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<td>Cranberry Giant Eagle</td>
<td>Cranberry Township, PA 16066</td>
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<td>South Hills Market District</td>
<td>South Hills Village Square Bethel Park, PA 15102</td>
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<td>Twp. of Pine Market District</td>
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Events offered may be free of charge or have varied fees.
Weighing the Options: New Medications for Weight Loss
Kelly M. Gaertner, PharmD

Physician Concerns and Issues for 2013
Michael A. Cassidy, Esq

After “The Cliff”
Charles J. Stout

Foundation Grants: South Hills YMCA Camp AIM

Examining Medicare Wellness Visits
Lisa M. Eisel, RN
Denise M. Schmook, RN

Professional Guidelines and Performance Measures: Do They Constitute the Standard of Care?
Ruth Ryan, RN, BSN, MSW, CPHRM

“An optimist is the human personification of spring.”
—Susan J. Bissonette

Cover Art:
Blue Bird, Waynesburg, PA
by Mark E. Thompson, MD

Dr. Thompson is an internist who specializes in cardiovascular disease.
Highmark is proud to welcome Dr. John Christoforetti. In addition to Board Certification, Dr. Christoforetti’s resume also includes membership in the American Orthopaedic Society for Sports Medicine, and service as an Associate Master Instructor of Hip Arthroscopy for the Arthroscopy Association of North America. These achievements are complemented by over 2500 successful hip, shoulder and knee procedures that have earned him the respect of the athletic community — and will earn the trust of your patients as well.

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Bias is broadly defined as any tendency that prevents an unprejudiced consideration of an issue. Financial incentives motivate people, but can be a source of bias in biomedical research, medical education and clinical practice. Real or potential conflicts of interest do not prove bias, but declaring financial arrangements is required in many settings.

Early last year, I learned that someone using the pseudonym “Maiwl” had written about me on AgoraVox, a French “citizen journalism” website run by volunteers and non-professional writers. Translating Maiwl’s comments, the post, titled Petit lieutenant de Big Pharma, was a “portrait of a renowned doctor who speaks of his conflict of interest only when it suits him.”

Maiwl’s post included links to abstracts of papers I had written. One was a comprehensive critique of an antidepressant manufactured by Novartis. Maiwl credited me for being critical of this drug while having declared past research funding from Novartis: “The message is clear: We do not buy Dr. Howland. Dr. Howland is independent.”

Additional papers pertained to three antidepressants manufactured by Forest Labs. Maiwl felt I was too positive about these drugs, noting that I didn’t declare a conflict of interest involving Forest. Believing “This is too good to be true,” that I “would have no financial reason that would bias the opinion,” Maiwl searched further. “BINGO!” Maiwl proclaimed. Maiwl found that “He receive[d] funding of…Novartis, NIMH, National Center for Complementary and Alternative Medicine, but also FOREST LABORATORIES,” a disclosure made in 2009 for a continuing education lecture.

Maiwl ended his post with these statements: “I say what I want, when I want it. After all, why not? Indeed, perhaps he had money from Forest in 2009, but more in 2011. But if it is true, why [is it] he speaks to Novartis, and he says nothing for Forest? Each to his opinion. Me, I’m set.”

I posted a brief response: “I appreciate your concerns about failing to identify conflicts of interest, but your criticism of me about this is misplaced. I have two comments. First, my past ‘financial support’ from Forest consisted only of the supply of the drug, citalopram, for two NIMH-funded research studies. No other financial support from Forest was provided for these two studies, and I have never received any other type of direct or indirect financial support from Forest. Second, you provide links to abstracts of papers that I have written, but the abstracts do not fully convey my thoughts and critical analysis of the data pertaining to the topic of these papers. I would be happy to provide full-text copies of these papers and all other pertinent papers to you and other interested individuals.”

Bias is not solely related to financial incentives. Raymond Nickerson reviewed the concept of confirmation bias in the journal Review of General Psychology, describ-
The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.

Dr. Howland is a psychiatrist and associate editor of the ACMS Bulletin. He can be reached at howlandrh@upmc.edu.

ACMS Medical Student Scholarship...

$2,000 will be awarded annually to each of two qualified medical students. For information on how to apply for the ACMS Student Scholarship or how to contribute to the scholarship fund, e-mail studentservicesfoundation@pamedsoc.org or call (717) 558-7854.

(Note: The PaMedSoc Foundation is administering the scholarship.)

Dr. Howland is a psychiatrist and associate editor of the ACMS Bulletin. He can be reached at howlandrh@upmc.edu.
I met Mr. B in the ED in the evening when I really wanted to go home for the day. Minutes before, my resident asked, “We have another admission; either of you guys want to see him?” She motioned to me and the other med student.

It was 6 p.m. on an already long day but, like good med students, we obliged eagerly, “Yes, we would love to see him.” I went down, knowing that my fellow med student and I would alternate this duty over the next few weeks. It wasn’t that I didn’t want to see the patient. One week into my medicine rotation at the VA Hospital and I was having a lot of fun, but I also had untied thoughts and tasks running through my head: Light’s criteria needed to be reviewed before tomorrow, along with the latest IDSA guidelines on neutropenic fever. Tasks and studying topics presented on morning rounds had continued to pile up. But there I was, mentally exhausted, going to see Mr. B.

I arrived, smile on my face, to meet the man with the chief complaint of worsening cough. I knew the second I saw him things were not good; he looked too healthy. I began talking with him, gathering the normal history: his symptoms, his past medical problems and a bit about his life. But the routine data gathering turned into a conversation, a chat about his quiet, retired life about two hours outside Pittsburgh. He told me about his wife of over 40 years, his children, his hobbies of tinkering in his garage and drinking coffee with his friends outside city hall. I was more interested in his service in Vietnam, his stint as town councilman, his love for his wife, his dog and the home he built himself rather than his actual presentation. And since the hospital was full that night, with no one rushing to see him, we kept talking.

He asked about me and my life as a med student, his glasses falling forward when he coughed, forcing us to stop mid-conversation for him to right them. Maybe an hour into our conversation I realized I should probably examine him: It was completely normal except for absence of breath sounds on his right side. He asked what I thought his cough was from, and I knew, but said, “I don’t know.” I left, walking to meet my resident and attending, hoping my top differential diagnosis was wrong, wishing for pneumonia, but they told me it didn’t look good.

Over the next few days, I met with Mr. B every day. He was scheduled to get a bronchoscopy. I never asked if the pulmonology fellow told him what the scope was for; I didn’t want to burden him with an uncomfortable discussion. Instead, I explained to him why he couldn’t eat before...
the procedure, helped to sort out his home meds when he was getting them incorrectly, and explained to him in layman’s terms the meaning of his lab values. In turn, he made me smile every morning and laugh every afternoon. He teased me about always being one step behind: I always had new information for him, but only after someone else had told him minutes to hours earlier. On more than one occasion, I carefully shooed him back to his room when he went in search of his nurse, his hospital gown open from behind and his boxer’s freely shown to the whole fifth floor.

His bronchoscopy was scheduled on his fourth day of admission; it had been a long holiday weekend and scheduling took time. Pulmonology told us it looked cancerous, most likely small cell, but we would have to wait for the pathology results. Mr. B had received the news and could go home for outpatient follow-up.

I went to see him, not quite sure what to say. He smiled when I came in, his glasses still settling at the bridge of his nose. “So I can leave?” he asked.

“It looks that way,” I replied. I half-sat, half-leaned on the ledge of the window, the setting sun streaming in behind us, waiting for him to speak. He didn’t.

“Um, so, do you want the team or me to call your wife? Explain the follow up to her?” He shook his head, “No, I don’t want to bother her now.” But, he asked, since he had driven to the ED and was still feeling the effects of the bronchoscopy’s anesthesia, would it be reasonable to spend the night and leave in the morning?

I looked up and, for a flash, a millisecond in time, saw the fear and panic in his eyes. He didn’t want to leave; he wasn’t ready.

And just as quickly, the panic left, softened by moisture as he began to cry. I was paralyzed, not knowing what to do or say, knowing there really wasn’t anything to say.

And so, instead, amidst the laughing nurses in the hallway, the roommate’s blurring television, the shuffle of medical teams wondering the halls, and the smell of dinner trays being distributed, I walked over, perched on the bed with him, gave him my hand and cried as well.

After all of our talking, words no longer seemed quite right.

Yet, with the sun setting outside the window, tears somehow did.

Ms. Rossiter is a second-year student at the University of Pittsburgh School of Medicine. She can be reached at brianna@medstudent.pitt.edu.

Got Something to Say?
If you’re an ACMS member and would like to write a Perspective, e-mail Linda Smith at lsmith@acms.org. or call (412) 321-5030, x105.

Thank You
for your membership in the Allegheny County Medical Society

The ACMS Membership Committee thanks you for your support. Your membership strengthens the society and helps protect our patients.

Please make your medical society stronger by encouraging your colleagues to become members of the ACMS.

Questions or Comments? Call the membership department at 412-321-5030, ext. 110 or e-mail membership@acms.org.
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New ACMS board members
The ACMS Board of Directors has welcomed three new members, effective January 2013-2015. Patricia L. Bononi, MD, who joined the medical society in 1989, specializes in endocrinology, diabetes and metabolism; she graduated in 1985 from the University of Pittsburgh School of Medicine. William K. Johnjulio, MD, who joined the medical society in 2004, is a family physician; he graduated in 1995 from the University of Iowa, College of Medicine. Brahma N. Sharma, MD, who joined the medical society in 1995, specializes in cardiovascular disease, interventional cardiology; he graduated in 1976 from Saiwai Man Singh Medical College, Rajasthan University, Jaipur, Rajasthan.

Practice Administrators Forum, March 19
The Allegheny County Medical Society Practice Administrators Forum will meet on March 19 at 8 a.m. at the ACMS facility. Paula Snyder, RN, CPHRM, will present Successful Communication and Professionalism for Physician Office Staff, highlighting risk management strategies designed to improve communications between physician office staff and patients.

Ms. Snyder, who is risk management manager at PMSLIC, will discuss the meaning of vicarious liability and the importance of managing practice staff in order to decrease potential malpractice risk exposures. Attendees will review methods and barriers to communication, dealing with angry/aggressive patients, tips for improving patient interactions, and interaction among staff members. She will also provide best practice guidelines for handling patient complaints and for telephone etiquette (taking and responding to calls from patients).

