and physicians with a single, unified voice.
- We advance the art and science of medicine.
- We promote ethical, educational and clinical standards for the profession.

When you continue your membership, rejoin or become a member of the Lee County Medical Society and Florida Medical Association, you are expressing your commitment -- to patients, to the profession, and to resolving important health care issues. Help us respond, support and fight for you.

Please pay your 1998 LCMS and FMA dues when you receive your statement. And ask another physician to join -- call the LCMS at 936-1645 for an application for your peer.

AS I RECALL...
Roger D. Scott, M.D.
"FINDING SUMICA"

November is the month of my birth. Now I share with you this very personal story.

For a goodly part of my life I did not know the precise location of my birthplace, as I was born at home at a place called Sumica in Polk County, Florida. Sumica was our sawmill town and when the sawmill moved (I was 1 year old) then all of Sumica disappeared. Daddy said it was south of Lake Wales; but there were no roads leading to Sumica except for dirt ruts (These are tracks made by driving in the sand in Florida without grading or any type of improvement). There was also a spur line of the Atlantic Coastline Railroad for shipment of lumber.

Years later as the clouds of war were approaching (WW II, not the Spanish-American War!), it was required that males register for the draft, and, to prove one's age it was necessary to have a birth certificate. Well, guess who never had a birth certificate because of being born at home in the true backwoods of Florida, with no one in attendance except my mother and some other lady. Mother and Daddy had to make affidavits and appeared before the County Judge to verify that I was indeed their child, rather than one of immaculate conception (on second thought, maybe I was). It is interesting that my birth certificate arrived with the issue date of 12/6/41, the day before the Japanese attacked Pearl Harbor. That wasn't my birthdate of course!

Well, that solved where I was born, but the town no longer existed and only was in existence for three years. No maps ever showed the location of Sumica. It was always embarrassing to me when people asked "Where were you born?" for me to have to answer with "I really don't know exactly, but it was somewhere in Polk County, Florida."

In 1959 Carl Johnson, a surveyor here in Fort Myers, asked the familiar question, and I explained to him that he wouldn't have any idea where it was, but he said that he had seen Sumica on an old map somewhere. Low and behold, about three years later he obtained a copy of an old Polk County map showing Sumica! What a treasure for me.

I was determined to return to Sumica, but just never got around to it until December of 1995.

The map of Sumica showed no roads, only the railroad spur, and many changes have occurred in the development of the area since my birth (Guess how many years.) From the old map Range, Townships and Sections (measurements used by surveyors in subdividing segments of land), we could locate Sumica on a current Polk County map. Once thus located, a Coast and Geodetic Survey map of the area gave extremely fine details and even showed the old railroad grade line coming to the sawmill area. From this map, the exact latitude and longitude could be calculated.

Cecil Miller was kind enough to allow me the use of a portable GPS device which is truly amazing because it can tell you where you are in the universe, as far as latitude and longitude are concerned, and can direct you to a new latitude and longitude. I knew about how to get to the area so I went to Babson Park, Florida, and the GPS yielded Sumica to be directly 8 miles east as the crow flies (straight as an arrow); however, there was a large body of water, Lake Weohyapka ("Walk on Water") making the drive approximately 22 miles to circumvent the

(continued on page two)

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The Editors welcome contributions from the members. Opinions expressed in the BULLETIN are those of the individual authors and do not necessarily reflect policies of the Society.

MEMBERSHIP ACTIVITY

CORRECTIONS TO *1997-98 PICTORIAL DIRECTORY*

Correct Address and Telephone Number:
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Rafael Climaco, M.D.
Family Practice (listed incorrectly under Pediatrics)

Add To Our Retired List:
J. Stewart Hagen, M.D.

AS I RECALL *(continued from page one)*

lake. A defunct subdivision (Indian Lake Estates) was within 3/4 miles of Sumica. At the border of the subdivision, the wild overgrowth of trees, palmettos, and thick scrub made it impossible to go any further. The GPS advised that I was 1/2 mile from Sumica.

Finally I had gotten close to Sumica and if you are ever interested in going up there, get a GPS and head to Longitude 81° 22min 30sec; Latitude 27° 46min 30sec; or you can find Polk County Range 29E, Township 30S, section 36.

Prior to my going to Sumica there was only one living person that knew about where Sumica was located. Two more people learned of the precise location of Sumica on December 24, 1995 and you in November 1997 have this information. You are now honorary members of the Sumica Scrub & Palmetto Club! Happy Birthday, Me!!

I feel a great personal loss with the passing of Stu Harrison - you're on my Memory Roll. Till we meet again.

WE GET LETTERS TO SHARE WITH YOU

October 16, 1997
Lee County Medical Society
3805 Fowler St., Fort Myers, FL. 33906-0041

Gentlemen:

Some doctors do not give patients a bill for services rendered unless they ask.

Patients are either too concerned with the ailment that brought them to the office or the diagnosis to remember the request.

May I suggest that a copy of the bill for services rendered be given to all patients before they leave the office. Thank you for your consideration.

Sincerely,

Milton J. Reingold

LEGISLATION EFFORTS ON YOUR BEHALF

Dr. Steven West Invited to Attend AMA National Grassroots Conference with FMA Delegation, Washington, D.C.

Steven West, M.D., LCMS Legislative Chairman

I was invited by Dr. Gerry Schiebler who is President of the Florida Medical Political Action Committee to participate in the AMA National Grassroots Conference in Washington, D.C. on September 17th and 18th. At that meeting, we had the opportunity to meet with the Florida Delegation to the House and Senate and discuss issues which were of prime importance to physicians and their patients.

