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Human rights are generally understood to be universal and egalitarian. They are inalienable, indivisible and derived from the ideology of natural law which seeks to uphold universally accepted moral principles. Providing comfort and assistance to the physically and emotionally ill is one of those universally accepted moral obligations, yet the question remains whether health care is a human right, or just another commodity to be rationed.

Those who support the idea of health care being a human right can cite several historically honored documents. The Universal Declaration of Human Rights (UDHR), which was adopted in 1948 by the United Nations in response to the mayhem of World War II, identified 30 internationally recognized human rights which subsequently formed the groundwork for human rights policy around the world.

Article 25 of the UDHR states, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

In 1966, the United Nations elaborated on the core principles of the UDHR in the treaty known as the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the ICESCR elaborates on the right to health in stating, “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

Further advocacy for health care as a human right came from the Declaration of Alma-Ata, a brief document written in 1978 at the International Conference on Primary Health Care. The declaration expressed the need “for action by all governments, all health and development workers, and the world community to protect and promote the health of all people of the world.”

Article 1 of the Declaration of Alma-Ata states: “The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right.” Almost all of the member nations of the World Health Organization and the United Nations Children’s Fund attended the International Conference on Primary Health Care and supported its right to health initiative.

A right to health care is considered a positive right as opposed to a negative right. The classic enumeration of negative rights includes life, liberty and the pursuit of happiness, and places no societal obligation other than to leave a person alone. Negative rights, therefore, oblige inaction.

A positive right, on the other hand, obligates society to take action, and fundamentally requires others to provide either a good or service. Positive rights are “positive” in the sense that they claim for each person the positive assistance of others in fulfilling basic necessities of human well-being. Universal health care would fall into the category of a positive right since its provision would impose an obligation upon others to assist the right-bearers in obtaining needed and appropriate medical services.

Claiming a positive right to health care creates a broad spectrum of societal obligations. These duties include allocating an adequate share of financial resources to health care needs, properly distributing different types of health care services, taking into account the competing claims of different types of needs, and ensuring that each person is entitled to a fair share of such services while balancing the factor of how these services will be paid for.

Because a positive right to health care implicates such a vast redistribution of resources and skills, it is arguably difficult to categorize the proper scope and limits of such an entitlement. A positive right to health care therefore inherently possesses the potential to conflict with the negative right to keep and benefit from one’s individual labors, free from the interference of others.

The argument for or against health care as a human right is therefore stemmed in the conflict between positive and negative rights. Positive and
negative rights often conflict since the obligations conferred by positive rights can entail infringing upon negative rights. For example, the positive right to any social welfare confers a duty upon the government to find a method to finance such a service, which would likely require raising taxes. A resultant tax increase, however, would infringe upon the negative right to not have one’s money taken away.

Further argument against funding health care as a basic human right incorporates the belief that people’s rights to health care is only a negative one. The concept of health care as a negative right obligates that the government only refrains from actively harming people’s health. The other relevant argument is that health care as a positive right is an impossibility, given the practical reality that the health care system can provide service only within the practical limits imposed by resource scarcity and distribution.5

Political philosopher Isaiah Berlin skilfully commented upon the distinctions between positive and negative rights in his famous lecture titled “Two Concepts of Liberty.”6 Berlin was able to see the delicate balance and interdependence between these ostensibly opposing concepts. He elaborated that if negative liberty is concerned with the freedom to pursue interests according to one’s free will and without external interference, then positive liberty addresses the degree to which one can act autonomously in the first place.

Ultimately, it remains an open question whether the positive and negative forms of liberty are two aspects of a common conception of rights or two distinct types of rights that are closely related without being identical. Regarding this distinction, Berlin wrote, “Where it is to be drawn is a matter of argument, indeed of haggling. Men are largely interdependent, and no man’s activity is so completely private as never to obstruct the lives of others in any way.”

From the perspective of Isaiah Berlin, one would ironically conclude that the question of whether health care is

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ExEcutivE committEE

Editorial

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a human right or a commodity is moot, as it is both a right and a commodity. Health care is in fact a unique commodity. Beyond being a business and an extension of capitalism, it also is inextricably linked to one of the guiding principles of humanity. If one accepts this as an axiom, then every government and corporate decision regarding allocating the resources of the health care commodity also is a reflection of that entities’ moral perspective. Yet is it reasonable to associate commerce with morality?

In 1925, Mahatma Gandhi published in his weekly newspaper “Young India” a list of what he referred to as “The Seven Social Sins,” which he identified as contributing to the colonial oppression of India. On that list was the concept of “commerce without morality.” At the time, he was referring to his concerns about the abuse of workers and natural resources, yet in reviewing his writings it is clear that he did not compartmentalize his life. For him, economics together with politics, morality and religion formed an indivisible whole.