The PMSLIC-sponsored meeting begins at 8 a.m. with registration, followed by the program at 8:30. A continental breakfast will be served. Registration is complimentary, but you must RSVP to attend. Contact Nadine Popovich at npopovich@acms.org or at (412) 321-5030 to RSVP or to become a member of the ACMS Practice Administrator Forum. The forum is dedicated to providing a strong professional network for health care management professionals.

2013 Clinical Update in Geriatric Medicine, April 4-6
The Clinical Update in Geriatric Medicine, sponsored annually by the Pennsylvania Geriatrics Society–Western Division and the University of Pittsburgh Institute on Aging, will be held April 4-6, 2013, at the Marriott City Center in Pittsburgh. Highlights of the two-day conference include sessions on evidence-based and practical care for older adults, patient safety and risk management designated lectures, geriatric

continued on page 113
Join us in presenting community awards and support medical, nursing and health care student scholarships.

**SATURDAY APRIL 6**

Omni William Penn Hotel

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Dayle B. Griffin, MD

**NATHANIEL BEDFORD PRIMARY CARE AWARD**
Gregory L. Molter, DO

**RALPH C. WILDE LEADERSHIP AWARD**
James D. Luketich, MD, FACS

**FREDERICK M. JACOB SERVICE AWARD**
Ralph Schmeltz, MD, FACP, FACE

**RICHARD E. DEITRICK HUMANITY IN MEDICINE AWARD**
Daniel H. Brooks, MD

**BENJAMIN RUSH INDIVIDUAL AWARD**
Kim Tillotson Fleming, CFA

**BENJAMIN RUSH COMMUNITY ORGANIZATION AWARD**
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**PITTSBURGH PROUD AWARDS**

**ALPHA Pittsburgh**
Bruce W. Dixon, MD

GO TO www.acmsgala.org OR CALL 412-321-5030 FOR TICKETS & DETAILS.
board review and clinical pearls in geriatric drug treatment case studies, as well as the popular Ask the Physician sessions when participants can pose challenging questions from their own practices.

This year’s guest faculty includes Martin Samuels, MD, DSc (hon), FAAN, MACP, FRCP, chairman, Department of Neurology, Brigham and Women’s Hospital, Boston; and Paul Friday, PhD, chief of clinical psychology, UPMC Shadyside, Pittsburgh. Dr. Samuels will present two key lectures: The Neurological Exam for the Elderly and Dizziness in the Elderly. Dr. Friday will present Aspiring to Inspire Before You Expire, constructing the framework to leading a balanced life. Distinguished local faculty will also provide key evidence-based sessions.

The national Hospital Elder Life Program (HELP) conference will be held in conjunction with April’s clinical update conference. Attendees of each conference will have the opportunity to attend sessions from both. Conference credits include AMA PRA Category 1 credits, Continuing Education Units (CEUs), and AAFP, ACPE and Nursing credits. For further credit information, contact the UPMC center for continuing education in the health sciences at (412) 647-8232 or at ccehcsconfmgmt101@upmc.edu.

Members of the Pennsylvania Geriatrics Society–Western Division receive a discount when registering for the conference. To inquire about becoming a member or current membership status, contact Nadine Popovich at (412) 321-5035, ext. 110, or at npopovich@acms.org. Membership applications can be completed online at www.pagswd.org.

Reminder: malpractice reporting
Under the MCare Act, physicians must report to their licensure board (either the State Board of Medicine or the State Board of Osteopathic Medicine within 60 days of:
• notice of a malpractice suit;
• notice of a disciplinary action by the licensing authority of another state;
• receiving information regarding sentencing under either §15 of the Osteopathic Medical Practice Act or §41 of the Medical Practice Act (both dealing with reasons for refusal, suspension or revocation of a license); or
• being arrested for criminal homicide, aggravated assault, a sexual offense or for violation of the Controlled Substance, Drug, Device and Cosmetic Act.

The PAMED website (www.pamedsoc.org) contains a self-reporting form that physicians may file with the appropriate licensure board. Failure to timely report one of the enumerated occurrences can result in a fine of up to $10,000 in addition to any other civil remedy or criminal penalty.

Thank You for Paying Your Dues

The ACMS Membership Committee thanks you for paying your dues. Your membership strengthens the society and helps protect our patients.

If you haven’t paid your dues, you will be receiving a reminder invoice shortly. Each dues mailing is costly in terms of postage, supplies and staff time. Paying promptly ensures that the medical society has the maximum resources for educational events and benefits for you. Thank you!

If you would like a statement immediately, please contact the membership department at 412-321-5030 ext.130 or e-mail membership@acms.org.
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In Memoriam

Joseph F. Novak, MD, age 97, passed away on January 22. Dr. Novak (ophthalmology) graduated in medicine from the University of Pittsburgh in 1938. Dr. Novak turned to ophthalmology when an injury to his leg made it clear his first choice, neurology, would not be likely. He went on to become a leader in the field, helping grow the UPMC Eye and Ear Institute and becoming instrumental in the design and use of industrial eye protection. Dr. Novak is survived by his wife Eve, daughters Anne Wayne and Carolyn Novak, son John Novak, two stepsons Ronald Hambrecht and Chris Spurgeon, and four grandchildren.

Thomas E. Allen, MD, age 93, passed away on January 26. Dr. Allen (obstetrics/gynecology) graduated in medicine from the University of Pittsburgh in 1943. He served as a doctor in the Army as first lieutenant during World War II, returning to private practice in Oakmont and Pittsburgh in 1951. Dr. Allen was a pioneer in establishing the therapeutic abortion clinic at Magee-Womens Hospital. He helped establish Women's Health Services for which he served as medical director from 1973-1994. Dr. Allen is survived by daughters Catherine Tai, Christine Murray, Cynthia Bartholomew, Carolyn Allen, Candace Urlicchio, son Thomas Allen, stepson Carlo Canava, and eight grandchildren.

Remembering Bruce W. Dixon, MD, 1939-2013

Bruce W. Dixon, MD, age 74, passed away on February 20. Dr. Dixon, who headed the Allegheny County Health Department for 20 years, instituted a number of innovative programs during that time, including his work in disaster planning and preparedness, inmate medical services at the Allegheny County Jail, and the Pennsylvania smallpox vaccination program.

Dr. Dixon graduated in medicine from the University of Pittsburgh in 1965, then completed an internship at Duke University; he served in the U.S. Air Force before returning to Duke where he was named chief resident. Dr. Dixon joined the faculty at the University of Pittsburgh in 1975, becoming an associate professor of medicine in the School of Medicine in 1979. He began working at the health department part-time during his tenure at Pitt and was appointed director there in 1992. Dr. Dixon was to receive the Pittsburgh Proud Award at the ACMS Foundation Gala on April 6, which recognizes individuals or groups who have made a significant contribution to improve health in our community that make us “Pittsburgh Proud.” The award will be presented posthumously and accepted by a close friend. (See ACMS Bulletin, February 2013, page 83, for more.) Words of remembrance by colleagues appear below.

from Daniel H. Brooks, MD

In September 1961 Bruce and I met as first-year medical students in the University of Pittsburgh School of Medicine anatomy laboratory. Dr. Jacob Priman, professor of anatomy, introduced us to the human body with the following statement: “This is the human body and you will treat it with dignity and respect.” Over the course of the next four years it was apparent to all who interacted with Bruce Dixon that this was a special person whose contributions to medicine would be extraordinary. No one was surprised when Bruce was identified as one of Jack Myers’ “special persons” in the class of 1965.

Bruce combined massive intellect with a logical reasoning process which led to evidence based and practical clinical, public health and institutional solutions to complex questions and challenges. His eclectic and successful approach to clinical diagnosis, teaching and problem solving was derived from his broad and deep interest in a variety of topics and people.

continued on page 116
Central to the achievements and contributions that Bruce Dixon offered to medicine and Pittsburgh was his lifelong commitment to the truth that he and I heard in September 1961: This is the human body; treat it with dignity and respect.

from John F. Delaney, MD
I have known Bruce Dixon since we had common Latin Class in tenth grade. Bruce took the third and fourth years because he had an interest in the classics and he excelled. He even began teaching himself Greek. We both attended Pitt as undergraduates and Bruce chose chemistry with extra time in the classics. In fact, he spent an additional year taking more classics courses before he started medical school. In high school Bruce always went by his middle name, Wayne, so when he returned to Pitt after residency and military service, I was confused by the new faculty person, Bruce Dixon, until I saw him.

Bruce was always well respected and always had a logical approach to problem solving. He had the talent to build an automobile and to remodel his old home, which actually was well restored and the subject of a newspaper article several years ago. Bruce had a calming effect during times of panic and always made time to talk with people to make them feel better. With all his talents he truly was a role model of being a doctor of medicine.

from Paul W. Dishart, MD
The death of Dr. Dixon is a great loss to the people of Allegheny County. He protected them against infectious diseases as the proactive and outspoken leader of the Allegheny County Health Department. Who else could close down noncompliant prominent restaurants, inspect the dirty sewers of Pittsburgh and hand out clean needles for addicts to prevent the spread of AIDS? His comments in the media, on television and in newspapers were accurately made to protect the public. Dr. Dixon’s knowledge base was so extensive that he needed little or no preparation to provide comments or lectures. His exceptional mind and skill educated the public and thousands of medical students, residents and fellows who gave him over the years a “basket of Golden Apples” for his teaching skills.

from Cyril H. Wecht, MD
Dr. Dixon was nationally recognized but was totally unpretentious, not a grandstander. I think people will remember Bruce as a dedicated public servant who provided very important medical expertise and never sought any...personal recognition and had no agenda of his own. His dedication combined with his medical knowledge and expertise were used to improve the quality of life and provide increased health safety for all of Allegheny County.

Dr. Dixon was a consummate professional. He was an excellent teacher and a skilled physician. His keen intellect, gracious personality and total devotion to his important governmental responsibilities will be sorely missed by everyone who had the opportunity to collaborate with him in his various endeavors.

FROM THE MAILBAG

January 26, 2013
Dear Bulletin Editor

I recently received a letter soliciting a donation to the “Alzheimer Disease Fund.” Having contributed regularly to the Alzheimer Association in the past, I pulled out my checkbook to send them another donation, but then I noticed this was NOT the organization I was accustomed to supporting. The name was surprisingly similar, but the slight difference prompted me to read the solicitation mailing more closely.

I learned from the fine print that the Alzheimer Disease Fund is one of three programs of “Project Cure,” the other two being the National Diabetes Fund and the Prostate Cancer Fund. I further learned the Alzheimer Disease Fund is not affiliated with Alzheimer disease research or the Alzheimer Association. Moneys donated to Project Cure go 75.93% to fundraising, 1.68% to administration, 16.87% to public education in conjunction with fundraising, and a pathetically small 5.52% to program services!