Issues that we discussed should be quite familiar to most of you. In Florida we have gotten the dual regulation of CLIA removed. CLIA is the Clinical Laboratory Improvement Amendment of 1988. We were in double jeopardy in Florida in that both the federal and state government were involved in regulating physicians' laboratories. However, in Florida we were able to repeal that state regulation. Currently, Senator K.A. Hutchinson of Texas and Representative Bill Archer of Texas have introduced bills to exempt physicians' offices that performed laboratory studies from CLIA, except those that performed pap smear analysis. This is very important because there is little, if any, demonstrative evidence that CLIA rules have resulted in an improvement in patient care. In fact, the regulators themselves concede that tangible benefits of the CLIA regulation do not exist. The intent of CLIA was to legislate quality, but the results have added inconvenience and expense to both patients and their physicians, especially the poor, the elderly, and children who have to travel, sometimes to a variety of sites, to obtain care. This has caused the CLIA regulation to become an obstacle to quality patient care. In many instances, access to care has been reduced. In Texas, for example, of physicians who provided testing services in their office prior to implementation of CLIA, almost a quarter of them have discontinued their office labs and almost a third have discontinued some type of in-office testing as a direct result of CLIA.

We also discussed with our legislator dual eligibility. Recently, as a result of the Balance Budget Act of 1997, a provision was enacted that allows Medicaid rates for cost sharing for qualified Medicare beneficiaries. This means that states would only be liable for what Medicaid would have paid had there been no Medicare coverage, and in most instances Medicare has already paid more than Medicaid. The state is not obliged to pay the co-payments and deductibles. We argued with our legislators that Congress needs to repeal the recent duel eligibility change. The current policy discriminates against physicians who treat poor Medicare patients and this will only compound the problem of access for the poor who are dependent on Medicare and Medicaid.

One of the most controversial issues was the Kyl Amendment of Section 45.07 of the Balanced Budget Act. Under this arrangement, physicians cannot receive Medicare reimbursement for any item or service either directly or on a capitated basis for two years if they agree to contract privately with a Medicare beneficiary for services which are provided by Medicare. This simply means that if a physician and a patient choose to go outside of the Medicare system and make an arrangement privately to pay for services that are covered by Medicare, that physician can no longer participate in Medicare for other individuals that he provides services to. The Kyl Amendment initially was added to the Balanced Budget Act so that physicians and patients would have the freedom to contract outside of the Medicare system if they so desired. However, the Clinton administration, literally in the middle of the night, amended the Kyl Amendment in such a manner that it places a restriction on physicians who contract privately with an individual patient so that they cannot participate in Medicare for two years. This was done because the administration is fearful that there will be a great demand for services to be rendered privately completely outside of the government sponsored health care programs. They are fearful that such an opportunity, if it's provided to individuals, would be the end of Medicare as we know it. Simply put, the Clinton administration is fearful of allowing competition. At the current time, I am happy to report, Senator Kyl and most of your Florida delegation support the FMA and AMA position. They are in favor of patients and physicians having the freedom to enter into private contracts if they so desire. Senator Graham, who is the Senior Senator from Florida, supports the administration's position and does not believe that Medicare beneficiaries and physicians should have the personal choice or freedom to enter into a private contract.

We also discussed at length the elimination of gag clauses. The Balanced Budget Act of 1997 does eliminate gag clauses and gag practices from Medicare contracts. We want the federal government to also now prohibit gag clauses in commercial contracts. This is most important so that physicians will feel that they have the freedom to discuss treatment options, as well as plan options when asked by their patients. The only way patients can make an informed decision is to be certain that their physician is able to discuss freely with them their concerns regarding their health.

Medical liability reform was discussed with the Florida delegation. It was pointed out that there must be a federal solution to curb the rising costs of health care liability. We discussed $250,000 cap on non-economic damages. We also discussed the importance of a tobacco settlement agreement. The AMA proposed the following changes in the tobacco agreement.

1. The FDA must have full jurisdiction over all tobacco products and nicotine delivery devices.
2. The Look Back Program for providing financial incentives to tobacco companies for reducing under-age tobacco use must include significant penalties if substantial reductions do not take place.

These were the major issues of the AMA National Grassroots Conference. There were also concerns about confidentiality of medical records. In the future, this will become a major area of concern with the development of computerized medical records. I welcome any questions or comments you have regarding my visit to Washington, D.C. and the top legislative issues of the American Medical Association.

ISSUE CONTACT RESULTS

FL. Delegation Member	CLIA Reform	Repeal of BBA '97 Dual Eligible Provision	Freedom to Contract w/ Medicare Pat.	Anti-Gag Legislation	$250,000 Cap Non-Economic Damages	Changes to Tobacco Agreement
Sen. Bob Graham	!	-	! Evaluating	Will evaluate & discuss w/AMA	Should be state responsibility	+
Sen. Connie Mack	+	-	+ Cosponsor	Needs more information	+	Wants more information
Rep. Mike Bilirakis	+	!	! Needs more information	Working w/ sponsors		
Rep. Charles Canady	+	No position at this time	+ Cosponsor	+ Cosponsor	+	No position at this time
Rep. Mark Foley	!	!	+ Cosponsor	+	+	No position
Rep. Tillie Fowler	+	+	+ Cosponsor	+ Needs more info	+	+
Rep. Porter Goss	+ Cosponsor	!	+	+	+	No position at this time
Rep. Bill McCollum	+	Needs more information	+ Cosponsor	+	+	+
Rep. Dan Miller	+	+	+	+	+	+
Rep. Cliff Stearns	+	!	+ Cosponsor	+	+	?
Rep. Bill Young	+	-	Leans toward support	+	+ Needs more information	?

Key: + = Supports AMA Position - = Opposes AMA Position ! = Member has taken no position

THE QUESTION MAN

OPINIONS - EDITORIALS
LETTERS TO THE EDITOR
John W. Snead, M.D.

"IS MANAGED CARE IMPROVING THE ACCESS TO HEALTH CARE?"