A more contemporary perspective on Gandhi’s concern regarding commerce without morality would suggest that every business transaction is a moral challenge to see that both parties are treated fairly. Ignoring this concern creates the risk of economic systems operating without a moral foundation, which would eventually lead to the creation of an immoral society.

I believe that the discussion and debate regarding resource allocation, whether it is on the national or regional level, has become compartmentalized. Simply stated, I am of the opinion that there is insufficient dialogue regarding the moral implications of decisions regarding the allocation of health care resources.

The question of whether health care is in fact a human right seems to have become secondary to the decision-making processes of the organizations that decide the fate of their subscribers. If Isaiah Berlin is correct, then this is a paradox. If Gandhi is correct, then this might be immoral. Both predicaments are avoidable, but it would involve a very personal internal dialogue on whether one truly believes that health care is a positive human right.

Dr. Lesaca is a psychiatrist specializing in children and adolescents, and is associate editor of the ACMS Bulletin. He can be reached at tlesaca@hotmail.com.

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.

Writers Wanted

Please don’t pass up the opportunity to have your voice be heard. To submit a writing sample or for more information, contact Bulletin Managing Editor Meagan Welling, (412) 321-5030, ext. 105, or email mwelling@acms.org.

References

When I practice, I see a variety of unusual problems, many of which have a variety of clinical options. An example is an acoustic neuroma, recently called vestibular schwannoma, a relatively rare skull-base tumor affecting 1 per 100,000 of the population. Recognition of this benign tumor is occurring much more frequently because patients with unilateral hearing loss or disequilibrium syndromes have early MRI scans. More than 40 years ago, an alternative management strategy for acoustic neuroma, stereotactic radiosurgery, was developed by Lars Leksell at the Karolinska Institute in Stockholm. More than 50,000 patients have been treated now worldwide. We have performed Gamma Knife radiosurgery for more than 1600 acoustic neuroma patients since the first North American Gamma Knife was installed in 1987 at UPMC.

Over the years, patients have learned to proactively evaluate various treatment options for their acoustic neuroma, a condition that does not require an urgent decision. Most patients select a variety of consultants to see, and those with portable insurance often scour the United States looking for centers with extensive experience. Whenever I see such a patient, the first thing I now ask them is: “Whom have you seen already?” After the patient has told me their list of prior consultants, I begin by telling them, “Here are the things you have already been told:"

- It won’t work; it will grow back; and when it does, it will be impossible to remove safely, and you will end up with a paralyzed face when I have to operate.
- Tumors treated by this technique often become malignant themselves or you will get another type of cancer caused by radiation.
- Maybe you should do nothing because hearing preservation rates are better with observation than they are with radiosurgery.
- You will become dizzy and lose equilibrium if you have radiosurgery, whereas if I take your tumor out and cut the nerve from which the tumor came, I will cure your problem.

We then spend a considerable amount of time refuting these inaccurate statements which have derived from a ubiquitous problem in our field: training and technology bias. During our training, we learn techniques of the current era and are rarely prepared for the evolution of change in medicine that occurs after we enter practice. We tend to cling to what we know and are very slow adopters of new management options. I believe that older surgeons are notorious for this, although academic medical centers continue to train innovative younger surgeons who often want to change the paradigm of care.

In addition, our economic system rewards certain procedures, especially microsurgery, and rewards volume. Although much is talked about switching the system to reflect quality and improved outcomes, unfortunately there is no effective strategy to match the easily trackable WRVU system which rewards quantity, not quality.

In medicine, we often link with various technologies both during our training and afterwards. Relationships with industry are always thought to raise eyebrows, and strict disclosure statements related to potential conflict of interest have become the norm. Paradoxically, it is precisely these physician/industry relationships that have fostered great advances in the delivery of care and they have benefited the bottom line of institutions who employ the physicians. Partnerships between doctors, hospitals and industry are critical to improve patient care.

Our government research dollars (when the government works) have been largely directed toward supporting basic science discoveries in the hope of winning the big molecular lottery. National Institutes of Health (NIH) does not seem interested in funding clinical trials that may have an early, direct effect on patient outcomes. Instead, grant dollars are directed at finding the...
Dr. DeMauro is board-certified in endocrinology, diabetes, and metabolism. She is dedicated to her patients and develops treatment plans with each patient tailored to manage chronic conditions and improve quality of life.

Her areas of expertise are in general endocrinology with special interest in polycystic ovary syndrome (PCOS), osteoporosis, parathyroid and thyroid disorders and thyroid cancer.

Dr. DeMauro received her medical training at the University of Medicine and Dentistry of New Jersey Medical School and completed an internal medicine residency at Yale New Haven Hospital and endocrinology and metabolism fellowship at Yale University. She is on staff at Allegheny General Hospital and joins The Center for Diabetes and Endocrine Health. She is accepting new patients aged 18 years and older.