A few minutes of browsing the Internet led me to the website of the Better Business Bureau, which recommends donations to charitable contributions be limited to organizations meeting their “Wise Giving Alliance Standards for Charity Accountability,” that states that at least 65% of total expenses be devoted to program activities and no more than 35% to fundraising.

Sounds reasonable, doesn’t it? The Alzheimer Disease Fund doesn’t even come close.

Beware Project Cure!

Phillip R. Levine, MD
prlevine@verizon.net
Activities & Accolades

Stanley M. Marks, MD (hematology, medical oncology), received the 2013 Lending Hearts Friend Award on February 28 at the Lending Hearts Gala. Dr. Marks founded the Oncology Hematology Association that later merged with the University of Pittsburgh Cancer Institute to form UPMC Cancer Center in 2000; he was instrumental in the development of the Hillman Cancer Center. The award was created to recognize an individual who “lends their heart” to the welfare of others in need of compassion and understanding in the fight against cancer.

Ronald V. Pellegrini, MD (cardiothoracic surgery), has been honored with the Peter J. Safar Pulse of Pittsburgh Award by the American Heart Association, Allegheny Division. Created to recognize an individual’s leadership in the fight against heart disease and stroke, this award was presented to Dr. Pellegrini at the 2013 Pittsburgh Heart Ball on February 23. Over a span of 40 years as one of Pennsylvania’s most respected cardiac surgeons, Dr. Pellegrini served as chief of surgery at Mercy Hospital’s Division of Cardiovascular Surgery; as director of adult acquired heart disease, clinical assistant professor of surgery, and director of adult cardiac surgery at the University of Pittsburgh; and as a distinguished cardiothoracic surgeon at West Penn Allegheny Health System.

Community Notes

National Healthcare Decisions Day, April 16
The National Healthcare Decisions Day (NHDD) initiative is a collaborative effort of national, state and community organizations committed to ensuring that all adults with decision-making capacity in the United States have the information and opportunity to communicate and document their health care decisions. This year NHDD occurs on April 16.

NHDD is designated to inspire, educate and empower both the public and providers about the importance of advance care planning. Individuals and organizations interested in advocating for a better public understanding of advance care planning with NHDD are encouraged to participate in this open and collaborative movement. To view the complete list of participating organizations, or to join the movement, visit the NHDD website (http://www.nhdd.org/join/).

The time is appropriate to think about how patients can access a document to begin the advance care process. All adults can benefit from thinking about what their health care choices would be if they become unable to speak for themselves. Raising awareness about the importance of advance care planning can occur on NHDD—and throughout the year.

The Health Care Power of Attorney and Living Will Form is a recommended directive, endorsed by both the Allegheny County Medical Society and the Allegheny County Bar Association. This form can be accessed from the home page of the bar association’s website (www.acba.org), where it can be downloaded or purchased.

Health Career Scholars Academy
Applications for the 2013 University of Pittsburgh Health Career Scholars Academy—formerly the Pennsylvania Governor’s School for Health Care—are now available. UPHCSA is a four-week summer residential program on the main campus of the University of Pittsburgh for high school students interested in pursuing a career in any health care field. Current high school sophomores and juniors are eligible to apply for the 2013 program, scheduled this year for June 23 through July 20. Pennsylvania residency is not required. Financial aid is available for qualified students. For more information, visit www.hcsa.pitt.edu or e-mail the program director at pgshc@pitt.edu.

Do you suspect or know someone who is a victim of domestic violence?
Where to Turn cards give important information and phone numbers for victims of domestic violence. The cards are the size of a business card and are discreet enough to carry in a wallet or purse.

Quantities of cards are available at no cost by contacting Allegheny County Medical Society at 412-321-5030.
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Opportunity!

FREE ONLINE CME ACTIVITIES. Sponsor: Pennsylvania Medical Society. All meet patient safety and risk management requirements. For information, visit www.pamedsoc.org/mainmenucategories/cme/cme-activities.

HIV/AIDS TRAININGS. Sponsor: Pennsylvania/MidAtlantic AIDS Education and Training Center, various locations. For information, visit www.pamaaetc.org.

REGIONAL MENTAL HEALTH TRAINING SERIES. Sponsor: UPMC Western Psychiatric Institute and Clinic. For information, call (412) 802-6918 or visit www.wpic.pitt.edu/oerp.

This listing includes local events that are coming up soon; a more complete list is available on the medical society’s website at www.acms.org or by calling (412) 321-5030.

HIPAA Training Webinar

♦ Have your office staff and providers been trained recently?
♦ Are Your HIPAA policies and procedures documented and up-to-date?
♦ Are you prepared in the event of a HIPAA audit?

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March is the month for the following national awareness programs: colorectal cancer, nutrition and eye wellness. April 1-7 is National Public Health Week. (Source: U.S. Dept. of Health and Human Services, www.healthfinder.gov/library/nho).

Mar 19, 8:10 am .................. Practice Administrators Section
Mar 20, 12:30-4 pm ............. Emergency Medical Services
Mar 22 ................................ Pittsburgh Ophthalmology Society Annual Meeting—Omni William Penn
Apr 3, 8:30 am-12:30 pm .... PA ACOG Videoconference
Apr 6, 6-10 pm ..................... ACMS Foundation Gala
Apr 9, 10:30 am-12:30 pm .... ACMS Alliance
Apr 18, 8-10 am .................. Practice Administrators Section
Apr 19, 8:30 am-12:30 pm .... Three Rivers Adoption Council

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The prevalence of obesity in the United States continues to rise, with over one-third of the adult population fitting the criteria for obese [body mass index (BMI) ≥30 kg/m²] in 2009-2010.1 Obesity poses a multitude of health risks, including cardiovascular diseases, diabetes, musculoskeletal disorders and certain types of cancers.1,2 It is estimated that in 2008, the medical costs associated with obesity were $147 billion.1

Pharmacologic options for the treatment of obesity are limited, with orlistat previously the only agent approved for long-term management. Until June 2012 when, for the first time in over a decade, the FDA approved an agent for chronic weight management. The approval of lorcaserin (Belviq™) on June 27, 2012, was rapidly succeeded by the approval of another long-term agent, phentermine/topiramate controlled-release (Qsymia™), on July 17, 2012. Both are indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with a BMI ≥30 kg/m² or ≥27 kg/m² in the presence of at least one weight-related comorbid condition, such as hypertension, dyslipidemia, or type 2 diabetes mellitus (T2DM).3,4

Lorcaserin is thought to reduce food consumption by increasing satiety and decreasing hunger via selective activation of the serotonin (5-hydroxytryptamine) 2C (5-HT₃₂C) receptors on anorexigenic pro-opiomelanocortin neurons located in the hypothalamus.5,6 The primary safety concern with lorcaserin stems from the weight loss medications fenfluramine and dexfenfluramine, which were removed from the market in 1997 due to an associated increase in cardiac valvulopathy. These agents are nonselective serotonin reuptake inhibitors, and activation of the 5-HT₃₂B receptors in cardiac interstitial cells has been implicated in the development of serotonergic valvulopathy.7 At the recommended dose of 10mg twice daily, lorcaserin is not expected to activate the 5-HT₃₂B receptor.3,8 Reported cases of valvulopathy associated with the use of fenfluramine and phentermine occurred after a range of 1 to 39 months of use.9 The safety and efficacy of lorcaserin has been evaluated in three phase-3 randomized,
double-blind, placebo-controlled clinical trials: BLOOM, BLOSSOM, and BLOOM-DM.10,11,12 All studies were for a duration of one year, with the exception of the BLOOM trial which spanned two years. The primary efficacy endpoints included the proportion of patients with a reduction in baseline body weight of 5% or more, change in weight from baseline, and proportion of patients with a reduction in baseline weight of at least 10% at the end of one year. All interventions included lifestyle modification counseling.

The Behavioral Modification and Lorcaserin for Overweight and Obesity Management (BLOOM) trial was a two-year study that included patients 18 to 65 years of age with a BMI of 30 to 45 kg/m² or 27 to 45 kg/m² with an obesity-related comorbid condition, such as hypertension or dyslipidemia.10 Patients with FDA-defined valvulopathy, moderate or worse mitral valve regurgitation or mild or worse aortic valve regurgitation, were excluded. Patients were randomized 1:1 to receive lorcaserin 10mg twice daily or placebo for 52 weeks. At week 52, remaining patients were randomized 2:1 to either continue lorcaserin or to begin to receive placebo. The mean patient age was 44 years and 83.5% were female. At baseline, the mean body weight and BMI were 100 kg and 36.2 kg/m², respectively. Of the 3182 patients randomized, 55.4% and 45.1% in the lorcaserin and placebo groups, respectively, completed the study. At 52 weeks, 47.5% in the lorcaserin group compared with 22.6% receiving placebo were able to lose 10% or more of their body weight (P<0.001). Significant reductions in waist circumference, BMI, systolic blood pressure, total cholesterol, low density lipoprotein (LDL), triglycerides, and fasting blood glucose were noted in the lorcaserin group.

The Behavioral Modification and Lorcaserin Second Study for Obesity Management (BLOSSOM) trial enrolled patients fitting the same criteria as that of the BLOOM trial; however, no patients were excluded based on echocardiographic results.11 Patients were randomized 2:1:2 to receive lorcaserin 10mg twice daily, lorcaserin 10mg daily, or placebo for 52 weeks. The mean patient age was 44 years and 79.8% were female. At baseline, the mean body weight and BMI were 100 kg and 35.9 kg/m², respectively. Of the 4008 patients randomized, 55.5% completed the trial. At 52 weeks, 47.2%, 40.2%, and 25% had lost 5% or more of their body weight (P<0.0001), which corresponded to an average loss of 5.8%, 4.7%, and 2.8% in the lorcaserin twice daily, lorcaserin daily, and placebo groups, respectively (P<0.001). Furthermore, 22.6% in the lorcaserin twice daily group lost at least 10%, compared with 17.4% in the lorcaserin daily and 9.7% in the placebo groups (P<0.001). Significant reductions in BMI, waist circumference, triglycerides, total body fat, and lean body mass, and an increase in high density lipoprotein (HDL), was shown in patients receiving lorcaserin twice daily.