Michael W. Rozenberg, M.D. General Surgery

"It is quite obvious to any practitioner that access to health care has not been improved by the advent of managed care. In fact, one can make the argument that managed care has had the opposite effect. In fact, the goal of managed care has never been to increase access to health care but to 'save health care dollars.' Again, one can make the argument that managed care has had the opposite effect. At least managed health care is consistent."

John A. Distasio Pediatrics

"Managed care markedly inhibits access to health care. Frequently, patients wish to bypass primary care givers and seek evaluation by subspecialists. For years, such immediate access has been available to them and encouraged. Today, patients must be evaluated by their primary care giver before being referred for subspecialty care. While cost saving and clearly beneficial in keeping insurance premiums to a minimum, patients are unhappy. They feel they have been deprived of the right to see subspecialists at will. The result: bad feelings toward primary care givers, who are contractually obliged to serve as gate keepers."

December's Question:

"WILL THE RECENT GOVERNMENT ANTI-TOBACCO STANCE RESULT IN DECREASED SMOKING AND BETTER HEALTH?"

Send your comments to the Medical Society. Bulletin deadline is the 15th of each month...we want to see you in the print media! ◆

NATIONAL PROVIDER IDENTIFIER PROJECT

The National Provider Identifier (NPI) project will create a uniform provider identifier for use by all federal health programs (i.e., Medicare, Medicaid, etc.).

Use of the NPI will also be an integral part of the Medicare Transaction System (MTS) initiative through its enhancement of safeguard activities and simplification of administrative activities.

The NPI will be unique to each health care provider regardless of practice location and replace both the carrier-assigned Provider Identification Number (PIN) and Unique Physician Identification Number (UPIN) for claims processing purposes.

Based on material available to us at this time, the NPI will be **required** on all Medicare Part B claims received on or after December 1, 1997. **There will be no grace period for this requirement, and all claims submitted without NPIs will be returned to the sender.**

Medicare carriers will be responsible for the dissemination of NPIs to existing providers. The current NPI project timeline indicates this activity began in August 1997.

LEGAL OPINION

Florida Patient Self-Referral Act of 1992

Dick Mount, Esq.

Safe Harbor Provision for Physician Group Practice Severally Restricted by Recent 1st District Court of Appeal Decision in Tallahassee.

I have, in previous publications of this Medical Society Bulletin, written articles concerning both the Federal (Stark Bill) Patient Self-Referral Act and Florida's counterpart. Unfortunately, Florida's restrictions on self-referrals were not developed in concert with the Federal provisions and, in some instances, are inconsistent with or markedly more restrictive than the Federal Stark requirements. The result is a lack of uniformity in an area of law that, because of its newness and inexperience of Federal and State Regulators with the issues, leaves health care providers with little confidence in their ongoing business dealings with other providers.

An example of this problem recently arose in the 1st District Court of Appeals. Charles Wingo, M.D. and Tallahassee Orthopedic Clinic, P.A. applied to the Florida Board of Medicine for a declaratory ruling permitted under Florida law regarding a specific issue for use of its MRI system.

The Clinic is composed of ten practicing orthopedic surgeons, two family practice physicians and eighty-five support personnel. It had been providing MRI services strictly to its own patients. The Clinic had recently ordered an expanded MRI system which greatly enhanced the availability of MRI services to the Tallahassee region. Many physicians who were not associated with the Clinic wanted to refer patients to the Clinic due to the expanded MRI services.

Dr. Wingo and the Clinic merely sought advice from the Board of Medicine about whether the Clinic could accept referrals of patients from outside physicians who had absolutely no ownership interest in the Clinic and would not receive any enumeration whatsoever as a result of their referrals.

The Board of Medicine, upon reviewing the specific issues and the Florida Patient Self-Referral Act, concluded that referrals from outside physicians would be permissible and that the Clinic could continue to use the MRI for its own group practice patients as well.

The ever aggressive Florida Agency For Health Care Administration, however, felt compelled to appeal the case to Court. When an administrative decision is appealed to Court, it goes directly to the local Court of Appeals rather than to the Circuit Court, which would normally be the next step. There are five District Court of Appeals in Florida. Tallahassee is located in District Number One, and we are in District Number Two.

The Court, upon reviewing Florida's Patient Self-Referral Act, concluded that the Clinic could not accept referrals from outside physicians even though the referrals were specifically allowed under the law, because the safe harbor for group practice under Florida law indicates that group practice physicians can refer their patients to the group practice provided that such referrals are the "sole" source of referral of patients to the group. The Court, in other words, indicated that the Clinic could either continue to serve its own patients or discontinue such use and begin taking referrals from outside physicians, but the Clinic could not accept referrals for their own patients and referrals from outside source physicians.

For those of you who are referring patients to any group for these services, you need to make sure that the group is not using these services for their own patients, otherwise your referral would be prohibited under the act.

It is clear from reading the court's decision that the Appellate Judges did not want to make this decision, however, due to separation of powers in the Government, the Court cannot change clear language of the Statute.

This is a very unfortunate situation because the Federal law does not use the word "solely" in its definition of group practice referrals. Under the Federal law, referrals from group practice physicians to their own group practice is permissible just as such referrals are permissible under Florida law. The Federal Stark Law, however, allows outside referrals to group practices provided there are no enumeration agreements for such referrals. It is interesting to note that the Florida law was passed in 1992 and became effective April 1, 1992. The Federal law was not passed until 1993 and did not become effective until January 1995. Florida was one of the first states to have its own patient self-referral act. There are many instances in the act where one word can change the entire scheme of things as compared to the Federal law.

The Florida law was designed to prohibit referrals to physician-owned facilities due to possible kickback issues. The group practice exemption was made available so that physicians could operate within their own clinics and not have to worry about any self-referral issues. The legislative history indicates that the Florida law was proposed and drafted primarily under the guidance of Florida's Agency for Health Care Administration.