The Behavioral Modification and Lorcaserin for Overweight and Obesity Management in Diabetes Mellitus (BLOOM-DM) trial enrolled patients 18 to 65 years of age with a BMI of 27 to 45 kg/m², type 2 diabetes mellitus treated with metformin, a sulfonylurea, or both, and a hemoglobin A₁c (HbA₁c) of 7-10% at screening.12 Patients with cardiac valve disease were excluded. Patients were randomized 1:1:1 to receive lorcaserin 10mg twice daily, lorcaserin 10mg daily, or placebo for 52 weeks. The mean age was 53 years and 54% were female. At baseline, the mean body weight was 104 kg with a mean BMI of 36 kg/m². Mean HbA₁c at baseline was 8.1% and mean fasting glucose was approximately 160 mg/dl. Of the 604 patients randomized, 66.0%, 78.9%, and 62.1% completed the study in the lorcaserin twice daily, lorcaserin daily, and placebo groups, respectively. At year 1, 37.5% in the lorcaserin twice daily group had lost 5% or more of their body weight, compared with 44.7% in the lorcaserin daily and 16.1% in the placebo groups (P<0.001). Mean weight change at 52 weeks was 4.5% among those receiving lorcaserin twice daily, 5.0% in those receiving lorcaserin daily, and 1.5% among those on placebo (P<0.001). Those able to achieve a weight loss of 10% or greater included 16.3%, 18.1%, and 4.4% in the lorcaserin twice daily, lorcaserin once daily, and placebo groups, respectively (P<0.001). HbA₁c decreased 0.9 ± 0.06 with lorcaserin twice daily, 1.0 ± 0.09 with lorcaserin once daily, and 0.4 ± 0.06 with placebo (P<0.001), and 50.4%, 52.2%, and 26.3%, respectively, were able to achieve an HbA₁c <7% at study end.
Fasting blood glucose decreased 27.4 ± 2.5 mg/dl with lorcaserin twice daily and 28.4 ± 3.8 mg/dl with lorcaserin once daily, compared to 11.9 ± 2.5 mg/dl with placebo. A significant reduction in BMI, hip and waist circumference, and heart rate, and an increase in HDL, were shown with twice daily lorcaserin.

With regards to safety outcomes, after one year in the BLOOM trial, 2.3% of patients in the placebo group and 2.7% in the lorcaserin group had developed FDA-defined valvulopathy, \( P=0.70 \text{ (RR 1.1; 95\% CI, 0.69-1.85)} \).\(^1\) At year 2, the rate of valvulopathy was 2.7% with placebo and 2.6% with lorcaserin. At the completion of the BLOSSOM study, 2.0% receiving lorcaserin twice daily, 1.4% receiving lorcaserin daily, and 2.0% on placebo developed new findings of FDA-defined valvulopathy.\(^1\) In patients with preexisting valvulopathy at baseline, those who experienced any increase in mitral or aortic regurgitation after 52 weeks was 12.1% in the lorcaserin twice daily group (\( P=0.014 \)), 11.1% in the lorcaserin daily group (\( P=0.056 \)), and 30.6% in the placebo group. At week 52 in the BLOOM-DM study, 2.9%, 2.5%, and 0.5% in the lorcaserin twice daily, lorcaserin once daily, and placebo groups, respectively, had valvulopathy that was not present at baseline.\(^1\) Among those with preexisting valvulopathy at baseline, 11.1% on lorcaserin twice daily (\( P=0.333 \)) and none on lorcaserin once daily (\( P=0.929 \)), compared with 12.5% on placebo, experienced any worsening at week 52. Disease state-related complications included hypoglycemia, which was more frequent among those receiving lorcaserin.

Lorcaserin is not recommended for use in severe renal impairment and is contraindicated in pregnancy.\(^3\) It has not been studied in combination with other serotoninergic or antidopaminergic agents. Lorcaserin should be discontinued after 12 weeks of use if at least 5% weight loss has not been achieved. The manufacturer recommends lorcaserin be used with caution in patients with congestive heart failure (CHF), as it has not been studied in this population and 5HT\(^{2B} \) receptors may be overexpressed in this disease state. Common adverse effects with lorcaserin include headache, dizziness, fatigue, nausea, dry mouth, and constipation. The American Diabetes Association recommends weight loss for all overweight or obese adults with T2DM, and acknowledges that even moderate weight loss, defined as 5-7% of starting weight, can produce significant health benefits.\(^1\) The most recent ADA position statement on nutrition recommendations and interventions, published prior to the approval of lorcaserin, also suggests the use of weight loss medications combined with lifestyle modifications to help achieve a weight loss of 5-10%. The results of the BLOOM-DM trial indicate that lorcaserin may assist diabetic patients in achieving this goal. Patients should be evaluated for the occurrence of hypoglycemia, and antidiabetic medications should be adjusted appropriately as necessitated by weight loss.

The sympathomimetic amine phentermine and the antiepileptic agent topiramate both result in weight loss when administered independently to obese individuals.\(^14,15\) Phentermine has been approved since 1959 for short-term obesity treatment and, until recently, randomized controlled trials evaluating its long-term use have not been previously reported. The combination of phentermine plus extended-release topiramate (Qsymia\(^\text{TM} \)) at fixed doses allows for an increase in weight loss while minimizing the potential adverse effects. The mechanism of action with regards to weight loss is unknown for topiramate, while phentermine reduces appetite and decreases food intake via hypothalamic stimulation and subsequent increase in release of catecholamines.\(^4\) Phentermine in combination with extended-release topiramate (PHEN/TPM CR) is available in combinations of 3.75mg/23mg, 7.5mg/45mg, 11.25mg/69mg, and 15mg/92mg capsules. The dose is gradually titrated to a goal of 15mg/92mg daily. The safety and efficacy of PHEN/TPM CR was evaluated in three phase-3 randomized, double-blind, placebo-controlled clinical trials: CONQUER, SEQUEL, and EQUIP. PHEN/TPM CR at the maximum dose has been shown to consistently produce a mean weight loss in keeping with the National Heart, Lung, and Blood Institute recommendations for a target loss of 10% of the initial weight.\(^16\) All trial participants received counseling for diet and lifestyle modifications.

The CONQUER trial included patients age 18 to 70 years with a BMI of 27 to 45 kg/m\(^2\) with at least two of the following comorbidities: systolic blood pressure 140-160 mmHg, diastolic blood pressure 90-100 mmHg, or taking two or more antihypertensive medications; triglycerides of 200-400 mg/dl or taking at least two lipid-lowering medications; fasting blood glucose greater than 140 mg/dl after oral glucose tolerance test; T2DM managed with lifestyle changes or metformin alone; and waist circumference of at least 102 cm for

\[\text{continued on page 124}\]
men and 88 cm for women. The mean age of the study population was 51 years and 70% were female. At baseline, mean body weight, BMI, and waist circumference were 103 kg, 36.6 kg/m², and 113 cm, respectively. Patients were randomized 2:1:2 to receive placebo daily, PHEN/TPM CR 7.5mg/46mg daily, or PHEN/TPM CR15mg/92mg daily for 56 weeks. Of the 2487 patients randomized, 62% completed the study. Mean weight loss was 6.6% in the placebo group, compared with 7.8% and 9.8% in the PHEN/TPM CR 7.5mg/46mg and 15mg/92mg groups, respectively. The percentage of those achieving at least 5% and 10% weight loss was 21%, 62%, and 70%, and 7%, 37% and 48% in the placebo, PHEN/TPM CR 7.5mg/46mg, and PHEN/TPM CR 15mg/92mg groups, respectively (P<0.0001). Those in the placebo group saw a mean decrease in waist circumference of 2.4 cm, while those in the PHEN/TPM CR 7.5mg/46mg experienced a decrease of 7.6 cm and those receiving PHEN/TPM CR 15mg/92mg decreased 9.6 cm (P<0.0001). Significant reductions were noted in systolic and diastolic blood pressures, total cholesterol, LDL, triglycerides, fasting glucose, and HbA₁c, and an increase in HDL with PHEN/TPM CR. A small but statistically significant increase in mean heart rate was seen with PHEN/TPM CR 15mg/92mg. Also associated with PHEN/TPM CR 15mg/92mg was an increased risk of nephrolithiasis, a dose-dependent risk of hypokalemia, and a greater percentage with depression or anxiety-related adverse events.

The SEQUEL trial was a 52-week extension to CONQUER and included 676 patients who maintained their original treatment assignments. At baseline, the mean age was 52 years and 66.7% were female. Mean BMI was 36.1 kg/m² and mean body weight was 101.7 kg. At week 108, 84.0% had completed the study. Mean weight loss at study end was 1.8%, 9.3% and 10.5% in the placebo, PHEN/TPM CR 7.5mg/46mg, and PHEN/TPM CR 15mg/92mg groups, respectively (P<0.0001). Achieving a weight loss of at least 5%, 47.2% lost at least 10%, and 32.2% decreased their body weight by 15% or more (P<0.0001). Those in the PHEN/TPM CR 3.75mg/23mg and placebo groups lost significantly less. Significant improvements in waist circumference, blood pressure, fasting glucose, triglycerides, total cholesterol, LDL, and HDL, were noted with PHEN/TPM CR. A statistically nonsignificant increase in resting heart rate was noted with PHEN/TPM CR.

PHEN/TPM CR is contraindicated in pregnancy, glaucoma, hyperthyroidism, and during use with a monoamine oxidase inhibitor. For those with mild hepatic impairment or a creatinine clearance less than 50 mL/min, the dose should not exceed 7.5mg/46mg daily. Recommended monitoring parameters include heart rate, electrolytes, serum creatinine, serum glucose, cognitive changes and mood disorders. Common adverse effects seen with PHEN/TPM CR include parasthesia, dizziness, dysgeusia, insomnia, constipation and dry mouth. Due to its teratogenic risk, PHEN/TPM CR has limited availability via a Risk Evaluation and Mitigation Strategy (REMS) program.

More combinations of currently available medications may be seen for weight management in the future. Naltrexone sustained-release (SR) and zonisamide SR are both being investigated in fixed-dose combinations with bupropion SR for weight loss. Phase-2 studies have been completed for zonisamide SR/bupropion SR, and phase-3 trials of naltrexone SR/bupropion SR are currently ongoing. Though zonisamide monotherapy has shown promising results with regards to weight loss, its use was associated with significant adverse effects. These medications may have beneficial effects on weight and subsequently metabolic and anthropometric...
measures, but their potential risks cannot be ignored. The studies indicate that PHEN/TPM CR produces superior weight loss, but may be associated with greater adverse effects. Long-term safety effects, including those on cardiovascular morbidity and mortality, are still unknown. Patients receiving these medications should be monitored routinely for adverse effects. Furthermore, both agents were studied in conjunction with diet and exercise programs, and are indicated as a supplement to appropriate lifestyle modifications. Only time will tell if these agents will have a positive impact or face market withdrawal as have many weight loss drugs of the past.

Dr. Gaertner is a community practice pharmacy resident at Allegheny General Hospital. Questions related to this article may be directed to the Allegheny General Hospital Drug Information Center. Tucker Freedy, PharmD, BCPS, is director of the center; he can be reached at (412) 359-3192 or tfreedy@wpahs.org.

REFERENCES

14Adipex-P [package insert]. Sellersville, PA; Teva Pharmaceuticals USA; 2012 July.
For the last several years I have written a New Year’s prediction about physician issues or posted something to that effect on my Med Law Blog. Although the prognostications change, they invariably fall into three major categories, i.e., physician governance on autonomy, reimbursement and the impact of technology. This year is no different.

**Physician governance**

Most national prognosticators predict that the physician employment model will continue to expand. This is probably no surprise; the surprise is that the national “employment rate” is somewhere between 35 percent and 40 percent. The local number is already much higher and, in my opinion, will continue to grow as both UPMC and WPAHS/Highmark and the other hospitals seek to either protect or expand their turf. The recent approval of the Highmark agreement to buy the primary financing bonds for WPAHS from Goldman Sachs at a discount should be approved by the Pennsylvania Insurance Department, and both increase the competition and lend some stability to this recruitment process.

**Reimbursement**

*Medicare reimbursement:* There is a “perfect storm” brewing, so something will happen, but the question is what. MGMA describes this coalescence of issues as the perfect opportunity to finally address comprehensive SGR reform.

- The Medicare SGR methodology is clearly broken. Continued postponement of the mandated and self-perpetuating and increasing cuts resulted in a 26.7 percent reduction for 2013.
- The American Taxpayer Relief Act only postponed the cuts by two months. Simply kicking the can to 2014 will produce a mandatory SGR cut in excess of 30 percent.
- In addition, the fiscal cliff remedy will impose mandatory across the board cuts of 2 percent. The common prediction is repeal of SGR coupled with across-the-board cuts of greater than 2 percent—but this is entirely dependent upon the political process.

2013 Medicare reimbursement changes:

- Multiple Procedure Payment Reduction (MPPR) will be applied to the technical component (TC) of certain cardiovascular-
cular and ophthalmological diagnostic services.
• Certified Registered Nurse Anesthetists (CRNA) may provide and bill for chronic pain management.
• DME Face to Face Encounters—ordering physicians must document and communicate to the DME supplier that the physician, or a physician assistant, nurse practitioner or clinical nurse specialist has had the required encounter with the beneficiary within six months prior to the date of the DME order.

Technology
Telemedicine and mobile health apps. These developments will be synergistic:
• Mobile apps usage is expanding, and the FDA will issue guidance on the standards and usage of mobile apps that meet the definition of “device” in section 201(h) of the Federal Food, Drug and Cosmetic Act (FD&C Act) and either are used as an accessory to a regulated medical device or transform a mobile platform into a regulated medical device. (Draft guidance can be found at http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm263280.htm.) The final guidance is anticipated in February or March of 2013. The critical issue will be communication versus treatment or diagnosis. Computers and mobile devices already communicate medical information; however, when they start to make “decisions” or “recommend treatment” without a provider’s input, they will probably be treated as medical devices regulated by the FDA.
• Almost all states now require some level of licensing for physicians whose presence within a state is digital, rather than physical.
• Medicare is expanding the number of approved telehealth services to include substance abuse assessment and preventive medicine.
• Self-pay practices, which are based upon diagnosis and prescription as opposed to physical treatments, will expand telehealth applications far beyond those approved for Medicare reimbursement.

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What Does ACMS Membership Do For Me?
State-based health insurance exchanges are a key component of the Affordable Care Act. These are intended to operate as online clearinghouses for state centered markets where individuals may purchase health insurance.

States have the option of operating their own exchange or partnering or defaulting to the Federal government. All exchanges must be operational by January 1, 2014. Pennsylvania has opted to default to the Federal insurance exchange. The Federal exchange will determine eligibility for individuals’ premium tax credits and cost-sharing reductions.

While it will concern some people that the Federal government will be even more involved in the delivery of health care, the more critical and practical question is, “What insurers will participate in the exchange?”

Health insurance is not like online auto insurance, where there will be countless auto repair places vying for the repair business. In order to deliver care, health insurance vendors need participating hospitals and physicians. Therefore, the critical question is whether the big players from the provider side (see “Physician governance,” page 126) will participate with other “exchange insurance vendors.”

Conclusion

Although the health care environment changes every year, many of those changes are national in scope, such as Medicare reimbursement and telemedicine will be this year. However, this year the big story will be local as we watch Highmark and WPAHS work to develop a credible competitive provider network.

UPDATE: Pennsylvania Rejects Medicaid Expansion*
William H. Maruca, Esq.
On February 5 Governor Tom Corbett announced that Pennsylvania would reject the expansion of Medicaid eligibility under the Affordable Care Act. The June 28, 2012, decision of the U.S. Supreme Court ruled that states had the choice whether to participate in the ACA’s Medicaid expansion, under which the federal government would cover all costs of increased coverage for the first three years, reducing the federal subsidy from 100 percent to 90 percent over the next six years. The majority of Republican governors have rejected the expansion, but a handful, including Florida governor Rick Scott, have broken ranks to accept the expansion and associated federal funding, although not without reservations about the unknown future costs and sustainability of Obamacare.

Gov. Corbett’s letter to Health and Human Services Secretary Kathleen Sebelius can be found at http://tinyurl.com/corbettltr. In the letter, he cites the lack of detailed guidance from Washington and the fact that Medicaid represents 30 percent of the entire state budget. He estimates that the Medicaid expansion would cost Pennsylvania $1.1 billion through fiscal year 2015-2016 and as much as $4.1 billion by the end of fiscal year 2020-2021. He asks HHS to grant states more flexibility to adopt state-specific approaches to Medicaid reform.

The decision will impact Pennsylvania hospitals that had received Federal disproportionate share payments that will be reduced under the ACA. Uninsured patients who will not qualify for Medicaid will still need to be evaluated and stabilized in Pennsylvania hospitals under EMTALA.

The governor’s announcement did not foreclose the possibility that Pennsylvania could reverse course and expand Medicaid in the future if the requested reforms and flexibility are offered.

“See “What will a Federally-run Health Insurance Exchange Mean for Pennsylvania?” (ACMS Bulletin, February 2013, page 84). Mr. Maruca is a health care partner of the law firm Fox Rothschild LLP which serves as council to the ACMS. He can be reached at wmaruca@foxrothschild.com or 412-394-5575.
In thinking about this month’s article, I asked myself: “Are we all better off—or worse off—as a result of the new tax law (the American Taxpayer Relief Act), the deferral of mandatory spending cuts to March 1, and the on-going debate about the need to further cut Federal spending?” As is the case with most fiscal issues, the answer is that there are some winners, some losers and a lot of us who won’t be impacted significantly one way or the other. Here’s a summary of my “scorecard” (at least for now):

The Winners

• The “Well-Off”—Those who have been able to accumulate modest wealth were pleased to learn that, under the new tax law, the Federal government is going to allow families to keep more of their assets as they are passed from one generation to another. That’s because the Federal Estate Tax (often simply called the “death tax”) will continue to be payable only on assets you own in excess of about $5,200,000, which is the new estate tax “exemption.” If you’re married, the exemption can be as high as $10,400,000! And the exemption will rise in the future with the inflation rate. As a practical matter, estate taxes aren’t payable at the death of a spouse if the surviving spouse is the sole heir, meaning that taxes really don’t become an issue until assets are passed to the next generation. So, the real beneficiaries of the new estate tax law—and the “permanently” higher exemptions—are your children!

• Taxpayers earning less than $200,000 (single) or $250,000 (joint)—With the exception of the increase in the payroll tax (from 4.2% to 6.2%), taxpayers earning less than $200,000 (single) or $250,000 (married, filing jointly), avoided increases in tax rates under the new law. So, this group still enjoys the 15% tax on dividends, the 15% tax on long-term capital gains and NO Medicare surtax.

• Charities—With increased income tax rates for higher income taxpayers (over $400,000 single and $450,000 joint), a charitable deduction is worth more. In addition, since this group will pay a 20% tax on long-term capital gains plus the 3.8% Medicare surtax, for a total of 23.8%, using appreciated long-term stock for charitable giving, should be an easier “sell” for charitable organizations.

• Parents of college students—That’s because the $2,500 American Opportunity Tax Credit was extended through 2017, and the deduction for qualified tuition expenses extended to December 31, 2013.
• High dividend paying stock investors—For most investors (those earning less than $400,000 if single or $450,000 if married, filing jointly), the 15% income tax on dividends was retained.
• Equity investors in general—At least while I write this (early February) the stock market appears to be reacting favorably to a little more fiscal certainty.
• Municipal bond investors—With tax rates rising for higher income taxpayers, many of whom like the tax-exempt nature of municipal bonds, the attraction of these investments is even greater. And so, even though interest rates have been moving higher (which is generally not good for bond values), municipals in general have held their value fairly well.

The Losers
• High income taxpayer—Income tax rates rose significantly for this group (defined as singles with taxable income over $400,000; or joint filers over $450,000). The list of tax rate increases for people in this category is really quite extraordinary:
  —higher marginal income tax rates on ordinary income, from a top bracket of 35% to 39.6%;
  —capital gains tax rate increase from 15% to 20%;
  —tax rate on qualifying dividends increase from 15% to 20%;
  —a Medicare surtax of 3.8% on investment income (such as interest, dividends and capital gains);
  —the phase-out of itemized deductions and personal exemptions.

High income taxpayers need to be more creative in their annual tax planning and begin to consider:
—Maximizing their participation in all retirement plans, such as 401(k)s, IRAs, deferred compensation plans, 403(b) plans, etc.;
—Converting small Regular IRAs to Roth IRAs;
—Avoiding capital gain taxation by using gifts of appreciated stock (held more than one year) for charitable giving.
—The prudent use of debt, especially at current interest rate levels.
• Taxable fixed income investors—As of this writing (early February), the returns on investment-grade taxable bonds have been trailing the equity market as a whole and, in many cases, are “in the red.” The market’s “mood” is that we might be entering a period of greater fiscal policy certainty, giving investors the willingness to assume some additional risk. The result has been a “rotation” from bonds into stocks, which has caused interest rates to rise, resulting in even more pressure on bond values. Many bond investors should review their fixed income investments and seriously consider shortening their average bond maturities and “duration” (a measurement of interest rate risk) if this trend continues.