I spoke to Attorney John Knight, General Counsel for the Florida Medical Association. The Association is going to seek immediate amendments to the Self-Referral Act in order to rectify this situation.

As it turns out, Tallahassee has a heavy demand for MRI use due to the athletic programs prevalent at the two major universities in Tallahassee. The evidence presented in the Wingo decision indicated that many physicians would have referred patients to the new and improved MRI system. Now they will have to send their patients outside of the Tallahassee area because existing MRI systems are either not able to handle the demand or are not sophisticated enough to handle many of the serious injuries that occur to the college athletes.

This is not a good situation, and hopefully, our Legislature will see that by eliminating one word from the Statute a more reasonable outcome will occur.

This decision will affect the following health care services which are covered under the act: clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic imaging services (the Wingo situation) and radiation therapy services.

For any physician who is a member of a health care organization providing any of these services, you need to review what kind of patients you are taking. You can either use these services for your own patients within the group or accept referrals from outside physicians who have no financial interest in your group practice and will receive no financial benefit from the referral.

For those of you who are referring patients to any group for these services, you need to make sure that the group is not using these services for their own patients, otherwise, your referral would be prohibited under the act.

There are some exceptions to the definition of "referral". The following referrals are not "referrals" under the Act since they are specifically exempted from the definition of referral under the act:

1. By radiologists for diagnostic imaging services;
2. By physicians specializing in the provision of radiation therapy service for such services;
3. By medical oncologists for drugs and solutions to be prepared and administered intravenously to such oncologists' patients as well as for the supplies and equipment used in connection therewith;
4. By cardiologists for cardiac catheterization services;
5. By pathologists for diagnostic clinical tests and pathological examination services;
6. By any health care provider for services provided by an ambulatory surgical center;
7. By any health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis;
8. By urologists for lithotripsy services; and
9. By nephrologists for renal dialysis.

Since the above referrals are not considered "referrals" under the Statute, such referrals are specifically exempted from any of the prohibitions under the Statute.

If you have any questions please seek legal advice. The Agency for Health Care Administration is out there and seems to be determined to act as the watchdog in these referring situations.

Penalties for a prohibition referral consist of the following:

1. A civil monetary penalty up to $15,000.00 for each improper referral;
2. Grounds for disciplinary action by the Board of Medicine; and
3. No reimbursement for the services rendered by the physician.

The civil monetary penalty applies to the physician to whom the patient is referred. The disciplinary action provision applies to both the referring and the receiving physicians.

I also urge you to contact your local Representatives in this matter. Hopefully, something can be done during the next Legislative Session to eliminate this problem that should never have occurred.

(Reprinted with permission of Mr. Mount and the Collier County Medical Society News.)

FLORIDA WORKERS' COMPENSATION HEALTH CARE PROVIDER FEE FOR SERVICE REIMBURSEMENT MANUAL, 1997 EDITION

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Florida Workers' Compensation Institute
Call Box 200
Tallahassee, FL 32302-0200

For more information call the Florida Workers' Compensation Institute at (850) 425-8156.

THE CLEVELAND CLINIC

From the Eyes of a Fort Lauderdale Physician

by Arthur E. Palamara, M.D.

Exceeded only by exuberant predictions of its own success, the Cleveland Clinic Florida opened its doors with great expectations and much political support in February of 1988. Reality has painted a different picture.

The Cleveland Clinic of Ohio enjoys an outstanding reputation, having made significant contributions in virtually every medical and surgical specialty. Patients flew in from around the world to bask in the cocoon of the Clinic's medical sanctuary. Using its highly successful clinic staff model, the Cleveland Clinic -- like the Mayo Clinic -- evaluated and treated the entire patient. Unfortunately, that style of practice was possible only when a great deal of money lay around to subsidize lengthy admissions for days of exhaustive testing. But times had changed; managing a hospital became an enormously difficult job because of pressures to contain costs. According to the Health Systems Agency of North Central Ohio, only 71% of the clinic's beds were occupied in 1985. In 1986, 61% were occupied. A well-placed source within the Cleveland Clinic stated that the Clinic was losing its grip on the Cleveland market. It had failed to develop enough new programs to make up for the patients they had lost. The Clinic looked around avenues to improve its census and bottom line. Dr. William S. Kiser, then the Cleveland Clinic's chief executive officer, settled upon a solution -- open a satellite in far-off Fort Lauderdale.

The Cleveland Clinic held itself out as different from other medical organizations in the area; a not-for-profit, multi-speciality group practice. Its purpose was to provide a "single center for diagnosis and treating patients with rare, complex medical problems that had resisted conventional treatment. Collegial collaboration and strict peer review would ensure high-quality, cost-effective, well coordinated care," wrote Joseph R. Millsaps, Chairman of the Board of Governors of the Fort Lauderdale Chamber of Commerce in the *Miami Herald* on April 16, 1989. "The Cleveland Clinic Florida physicians are carefully selected for their credentials and training," he went on. "All have Florida licenses; however, 13 senior specialists were given licenses under a temporary exemption. South Florida is an enormous, dynamic, metropolitan area that offers a wealth of talent in many industries. Shouldn't it have the benefit of a world class medical center?"

Spurred by countless editorials and a truly admirable sales job, the public bought into the concept and welcomed the Clinic with open arms. The advance work had been done well. Newspaper editorials warmly supported their arrival, the business community dry-cleaned the red carpet, and politicians placed red lanterns on their mail boxes. One group did not greet the Clinic with similar enthusiasm; the medical community remained cautious and skeptical. And, as it turned out, rightly so.