Mr. Stout is president of D.B. Root & Company, focused on personal and institutional wealth management. He can be reached at (412) 227-2800 or cstout@dbroot.com. Securities and advisory services offered through Commonwealth Financial Network, a registered investment adviser. Member FINRA/SIPC.
Foundation Grants: South Hills YMCA Camp AIM

Each year the Allegheny County Medical Society Foundation fulfills its mission of supporting charitable and educational projects in our community, providing $2.26 million to the community since its inception in 1960. The ACMS Bulletin will periodically highlight recipients of foundation grants, this month featuring the South Hills YMCA Camp AIM.

At South Hills YMCA, a keystone of each year’s Campaign for Strong Communities is the Camp AIM program. Since 1968, Camp AIM has provided nearly 4,000 children and young adults who have physical, cognitive, emotional, social and communication challenges with opportunities to Achieve, support to become Independent and encouragement to become Motivated (AIM).

This unique six-week summer program combines life skills, social and recreational activities with aquatics, physical education, home economics, music and art. Depending on the needs of the individual, campers are provided with opportunities for positive social interaction with peers, activities that enhance and improve both small and large muscle coordination, and projects that build upon instruction/vocational education and/or responsibility training. Our program areas encourage expression through the arts and countless ways to have fun!

Camp AIM is a welcoming place for children with: physical challenges such as cerebral palsy, muscular dystrophy, spina bifida and other medically fragile diagnosis; cognitive challenges such as Down syndrome and low incidence disabilities; social and communication challenges such as autism, including PDD and speech and language impairments; emotional/behavioral challenges, including ADHD, oppositional-defiant and bipolar disorders and SED.

Children who attend Camp AIM benefit from activities that promote community awareness, self-esteem and the positive feeling of being a part of a group. Throughout the summer we successfully immerse our campers into their community, including field trips to the Pittsburgh Zoo, South Park and Crafton Park. Representatives of local educational institutions such as the Children’s Museum, the Carnegie Museum of Natural History and Carnegie Science Center have come to share their knowledge with our campers. We have an ongoing partnership with the Center for Theater Arts and Kids on the Block, who give our campers even more reasons to sing, dance and smile.

It is the goal of our program to create an environment that offers a variety of activities centered on positive recreational and social interactions that enrich the lives of our campers. Our staff and volunteers are dedicated to this endeavor. The administrative staff at Camp AIM consists of individuals who have been with the program for an average of 15 years; they are teachers, behavior specialists, assistants or administrators in mainstream or special education who work with children with special needs on a year-round basis. Our qualified counseling staff have experience in special education, psychology or counseling and social work and have chosen a career in caring for people with special needs. Our program benefits from those staff members, their caring attitude and their knowledge of the campers whose challenges we address. We also utilize the services of volunteers who give their time.
to assist campers in day-to-day programming.

The measurement of success is a very important part of Camp AIM. Every child begins Camp AIM with identified individual goals and objectives provided through the ESY (Extended School Year program). Camp AIM is a sanctioned Extended School Year (ESY) provider for 15 school districts in Allegheny County. The camp makes available daily progress reports for ESY and for review with parents and other caregivers. We pride ourselves on providing a complete recreationally and socially beneficial six-week day camp opportunity to all of our campers.

One Camp AIM parent says, “I can’t tell you what a wonderful blessing Camp Aim is to us every year. We have met such wonderful, knowledgeable and helpful people through Camp AIM, who have given my daughter wonderful summers for eight years in a row.”

Thanks to Michael E. Lloyd, Esq. for facilitating this article. For more information on Camp AIM, visit southbillareaymca.org or call (412) 833-5600.

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Shoes
As of January 1, 2011, the Affordable Care Act provides Medicare coverage for two types of annual wellness visits. The Initial Preventive Physician Exam, also known as the “Welcome to Medicare Preventive Visit,” and the initial and subsequent Annual Wellness Visit. Coverage for both are provided by Medicare, and the copayments and deductibles are waived. This article will provide information on patient eligibility, visit components, documentation requirements, qualifications for performing the wellness visit and coding information.

The Initial Preventive Physician Exam (IPPE)

Patients or beneficiaries become eligible for the IPPE when they first enroll in Medicare Part B, and they must receive their IPPE within the first 12 months of Medicare coverage. This is a once in a lifetime benefit. Example: Patient A’s Medicare coverage begins on 6/1/2012; this patient can receive the IPPE between 6/1/2012 and 6/1/2013.

Three Components of the IPPE include:
(1) Review of the beneficiary’s medical and social history, including: past medical/surgical history; current medications and supplements; family history; history of alcohol, tobacco and illicit drug use; diet and physical activities.
(2) Review of beneficiary’s potential risk factors for depression and other mood disorders. Use any appropriate depression screening tool for persons without a current diagnosis of depression recognized by national professional medical organizations.
(3) Review of beneficiary’s functional ability and level of safety. Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review at minimum, including hearing impairment, activities of daily living, falls risk and home safety.

Two required documentation components of the IPPE examination include:
(1) An examination, including: height, weight and blood pressure; visual acuity screen; measurement of body mass index and other factors deemed appropriate based on the beneficiaries medical and social history and current clinical standards.
End-of-life planning: This is a required service upon the beneficiary’s consent. End-of-life planning is verbal or written information provided to the beneficiary regarding the beneficiary’s ability to prepare an advance directive in the case that injury or illness causes the beneficiary to be unable to make health care decisions, and whether or not the physician is willing to follow the beneficiary’s wishes as expressed in the advance directive.

Two required documentation components for IPPE counseling include:
(1) Education, counseling and referral based on the previous five components (from the history and examination).
(2) Education, counseling and referral for other preventive services such as colorectal cancer screening, diabetes screening tests and glaucoma screening.

Who can perform the IPPE?
A doctor of medicine or osteopathy, nurse practitioner, physician assistant or clinical nurse specialist.

Which diagnosis code should be used for the IPPE?
Centers for Medicare & Medicaid Services (CMS) does not require a specific diagnosis code.

Which Healthcare Common Procedure Coding System (HCPCS) code should be used for the IPPE?
G0402

The first and subsequent Annual Wellness Visit (AWV)
Patients or beneficiaries become eligible for their first AWV one year after the patient’s Medicare coverage begins or one year after the patient’s IPPE visit. This is a once in a lifetime benefit. The subsequent AWV can be performed one year after the patient receives his or her first AWV. This is an annual benefit. Example: Patient A’s Medicare coverage begins on 6/1/2012, patient receives an IPPE on 9/1/2012. Patient is then eligible for the first AWV no earlier than 9/1/2013. Patient A is then eligible to receive subsequent AWVs no earlier than 9/1/2014.

Three documentation components are required for the counseling (first AWV):
(1) Establishment of the beneficiary’s medical/family history, including: past medical/surgical history; use or exposure to medications and supplements; medical events in the beneficiary’s parents, siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk.
(2) Review of the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders. Use any appropriate screening instrument for persons without a current diagnosis of depression which the health professional may select from various available standardized screening tests and recognized by national professional medical organizations.
(3) Review of the beneficiary’s functional ability and level of safety. Use direct observation or any appropriate screening questionnaire which the health professional may select from national professional medical organizations to review at a minimum, including: hearing impairment; ability to successfully perform activities of daily living; fall risk; and home safety.

Three documentation components are required for the examination (first AWV):
(1) An examination, including height, weight, blood pressure, body mass index and other routine measurements as deemed appropriate based on medical and family history.
(2) Establishment of a list of current providers and suppliers. Include current providers and suppliers that are regularly involved in providing medical care to the beneficiary.
(3) Detection of any cognitive impairment that the beneficiary may have. Assess cognitive function by direct observation, with due consideration of information obtained by way of patient reports and concerns raised by family members, friends and caretakers.

Three documentation components are required for the history (first AWV):
(1) Establishment of the beneficiary’s medical/family history, including: past medical/surgical history; use or exposure to medications and supplements; medical events in the beneficiary’s parents, siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk.

Continued on page 137
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*The American Cancer Society recommends for people over 50 a multiple sample method for take home FOBT or FIT screening test; FOBT or FIT testing done during a digital rectal exam in the doctor’s office is not recommended.

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(2) Establishment of a list of risk factors and conditions of which the primary, secondary or tertiary interventions are recommended or underway for the beneficiary, including any mental health conditions or risk factors/conditions identified through an IPPE, and a list of treatment options and their associated risks and benefits.

(3) Furnishing of personalized health advice to the beneficiary and a referral as appropriate to health education or prevention counseling, including: community-based lifestyle interventions to reduce health risks and wellness promotion; weight loss; physical activity; smoking cessation; fall prevention; and nutrition.

Who can perform the first AWV?
A doctor of medicine or osteopathy, nurse practitioner, physician assistant, clinical nurse specialist or a health professional (health educator, registered dietitian, nutrition professional, or other licensed practitioner) working under the direct supervision of a physician.

Which diagnosis code should be used for the first AWV?
CMS does not require a specific diagnosis code.

Which HCPCS code should be used for the first AWV?
G0438.

One documentation component is required for the (subsequent AWV) history:
(1) An update of the beneficiary’s medical/family history. At a minimum, document the following: past medical and surgical history; use or exposure to medications and supplements; medical events in the beneficiary’s parents, siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk.

Three documentation components are required for the (subsequent AWV) examination:
(1) An examination, including weight, blood pressure and other routine measurements as deemed appropriate based on medical and family history.
(2) An update of the list of the current providers and suppliers, to include current providers and suppliers that are regularly involved in providing medical care to the beneficiary.
(3) Detection of any cognitive impairment that the beneficiary may have; assess cognitive function by direct observation, with due consideration of information obtained by way of patient reports and concerns raised by family members, friends and caretakers.

Three documentation components are required for the (subsequent AWV) counseling:
(1) Update to the written screening schedule for the beneficiary. Base written screening on: recommendations from the U.S. Prevention Services Task Force and the Advisory Committee on Immunization Practices; the beneficiary’s health status and screening history and; age-appropriate preventive services covered by Medicare.
(2) Update to the list of risk factors and conditions of which the primary, secondary or tertiary interventions are recommended or underway for the beneficiary, to include any such risk factors or conditions that have been identified.
(3) Furnishing of personalized health advice to the beneficiary and a referral as appropriate to health education or prevention counseling, including: community-based lifestyle interventions to reduce health risks and wellness promotion; weight loss; physical activity; smoking cessation; fall prevention; and nutrition.

Who can perform the subsequent AWV?
A doctor of medicine or osteopathy, nurse practitioner, physician assistant, clinical nurse specialist or a health professional (health educator, registered dietitian, nutrition professional, or other licensed practitioner) working under the direct supervision of a physician.

Which diagnosis code should be used for the subsequent AWV?
CMS does not require a specific diagnosis code.

Which HCPCS code should be used for the subsequent AWV?
G0439.

Conclusion
It is very important to educate your patients regarding the difference between the above wellness visits and the “yearly routine physical exam” as this can be very confusing to some senior patients. The IPPE and the AWV focus on health promotion, disease prevention continued on page 146
Professional Guidelines and Performance Measurers: Do They Constitute the Standard of Care?

RUTH RYAN, RN, BSN, MSW, CPHRM

Three actual events: What is the common error?

- A cardiologist practicing in a large urban hospital received a form letter signed by the physician chairman of his hospital’s Quality Review Committee. Referring to an instance when the cardiologist’s care of his patient failed to satisfy a Joint Commission core measure, the letter asked him to explain why he had “violated the standard of care.”

- A general surgeon employed by a free-standing ambulatory surgery center was informed by his facility administrator that a certain NSQIP measure (National Surgical Quality Improvement Program) was the “standard of care,” and that he would be judged in accordance with that standard in a court of law if he violated it in an individual patient’s case.

- A national medical specialty organization posted its practice guidelines on its website, referring to them prominently as “Standards of Care” on the top of each page of the guideline section.

Standard of care versus guidelines

On all three of these occasions, the parties involved misused the term “standard of care,” erroneously equating it with professional guidelines or performance measures. In fact, “standard of care” is a legal term. It defines the professional duty the physician owes to the patient. A “breach in the standard of care” defines negligence or medical professional liability (MPL). For this reason, the term should be limited to the legal setting.

Twenty years ago, the American Medical Association warned about this alarming trend by physicians and hospitals—wrongly equating the standard of care with professional guidelines. The misuse of this term has persisted and has been expanded to include hospital quality initiatives and performance measures such as NSQIP and The Joint Commission’s core measures.

Like the cardiologist and the general surgeon in the three examples described above, physicians who do not follow the performance measure in an individual case may be labeled as “violating the standard of care,” thereby handing a gift to plaintiff attorneys.
What is a professional guideline?
Unlike the standard of care, which is determined by a judge in a court of law, professional guidelines are written by physicians and promulgated by medical specialty organizations.

Physicians and their defense attorneys should know that guidelines are a tool, an aid to the physicians’ decision-making—not a substitute for it. Guidelines are not intended to apply to all patients under all circumstances.

Many organizations have embedded this principle within the introduction to their guidelines. Here are some examples:

The American College of Chest Physicians—from the preamble to the 2008 ACCP Guidelines:
No clinician, and nobody charged with evaluating a clinician’s actions, should attempt to apply our recommendations in rote or blank fashion…Clinicians…should not construe these guidelines as absolute…Even Grade 1A recommendations will not apply to all circumstances and patients.

The American Geriatric Society—from the AGS Beers 2012 criteria for prescribing to the elderly:
This list is not meant to supersede clinical judgment or an individual patient’s values and needs. Prescribing and managing disease conditions should be individualized and involve shared decision making.

The American College of Obstetricians and Gynecologists—in its “Practice Bulletin” on prevention of thromboembolism, ACOG states that its guidelines:
…should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on needs of the individual patient, resources and limitations unique to the institution or type of practice.

The American College of Radiology—from the Preamble to the ACR guidelines:
The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment…All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.

In a court of law, the standard of care refers to the community standard, the reasonable and average care available, not the best possible care in any location. It’s not determined with the benefit of hindsight—it’s based on the information available to the physician at the time the care was rendered. The standard of care at issue in a particular case is provided in testimony by an expert witness, and is then decided on by judge and jury. The law recognizes that there may be more than one standard of care, just as there may be more than one text or authority on a subject. The law recognizes that perfection is not the standard of care, and that a bad outcome is not always due to a breach in the standard of care.

So the concept “standard of care” is actually multidimensional, but it should not be confused with professional guidelines and performance measures (Table 1). Physicians, health care organizations, and PIAA member companies would do well to declare a moratorium on the use of the term “standard of care,” unless they are referring to an actual claim.

<table>
<thead>
<tr>
<th>Table 1. Standards of Care vs Professional Guidelines</th>
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<tbody>
<tr>
<td><strong>Standard of Care</strong></td>
</tr>
<tr>
<td>Legal term</td>
</tr>
<tr>
<td>Applies only to a single case</td>
</tr>
<tr>
<td>Determined by expert witness testimony, judge, and jury</td>
</tr>
<tr>
<td>Static: applied to one fixed case at one fixed point in time</td>
</tr>
<tr>
<td>Determined after the fact</td>
</tr>
<tr>
<td>Applied by a court of law</td>
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This misuse of the term “standard of care” has served to add fuel to another false equation: implicaing guidelines as “cookbook medicine.” In this view, guidelines are erroneously depicted as heavy-handed mandates imposed on patients and physicians, intended to apply to all cases.

Equating guidelines and standards of care has one more ill effect: It contributes to a culture of blame in continued on page 140
health care. Physicians have been conditioned to expect a punitive approach to medical error, stemming in part from the actions of state boards and claims filed by plaintiff’s attorneys. Blame and punishment in medicine have the chilling and counterproductive effect of driving errors underground. This approach is premised on the notion that rooting out the bad apple will eliminate error.

In reality, no physician wants to make a harmful mistake. Medical errors are better understood and studied as pitfalls: What one person can fall into, so can others in the same circumstances. Solutions can be better identified and carried out when blame is removed and data is collected in a no-fault atmosphere, permitting lessons to be learned and pitfalls to be remedied.

Guidelines are not the same thing as evidence. They are created by many different organizations, and they are based on greater and lesser strengths of evidence. Some are based on data from published studies; others are based on expert consensus. The prudent physician will consider the source of the guidelines and the strength of the evidence supporting it. (Table 2)

Guidelines are not the same thing as outcomes. Guidelines may be drawn up from data suggesting that a certain measure might improve outcomes. For example, studies have found that the frail elderly at risk for falls are deficient in vitamin D. So, high doses of vitamin D were recommended and prescribed. But subsequent studies show that high-dose vitamin D really doesn’t diminish the number of falls, so it is no longer recommended.

Guidelines are a work in progress. Some guidelines eventually pass into standard practice (hand-washing before seeing a new patient, for example), some are modified (universal venous thromboembolism—VTE—prophylaxis), and some are discarded over time (the requirement for face-to-face notification of HIV/AIDS test results).

What about clinical pathways and performance measures?

Many clinical pathways or performance measures are based on data from peer-reviewed studies and professional guidelines. They may consist of hypotheses, derived from the data, not yet shown conclusively to improve outcomes. They may be drawn up by medical specialty organizations, accreditation bodies and government agencies. They are adopted by facilities and institutions. Some are unilaterally imposed by payers, a sore spot for physicians, especially when the supporting evidence is little to none. One example of these unilateral requirements is the designation of patient falls and other occurrences as “Never Events.”

The oxymoronically named “Never Events” are the exception; it is usually not expected that there will be a compliance with performance measures 100% of the time, because they don’t apply to all patients. For some people, beta blockers after a heart attack are contraindicated. For some women, elective delivery prior to 39 weeks’ gestation is appropriate and necessary. And there are patients with bleeding disorders who cannot tolerate VTE prophylaxis, and others who just won’t comply with instructions to use compression stockings after orthopedic surgery. The most that can be anticipated for these measures is improvement, not perfection.

Like guidelines, clinical pathways and performance measures are a work in progress. Some eventually pass into standard practice, some are modified, and others are discarded over time. The prudent physician will consider the source of the guidelines and the strength of the evidence supporting it. (Table 2)
measures are a work in progress. When data shows that
certain performance measures don’t improve outcomes,
they are discarded and new measures take their place.
Some measures are associated with very good compli-
ance and very good outcomes, and these pass into
common practice or standard practice.

From evidence to standard practice
Evidence takes a long time to work its way into
common practice—on average, 17 years. The proper
goal of guidelines and performance measures is the
improvement of patient outcomes based on the best
evidence. Some guidelines have improved patient
outcomes, have been validated time and again, and have
become common or standard practice. The physician
who routinely treats his or her patients contrary to those
guidelines, without any documented rationale for doing
so, may be difficult to defend in a claim of malpractice.

When guidelines collide
Cancer screening is one example of the current
controversy in regard to guidelines, especially for pros-
tate specific antigen testing. There are conflicting recom-
mendations from the U.S. Preventive Services Task
Force, the American Cancer Society, the American
Urological Association, and other groups.

Physicians may consider their patients well served if
they mention their own preference among the various
guidelines in conferring with a patient, offer their
recommendations, elicit the patient’s views, and partner
with the patient to arrive at a shared decision.

Another example of warring guidelines: the recom-
mendations on VTE prophylaxis after hip and knee
replacement. The American College of Chest Physicians
and the American Academy of Orthopedic Surgeons
have conflicting recommendations, though they are now
working to make their recommendations more compat-
ible. To complicate matters, the Joint Commission
required hospitals to have policies on VTE prophylaxis,
and the Centers for Medicare & Medicaid Services now
withholds payment for VTE after joint replacement—
despite evidence that not all VTEs can be prevented.

Which guidelines?
How can a physician sort his way through the
proliferating, and even conflicting, guidelines and find
the best ones with the strongest evidence? As a first
check, physicians should look for the most current
guidelines adopted by their own medical specialty
organizations, and also look for the recommendations
adopted by their own institution. If there are no guide-
lines provided by one’s specialty organization, physicians
should look for the most reliable source with the most
relevance to their practice. There is also a website,
www.guidelines.gov, a free searchable database of prac-
tice guidelines. It includes a ranking, according to the
relative strength of evidence for each guideline.
The guidelines.gov website is maintained by the
Agency for Healthcare Research and Quality. The user
types in a desired topic such as “pediatric sinusitis,” and
a list of guidelines appears. The user can select the most
recent (and most applicable) one that is based on the
strongest evidence.