Doctors in Fort Lauderdale kept hearing that the Cleveland Clinic planned to bring the world's leading experts to an area that was underserved. In the mid '80's, 85% of all the physicians in Broward County were board certified. The vast preponderance of the physicians were university trained. Five hospitals offered open heart surgery in Broward County alone. The University of Miami, a world class institution itself, was 30 minutes away and six more cardiac programs could be found throughout Dade County. Physicians kept wondering why these "experts" were needed and what the Clinic had to offer. Proponents of the Clinic promised to continue "The Cleveland Clinic Foundation's legacy of integrating research and education with patient care. They will freely share their innovations and discoveries with the medical community." (Millsaps)

Broward physicians were slow to react to the arrival of this new kid on the block who would be tolerated so long as he minded the rules. But the new kid had powerful friends who were used to getting their way and, in fact, made the rules. The medical community wondered why, if these doctors were so great, they couldn't just apply for a license like the rest. Some 13 of their doctors were given complimentary licenses by the legislature. Local physicians, having been trained in the great medical centers throughout the United States, wondered how the Clinic would be able to send several professors to Fort Lauderdale and have these few individuals recreate what had taken 70 years to establish in Cleveland. The Cleveland Clinic gave the appearance of attempting to distribute medical expertise like a McDonald's hamburger franchise. Local physicians objected that Cleveland Clinic Florida would be totally dissimilar to the Clinic in Cleveland. They maintained that exaggerated claims for the Cleveland Clinic of Florida's expertise were false and misleading. For raising this criticism, local physicians were castigated by the press as being selfish and afraid of competition. The battle lines were drawn a little deeper in the sand.

While community leaders could be easily persuaded of the value of the Cleveland Clinic, state regulatory authorities were more sanguine. The Clinic paid $18 million for 300 acres of land in an affluent, newly-constructed area of Broward named Weston. Sitting next to I-75, Weston gives easy access to both Miami and Palm Beach. It is populated by well-heeled professionals -- perfect for improving the bottom line of an ailing institution. With half the beds in Broward County sitting empty, there was simply no way to justify another hospital. Florida's H.R.S. turned them down flat. With more than enough facilities performing cardiac surgery, the H.R.S. also rejected the Clinic's bid to perform open heart surgery, cardiac catheterization, and radiation therapy. "In fact, the H.R.S. rejected every major contention and myth that the Cleveland Clinic and its champions presented," wrote Diran Seropian, Chief of Staff of Broward General Hospital in the May 7, 1989 edition of the *Miami Herald*.

Forced to seek other solutions, the Cleveland Clinic bought North Beach Hospital, situated on the "Gold Coast" next to the Atlantic Ocean. It was located among an elderly, condominium population, and the Clinic spent lavishly to reconstruct this small antiquated hospital which did not really meet its needs. The Clinic itself located some distance away on West Cypress Creek Road. To the chagrin of the local medical community, the Clinic began hiring local doctors to join their staff, many of whom were foreign trained. The local medical community wondered what -- if anything -- the Cleveland Clinic offered that wasn't already available. The Clinic still had to find itself a location to operate its much ballyhooed open heart program. When the Clinic approached Broward General Medical Center to arrange an agreement to perform its specialty services ... the volcano erupted.

When Cleveland Clinic doctors approached the hospital for privileges, they also requested exemption from performing emergency room coverage and providing care for indigent cases. Broward General provides extensive services for the poor and needy; as many as 90% of its in-patients fall into the category of indigent by some estimates. The credentials committee objected to granting privileges with this exemption. To quote from Dr. Seropian: "The Cleveland Clinic had their in-house lawyers and high-priced counsel present their case, and we, the staff of Broward General Medical Center, presented ours. After more than ten hours of sworn testimony, examination and cross-examination, the Commissioners of the North Broward Hospital District (the ultimate governing body) voted 5 to 2 to support the recommendations of the BGMC physician staff."

The Commissioners faced enormous political pressure from many, including Senator Jack Tobin who had originally co-sponsored the Cleveland Clinic Bill and shepherded it through the legislature. The BCMG medical staff leadership was excoriated from pillar to post for "not entering into reasonable negotiations." An emergency meeting of the Commission was called on January 25th, 1989, and the Commission rescinded their vote. The Miami Herald wrote in its editorial of January 27, 1989, "There remains the issue of healing the wounds within the local medical community, which didn't cover itself with glory." Local physicians felt that they had followed the rules and did not ask for special consideration. They felt that special interests had displayed enormous indifference to the defined benefits for indigents and that the burden for that care remained squarely on the shoulders of local physicians. The Cleveland Clinic physicians had won their exemption.

At the urging of the contentious and since-departed Chief Executive Officer Richard Stoll, III, the Hospital Commissioners threw out the medical staff bylaws in a consummate display of arrogance. To resurrect the medical staff structure, Broward General spent $20,000 in consulting fees, transportation costs, and expenses to bring in outside doctors as an ad-hoc committee which immediately approved the credentials of the Clinics's staff (*Cleveland Plain Dealer*, July 30, 1989). The previous medical staff was no more. The "former" medical staff officers complained to several organizations, including the Joint Commission on Hospital Accreditation, to no avail. They alleged that the hospital board acted illegally and outside its bylaws when it granted privileges to the Clinic's physicians.

Individual physicians voted with their feet by admitting their private patients to nearby Holy Cross Hospital, which for many years remained the beneficiary of this controversy. Broward General's revenues fell $1.35 million the month following the Commission's decision and hospital officials were quoted as saying that "the decline was due largely to opposition to the Clinic coming on board" (*The Miami Herald*, April 14, 1989). The hospital continued to experience a significant shortfall from the loss of its revenue patients for the next several years. Having experienced the wrath of its physicians, the Clinic and Broward General Medical Center retaliated by initiating a Federal Trade Commission investigation. At issue was whether physicians participated in an organized boycott to keep the Cleveland Clinic out of Fort Lauderdale. The conflict escalated "to the point of unprecedented ferocity." The Cleveland Clinic filed suit in federal court in Miami against two named and two other unnamed physicians, alleging antitrust violations and seeking more than $1 million in damages. The Clinic said that "not one pulmonary specialist in Broward County would respond to an emergency call from the Clinic to see a seriously ill patient on a respirator" (Cleveland Plain Dealer, July 23, 1989).