Summary of risk management suggestions
Now, here is a recap of the recommendations in this
article.
- “Standard of care” is a legal term. Don’t use it to refer
to professional guidelines.
- Guidelines are an aid to, not a substitute for, the
physician’s decision-making.
- Guidelines are a work in progress; anticipate an
evolutionary process.
- Be aware of the guidelines promulgated by your own
medical specialty organization and those of your own
facility or institution.
- Weigh the strength of evidence that stands behind the
guidelines. When you depart from them, it’s a good
idea to document your rationale for doing so.
- Let the record show that you were aware of the rel-
levant guidelines, that you took into account the
individual circumstances and preferences of your
patient, and that your treatment decisions were guided
by what was best for your patients.

For related information, see
References for this article
appear on page 146.

Ms. Ryan is senior risk management education specialist at
LAMMICO.
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MEMBERSHIP APPLICATIONS

Leadership and Advocacy for Patients and Physicians

Supriya Narasimhan MD, Infectious Disease.15212-7018. Lokmany Tilak Mun-Bombay Univ/02
Kenneth C Nash MD, Child And Adolescent Psychiatry.15213-2593. Univ Of Louisville Sch Of Med/90
Heo-Jeng Ooi MD, Ophthalmology.15213-3661. Med College Of Georgia/05
Kristina Paley MD, Dermatology.15243-1200. Cornell Univ Medical College/03
Christopher George Pastor MD, Internal Medicine.15237-5436. Temple Univ Sch Of Med/05
Thomas R Powell MD, Nephrology.15243-1012. Ohio State Univ Col Of Med/90
Neeta C Raja DO, Internal Medicine.15243-1038. Ohio Univ Col Osteopathic Med/97
Manjusha Rajamohanty MD, 15238-3191
Eileen M Rice MD, Neurology.15213-3234. Univ Of Pittsburgh Sch Of Med/74
Renee F Rubinstein MD, Family Medicine.15090-9525. Amer Univ Of The Caribbean/08
Mandi Popovich Sachdeva MD, Dermatopathology.15213-1807. Ohio State Univ Col Of Med/03
Andrew Graham Sahud MD, Infectious Disease.15212-4773. Chicago Medical School/00
Patricio Andres Sanchez Cueva MD, Internal Medicine.15146-1700. .00
Kelly T Shannon MD, Anesthesiology.15215-3301. Baylor College Of Medicine/88
Vivek Sharma MD, General Surgery.15090-7382. Seth GS Medical College, Univ of Bombay/00
Ashwin R Shetty MD, 15224-2254
Przemyslaw J Sutkowski MD, Nephrology.15215-3247. Alaska Akademia, Katowice-Ligota/91
Peter P Tanzer MD, Internal Medicine.15213-3221. George Washington Univ Sch Med/78
Alok Vikramkumar Trivedi MD, Family Medicine.28027-7259. B.J. Med Col Gujarat Univ/03
Swaminathan Valliappan MD, Medical Oncology.45154-8960. Stanley Med College Madras U/65
Gregory A Watson MD, General Surgery.15213-2536. Univ Of Pittsburgh Sch Of Med/00
Brian W Zimmer DO, Nephrology.15215-3247. Phila Col Osteopathic Med/02

Administrative
Lori Lynn Brown Administrator, 15224-2156
Lynn M Garver Administrator, 15217-1725
Leslie A Hastings Administrator, 15090-8386
Marlene J Joyce Administrator, 15215-3234
Michael J Lutz Administrator, 15122-2474
John Stefanowicz Administrator, 15146-2141
Felicia Steinsdoerfer Administrator, 15090-8758
Karen Xander Administrator, 15017-2889

Associate
David M Lolley MD, Thoracic Surgery.15238-1207. Tulane Univ Sch Of Medicine/68

Resident
Adnan Bashir MD, Anesthesiology.15213-1250. Jefferson Med Col Thomas Jefferson/11
Gabriel Alberto Benitez MD, Ophthalmology.15212-2474
Ashley Lauren Kittredge DO, Dermatology.15241-1314
Lakshmi Kalyani Kodey MD, Family Medicine.15120-5051. Rangarya Medical College, Univ Of Health Sciences, Kakinada/07
Gregory Leo McHugh MD, Anesthesiology.15217-2775. Medical College Of Wisconsin/08
Mary Margarette Naguit MD, Family Medicine.15132-1126. Col Of Med Univ Of The East/04
Sokpoleak So MD, Anesthesiology.15217-2264

Student
Amanda Brase , 15213-4212
Myung Sun Choi , 15213-2556
Alex D’Angelo , 15207-1141
Kathleen Engeln , 15213-2558
Eric Wayne Etchill , 15206-4446
Molly Hef-Nel , 15217-2313
Jennifer Hu , 15217-2122
Jordan Knox , 15232-2703
David Lehman , 15213-2538
Anita Bernadette Lyons , 19103-2516
Kunal Mehta , 15213-2538
Sarah Michelson , 15213-2538
Abhigyan Mukherjee , 15213-1232
Enyinna Nwachuku , 15224-2126
Michelle Perry , 15232-2739
Lucy Rosenbaum , 02906-5506
Nikita Roy , 15213-2552
Lauren Ashley Salesi , 15206-4220
Sarah Sears , 15213-1859
Claire Elizabeth Sesson , 18708-8020
Humza Shaikh , 15213-2727
Cindy Y Teng , 15213-2551
Max Wayne , 15206-4324
Meghan Elise Wilson , 15208-2350
Emily Zhao , 15213-2549

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Leo R. McCafferty, MD, chair, called the meeting to order at 6:05 p.m. and welcomed PMSLIC President Jaan Siderov, MD, and Mr. Timothy Friers, PMSLIC senior vice president of underwriting and policyholder services.

Dr. Siderov presented his company’s annual review and forecast. PMSLIC is a physician-directed, mutual national organization (writing in Pennsylvania) that is owned by NORCAL (California), which recently acquired Medicus (Texas). These physician-owned and directed companies are rated “A” by AMBest rating agency. They are committed to organized medicine and endorsed by 45 county, specialty and state medical societies. They have a committed defense team and a history of policyholder dividends. Current assets are $1.5 billion, with policyholder surplus for 2012 at $606.3 million. In September 2012 PMSLIC returned a dividend to its policy holders. In Pennsylvania, PMSLIC has 4,000 insureds statewide, 600 in Allegheny County. Dr. Siderov said that, with the consolidation and acquisition of physician practices by hospitals and health systems, it is no surprise that independent practices have gone down significantly over the past few years. In the current soft market, claims frequency remains stable and claims severity shows a modest increase.

Board business:
- **Editorial Board:** Upon recommendation by the ACMS Editorial Board, the Board of Directors approved the following associate editors for the noted terms:
  - Robert H. Howland, MD, and Adam J. Gordon, MD, MPH, FACP, FASAM, for their first two-year term (January 1, 2013–December 31, 2014);
  - Drs. Timothy Lesaca and Michael Weiss for a second two-year term (January 1, 2013–December 31, 2014);
  - Dr. Frank Vertosick for a third two-year term (January 1, 2013–December 31, 2014).
- **House of Delegates:** Dr. Amy Paré reported that ACMS and the Philadelphia County Medical Society met in joint caucus to review the PAMED House of Delegates resolutions. The main discussion was on the governance issue, including moving policymaking power to the Board of Trustees from the House of Delegates, creating a smaller board. The ACMS Board of Directors agreed to meet with the PAMED leadership or host a regional meeting to discuss concepts for a new governance and policymaking structure.
- **ACMS Election:** The 2013 ACMS Election results were posted during the meeting for approval. A copy of the final report is on file. Letters have been sent notifying the elected physicians for officers, board of directors and delegation.
- **Awards Committee:** The board approved the Awards Committee recommendation, as presented by Dr. Donald Middleton, that selection and approval of the awardee for the Frederick M. Jacob Award should be the responsibility of the Board of Directors. The board nominated and approved Ralph Schmeltz, MD, for the 2012 Frederick M. Jacob Award.
- **Finance Committee:** The board approved the Finance Committee report (November 13, 2012 / 2013 Budget) as presented by Dr. Christopher Daly, who reported that, with the financial market improving slightly, investments have grown and the society is in good financial health.
- **Foundation Gala Committee:** Mr. John Krah reported for the Foundation Gala Committee that plans...
were under way for the April 6, 2013, Annual Foundation Gala at the Omni William Penn; the 2012 ACMS Foundation Scholarship Awardees include Anita B. Lyons and Christine M. Pennesi (“ACMS Foundation Gala, Bulletin, February 2013, page 62).

- **Medical Students Report:** Elizabeth O’Neill, MS1, thanked the members of the board who participated in the Medical Student Career Night and the Health Care Debate. Arrangements are underway for the shadowing program. Ms. O’Neill introduced Mark Evans, MS1, who will be the new representative on the ACMS Board of Directors.

- **Membership Report:** Ms. Nadine Popovich reviewed the actions of the membership staff for 2012, including:
  - outreach to primary care groups in the area;
  - recruitment mailings to health clinics;
  - promotion of the $95 special introductory membership rate;
  - recruitment letters to emergency medicine physicians;
  - visits and information mailings to pediatric specialties;
  - focus on group recruitment (ACMS working with PAMED);
  - board outreach requests; and
  - planning for 2013 for young physicians programs.

- **Practice Administrators:** Mr. James Ireland reported that both the 2012 Practice Manager Forum and Administrator’s Appreciation Night were well attended; feedback from participants helped set the 2013 calendar for practice managers, including coding, ICD-10, HR issues, HER, office efficiency and workflow, IT security issues and regulatory update.

- **Executive Director’s Report:** Mr. Krah noted the following individuals whose terms have expired on the Board of Directors: Drs. Leo McCafferty (2012 chair), Adam Gordon and Anthony Spinola. The board thanked the physicians for their time and service.

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References
3. American Geriatric Society. From the AGS Beers 2012 criteria.
8. Streiff MB, Haut ER. The CMS ruling on venous thromboembolism after total knee or hip arthroplasty; weighing risks and benefits. JAMA. 2009;301(10):1063-1065.

PRACTICE MANAGEMENT (from page 137)

and detection. These visits are covered by Medicare, and the copayments/coinsurance and deductibles are waived. The wellness visits do not address new or existing health problems. A separate Evaluation and Management (E & M) service can be billed at the same time as the wellness visit. You must add a modifier 25 to the Current Procedural Terminology (CPT) codes 99201-99215 and, in this case, the copayment/coinsurance and deductible applies.


Ms. Eisel and Ms. Schmook are the owners of Sláinte Quality Solutions, LLC. They can be reached at lisameisel@gmail.com and dschmook@comcast.net. For more information, visit www.slainteq.com4.
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