Amidst this turmoil, Bill Kiser, the Cleveland Clinic's chief executive officer, resigned. Kiser said the clinic invested $15 million cash in the Florida branch and borrowed $25 million for its startup. Behind the resignation was the indication of leaner times at the Clinic and of dissent within the ranks of the 500 doctors who worked there. He also acknowledged dissent among clinic doctors over cost-cutting efforts and the rancor that resulted from the Cleveland Clinic Florida subsidiary.

Over the next eight years, the Cleveland Clinic Florida operation barely survived. The open heart program at Broward General Hospital never generated huge numbers and has never even approached the number of cases performed at other Broward County cardiac programs. The Cleveland Clinic style of comprehensive practice became an economic liability for Broward General Medical Center. Now in the era of DRGs, with the emphasis on minimal in-patient testing and treatment, a high-level official at that institution was quoted as saying that "I wished that I had never heard of the Cleveland Clinic."

Several specialists brought from Cleveland, left the Clinic and went into private practice locally. One recently commented that he was disappointed in the Clinic's conduct and feels that they have been a failure. The Clinic failed to deliver on its promise to create a medical mecca. He reminisced that the Clinic came within a hair's breath of closing, saved only by local physicians who increased their admissions to North Beach Hospital. He remains an admirer of the "staff-model" system of medical practice where physicians are able to practice the pure science of medicine free of external worries. Yet, other physicians currently with the Clinic state that they are besought by financial pressures to the same degree as any private physician. There is rarely any time left to devote to research. This physician, too, is disappointed by the Clinic's failure to evolve.

After ten years of being rebuffed by the H.R.S., the Cleveland Clinic was finally awarded a certificate to build its hospital in Weston. In a surprising deal, a compromise between the Clinic and lawyers for the South Broward Hospital District, Columbia, and Tenet was finally reached. While this agreement allows the Clinic to build its long desired hospital, it is not without strings. The deal restricts the Clinic from offering in-patient obstetrical and pediatric services for three years. This restriction places the Clinic at a competitive disadvantage since Weston is comprised of affluent young families who would most benefit from this service. In the milieu of managed care, time will tell if a hospital will be enough to allow the Clinic to achieve its potential. A major South Florida politician commented, "This new hospital is totally unnecessary. With half the hospital beds in Broward County unoccupied, a new hospital is redundant."

EPILOGUE

The F.T.C., after years of harassing physicians with subpoenas, interviews, and threats, finally left Broward County physicians with little more than a bad impression of the federal government. There was no evidence that physicians had engaged in an organized conspiracy. Colleagues who had sent Dr. Seroplan letters of support found themselves visited by the F.B.I. There is no record that any physician paid any fines or awards. Dr. Diran Seropian, the Chief of Staff of Broward General Medical Center, never yielded. He remained steadfast in his conviction that the Governing Board had acted illegally. After years of haggling, Dr. Seropian finally accepted a consent degree whereby he would no longer hold an office on the medical staff of Broward General. We can only admire the courage and conviction of the modern hero who defended a position that he knew was morally correct. It is not easy to appreciate the enormity of the pressures that he experienced while under the federal microscope. Yet, he remained resolute in his determination.

By offering only a tepid consent degree, the federal government essentially gave up. BGMC changed leadership and resumed its true rule providing care to all patients of Broward County, paying and indigent alike. The Cleveland Clinic is still here. Most doctors rarely think about it, and very few lose patients to them. They have become part of the landscape. Essentially, the Clinic has become superfluous.

Dr. Palamara is a member of the Broward County Medical Association and is a Fellow of American College of Surgeons, Cardiovascular Surgery. Reprinted with permission of Dr. Palamara and the Collier County Medical News.

NEW GUIDELINES FOR E&M CODING TO TAKE EFFECT JANUARY 1

by Karen S. Schechter, AM News Contributor

Q: We've been hearing bits and pieces about Medicare's new E&M documentation guidelines. Can you summarize the changes? What are the implications for our practice?

A: Medicare has developed new guidelines for documenting the Evaluation & Management (E&M) services, which will become effective Jan. 1, 1998. These guidelines provide specific instructions as to what documentation must be present in the patient's chart to substantiate the CPT code assigned on the claim form.

As you are probably aware by now, the new E&M codes consist of three components: history, examination and medical decision-making. While there are a few changes to the history and medical decision-making components, the new guidelines primarily focus on the examination component.

As in the past, there are still four levels of examinations: problem-focused, expanded problem-focused, detailed and comprehensive. However, under the new guidelines, the documentation for each level has to show very specific clinical procedures.

The Health Care Financing Administration has developed 11 tables identifying what those procedures are. The first table is for general multisystem exams; the others are for specific body system exams. Each table lists the clinical elements (by body area or system) that can be covered in that type of examination.

The provider must document a certain number of those elements for each level of E&M service.

For the problem-focused exam, the provider must perform and document one to five elements listed in the table. For expanded problem-focused exams, the provider must perform and document at least six elements.

If the provider is performing a general multisystem exam, he must perform and document at least two elements from each of six areas/systems or at least 12 elements identified in two or more areas/systems. For a system-specific detailed exam, the provider must address at least 12 elements in the pertinent table.

A comprehensive general exam must include at least two elements identified from each of nine areas/systems. The specific body system exams require that all elements in the appropriate area/system box on the table be performed and documented.

The rules also re-emphasize that documenting just one of the three components at the highest level does not mean that the service can be coded at the highest level.

What this means for you is that complete documentation is even more important than ever. It is not enough to simply state that an exam is normal or abnormal.

You will have to document that you have examined that specific area and if it is abnormal, describe the abnormality. This is not necessarily a change in the way you perform examinations; rather it is probably a change in how you document what you are doing.

Your Medicare carrier should be sending you these new guidelines within the next two months. It is imperative that every physician review these guidelines, along with the coding and billing staff, to ensure that by Jan. 1, 1998, your practice will be prepared to code E&M services properly and receive appropriate reimbursement on a timely basis.

Q: Our practice is taking on more and more capitated contracts. Some of my peers have suggested that I consider carrying private stop-loss insurance. What is the purpose of stop-loss insurance and when is it appropriate to purchase it?

A: The purpose of stop-loss insurance is to help physicians protect themselves against financial disaster by managing the risk of delivering patient services under capitated provider agreements.

In other words, it helps cover additional costs when a patient's condition causes the physician to provide services outside the normal practice pattern (and beyond the pre-negotiated carve-outs and exclusions).

Experts recommend that the practice get stop-loss insurance for every capitated contract.

It's particularly important if your capitated contract covers a small number of lives. Practices with a fewer number of capitated patients stand a greater risk because the lower amount of capitation dollars they are receiving may not offset a larger cost incurred from a single case.

There are generally two ways to buy stop-loss insurance: individually from each payer or directly from an outside insurer. Some payers include the premium price in the per-member-per-month rate. Others offer the option to purchase the insurance separately.

If you have only a couple of small capitated contracts (with 10,000 lives or less), using the individual payers' coverage is adequate. However, once your practice has three or more capitated contracts, consider a single office policy. There are a couple of reasons for this.

First, when you have several policies, it could become an administrative nightmare to monitor each one having different premium amounts, renewal dates, deductibles and reimbursements. There is also the matter of cost. Once your practice has more than 10,000 capitated lives, it may be easier to negotiate your rates with a single insurance carrier since the risk would be spread over a larger population.

When looking at private stop-loss insurance coverage, you will want to make sure that the cost of the premiums are not greater than those being charged by the managed care company. Other items to look for include patient exclusions and payment methodologies. You should also ask the insurance carrier to tell you how the policy calculates the reimbursement. Compare that to the reimbursement received under the capitated contract.

Many large insurance carriers provide stop-loss insurance. However, it is advisable to purchase this type of insurance from an insurance broker who has experience in the health care field. *(Reprinted from the AM News.)*

EDITORS NOTE:

Dec. 3: Lee County Medical Society will sponsor a Documentation of Evaluation and Management Services seminar Wednesday, December 3, 1997, 9:00 a.m. - 12:00 noon, by Physician. First For Information. Call the Society office at 936-1645.

LCMS ALLIANCE/FOUNDATION NEWS

Respectfully submitted by Kathy Marchildon, Corresponding Secretary

1998 CHARITY BALL NEWS

Preparations for the 1998 Charity Ball, "Moon Over Havana" are well under way. As many of you know, the major recipient for 70% of the 1997 Charity Ball's proceeds is the **Lee County Breast Screening Program** (LCBSP). LCBSP targets over 90,000 Lee County women, ages 40 and over, usually from low income households.

We would like to recognize and thank our first generous major underwriters:

- Barnett Bank (Guest Gifts)
- Columbia HCA (Cocktail Party, Program Book, Golf Tournament)
- First Union Bank (Pink Ribbon Campaign, Hold the Date Cards)
- NationsBank (Dancers)
- Northern Trust Bank (Band)
- Lee Memorial Health Systems (Brunch/Entertainment, Photos, Mailings)
- Suntrust Bank (Invitations, Raffle Tickets, Mailing)

Sponsorship letters were mailed in October. Kindly check with your office managers concerning your tax deductible donations. The Lee County Breast Screening Program is in dire need of funds. The above mentioned underwriters aid tremendously, but sponsorship dollars go directly to the charity and this is where you can help. If you would like more information, please contact Charity Ball Chairman Barbara Rodriquez at 433-9654.

LEGISLATIVE BREAKFAST

The Annual Legislative Meeting was held October 15th at the Magnolia Pointe Model Home. A lively discussion of some of the issues that affect the practice of medicine in our community ensued. High on the list of priorities was the question of expansion of the *Wrongful Death Act in Florida* and on the national front, Private Contracts Under Medicare. Thanks to all who attended, members and panelists, and particularly to the Collier County Medical Society Alliance members who performed a skit demonstrating the thirty second lobbying phone call which will be actively used in the upcoming legislative session.

1997 HOLIDAY PARTY

The Holiday Party will be held on Monday, December 8th, 7 p.m. at the Veranda. In keeping with the AMA Alliance's national commitment to **Stop America's Violence Everywhere (SAVE)**, Holiday Party Co-Chairs Barbara Lutarewych and Jody O'Konski are asking LCMSA members to save "work clothes" no longer being worn and donate the clothing to the 1997 Holiday Charity, *Abuse Counseling and Treatment, Inc. or ACT*. The clothing will be distributed by ACT to survivors of domestic violence who must return to work to support their families. Often, these women don't have suitable wardrobes for work and these no longer needed items can give them the confidence to face job interviews and employment. So the next time your spouse says "I have nothing to wear!" and you say "But the closet is full", help her pack the unused clothing and donate it to a very worthy cause on December 8th or call Jody at 489-2082 and Barbara at 466-0999. *Stopping violence in America is an ongoing obligation.*

FC-PRN

The Florida Medical Association needs you to participate in citrus sales. Money raised goes towards the Family Component Program of Physician Resource Network. This program helps the families of physicians members who have been effected by alcohol, chemical dependency or mental illness. Please support the medical family by remembering special friends and relatives with the delicious gift of Florida Citrus; what could be better? For more information, call Julie Bobman at 481-3854.

AMA-ERF/Holiday Sharing Card

The American Medical School Association Education and Research Foundation is a national organization sponsored by Medical Society Alliances across the nation. The AMA-ERF provides much needed funding to medical schools and medical students. A flier has been enclosed for your opportunity to participate in our 1997 Holiday Sharing Card to benefit AMA-ERF. You choose whether you want your donation to be used toward your medical school's Excellence Fund or Assistance Fund. The Medical School Fund of your choice receives 100% of all your donated funds. Please, make checks out to AMA-ERF and forward them to Cheri O'Mailia at 1806 Monte Vista Avenue, Fort Myers, or call her at 334-3375 for more information.

WILL YOUR NAME BE ON THE HOLIDAY SHARING CARD?

JOIN THE AMA-ERF's LEGACY OF SHARING AND GIFT-GIVING
and make 1997 Lee County's best Sharing Card Year yet!
Please consider a gift of $50 or more.
ALL* of the following information *IS REQUIRED.

•NAME(s) to appear on the Sharing Card:

_____

(For example: Dr. and Mrs. John Doe or Jane and John Doe)

•ADDRESS so that we may mail you a tax-deductible contribution receipt:

_____

_____

•MEDICAL SCHOOL (and location) to receive your contribution:

_____

•FUND to receive your contribution:

_____**Medical Student Assistance Fund**

_____**Medical School Excellence Fund**

Please mail you check (*payable to AMA-ERF*) and this form to:
Cheri O'Mailia
1806 Monte Vista Avenue • Fort Myers, FL 33901
DEADLINE: November 15
THANKS FOR YOUR HELP AND GENEROSITY!!!

1000 CLUB

- The 1000 Club, a committee of FLAMPAC, was created to provide *pro-medicine candidates* who have been delegated as a "target race" by their opposition, additional funding to assist them in their efforts to run a successful campaign.
- 1000 Club funds are generally used by candidates for TV and radio campaign advertising, phone banks and targeted direct mail during the final stages of their election.
- 1000 Club members pledge contributions totaling $1,000 to pro-medicine candidates located throughout the state during the course of an *election cycle or two years.*
- 1000 Club members will be asked to make contributions in the amounts of *$250 and $500* during the months of August through November of an election year. The 1000 Club members will receive a letter requesting them to forward the designated contribution to a candidate.
- Candidates who receive 1000 Club contributions are determined by the 1000 Club Committee with input from local physicians and their spouses.
- In the 1996 Elections, the 1000 Club was able to make a difference in several key House and Senate races in the Florida Legislature. Particularly notable was the re-election of several incumbent physician members. Senator William "Doc" Myers, M.D., and Representatives Durell Peaden, M.D., and Bob Casey, M.D., were re-elected despite facing significant opposition. Additionally, and equally important, was the 1000 Club support in the election of a physician's spouse, Anna Cowin, to the Florida Senate.
- Through FLAMPAC and the 1000 Club, organized medicine is making a difference in Tallahassee.

Join individually, as a group or a group of friends. Contact FLAMPAC office at 1-850-224-6627 for more information, or Steven West, M.D., LCMS office, 936-1645.

LCMS 1000 CLUB MEMBERS
1997 Participants

Robert Brueck, MD
Ronald Gardner, MD
Eliot Hoffman, MD
F.L. Howington, MD
John C. Kagan, MD
Mrs. Elizabeth P. Kagan
George C. Kalemeris, MD
David M. Reardon, MD
Alan D. Siegel, MD
Steven R. West, MD

FMA OFFICE OF HEALTH POLICY AND REGULATION
1998 Clinical Lab Changes/Coding

Medicare Enforcing CLIA Standards: Beginning October 1, 1998, the Health Care Financing Administration (HCFA) advised Medicare carriers to begin denying claims for diagnostic clinical laboratory tests performed in physician office laboratories if a physician office laboratory (POL) has an expired CLIA certification or if a laboratory bills for tests which are not approved for the laboratory's current CLIA certificate. October 1, 1997 - January 1, 1998 is the grace period allowed for physician office labs to implement billing changes.

POL will be required to submit their CLIA number on all claims. For paper claims, the information must be entered on item 23 of the HCFA 1500 claim form. Electronic claim filers must enter this information in the FAO record, field 34, position 164-178, of the National Standard Format. After January 1, 1998, claims submitted without CLIA numbers will be denied. Taking advantage of the grace period will reduce denied claims in the future.

Increase in CLIA Fees : If your office needs to renew your CLIA certificate, you may want to do so before January 1, 1998. The Health Care Financing Administration is increasing CLIA fees. The old fees are effective from now until January. For example, the current fee for a certificate for an office that only performs waived tests is $100, which will increase to $150 after January 1, 1998.

New CPT Codes: The AMA is currently revising multichannel test codes for CPT codes 80002-80019 to ensure that the groups are more clinically grounded. The 1998 CPT code book will include several new codes. The Health Care Financing Administration has established an implementation date of January 1, 1998. An update will be issued in the November edition of the AMA CPT Editorial. To order the 1998 CPT book, contact the AMA at 1-800-621-8335.

Providing Diagnosis for Services Performed by Non-Physician Practitioner: Section 4317 of the Balanced Budget Act of 1997 includes non-physician practitioners in the requirement to provide diagnostic codes for physician services. When the service is performed by another entity, if the Secretary of Health and Human Services (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered. An effective date of January 1, 1998 has been established. Instructions should be issued to the Medicare contractor, Blue Cross/Blue Shield, around mid-November.

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November 17, 1997
CME Re-Licensure
HIV/AIDS Update
Royal Palm Yacht Club