As always, new patients are welcome. Most major insurances are accepted.
A time for reflection

The deep freeze of our Pittsburgh winter this year freezes time, if only for a few weeks. Frosted sidewalks and solid rivers give pause. In this, the quietest time of year, ideas, like snowdrops, are barely waking beneath the ice. Every future you contemplate is possible, and only awaits your commitment. Once the sun returns, life begins in earnest, and no time for rest remains. Such is the wonder of having seasons; even darkest winter can be a gift, for time stands still so that we may think and plan in peace.

Reflection also is key; in this issue you will find the legislative summary for the past year and pieces on the Affordable Care Act. Please use them to prepare for the year ahead, and remember to stay involved with patient/physician advocacy this year. Your voice does matter; let it soar this year. Your comments and ideas for future issues are warmly welcomed.

Dr. Paranjpe is an ophthalmologist and medical editor of the ACMS Bulletin. She can be reached at reshma_paranjpe@hotmail.com.

From Page 49

big scientific breakthrough that may lead to long-run improvements in care and benefit multiple problems and multiple disciplines.

Our trainees are greatly affected by training and technology bias. It is critical that we show them multiple options in the care of patients so that they are prepared for a future filled with technology innovation. It also is incumbent on physicians and surgeons to demonstrate that such innovations improve outcomes and enhance cost-effective patient care. As such, residents must be exposed to multiple therapeutic options that are individually tailored for each patient. They need to be able to critically evaluate the medical literature. They also must learn to tell patients only what has been demonstrated in the literature and to be able to understand opposing views.

As head of the UPMC Technology and Innovative Practice Committee, I have evaluated numerous fascinating and innovative projects over the years. Our technology reviews are done in partnership with fiscal representatives of the hospital, since introduction of new and innovative technologies must pass both merit and fiscal impact reviews.

Back to the patient who has an acoustic neuroma. We try to point out the data reflecting the various outcome strategies for management of this problem. When needed, I refute misperceptions or outright falsehoods apparently provided to direct the patient to the approach a prior consultant prefers. I then make a recommendation for that patient. It is up to the patient to make a final decision, but the patient needs to have accurate data, free of training and technology bias.

Dr. Lunsford is Lars Leksell professor and distinguished professor in the Department of Neurological Surgery at the University of Pittsburgh. He is the director of the Center for Image-Guided Neurosurgery and Neurosurgery Residency Training Program at UPMC, previously serving as department chair from 1996-2006. Dr. Lunsford is the author of more than 500 published articles, 250 book chapters and 11 books. Dr. Lunsford has represented the School of Medicine as an elected member of the University Senate for 5 years. He can be reached at lunsld@upmc.edu.
Health care reform is now in full swing. When the Affordable Care Act was signed into law by President Obama March 23, 2010, some celebrated and others raised their voices in protest. At that time, most Americans agreed that while the quality of their health care was good, there also were many problems, not the least of which were high cost and poor access for some. Let’s look at these and other problems in light of the American experience.

Thomas Paine, author of the instant best-seller “Common Sense,” wrote “the cause of America is, in a great measure, the cause of all mankind.” Its publication in 1776 became the leaven for the ferment of the times, strengthening the colonists’ resolve and resulting in the successful American Revolution. As was the case then, the decisions we are making will have profound effects for us and for our children and grandchildren. But most importantly, the circumstances affecting our health care are universal. Our solutions will be the concern of every man.

Government-run health care

I want to comment on government-run health care, as some Americans favor this as a solution for our health care woes. Some people think government is the only entity large enough to understand and control our complex health care system. They think that government will run a better health care system by negotiating harder and telling businesses what to do. For example, electronic health records have potential for good through improved communication and reduced paperwork. But there are high costs to set them up, so a government role may help. Other people think government is the only entity rich enough to pay for all the people within our borders they would like to see having health care. But let’s face facts: The idea that government can deliver services and reduce costs better than the free markets is a triumph of hope over centuries of experience.

Also, why would we want to turn over health care to government when government has been responsible for so many of our current problems? Government has failed us in its responsibility of regulating health care. As examples, providers that have cheated and stolen from Medicare and Medicaid and those in health care who have made outrageous profits from the misfortune of patients should have been identified and punished from the very beginning. And let’s also face this fact: Our American government has not been able to run other businesses effectively (e.g., the railroads, post office).

In my opinion, government by its design is incapable of being efficient and competent in business. Let me explain by comparison with my business. I frequently have to make purchases, sometimes at great cost. So I am diligent in finding the things that best perform in the manner needed and at the lowest cost, because everything I buy I do so at the expense of my income. And therein is the difference between the way businesses are run in the private sector and in the government.

You see, government spends someone else’s money, not their own. Do you remember when you were young and your parents gave you a few bucks? While you were unlikely to be frivolous with that money, you were not nearly as careful in spending it as you were with the paycheck from your first job. Having had to earn it changes your views about money. We are much more inclined to find value in the things we buy with the money we have earned ourselves. Private businesses are run with the money their owners earn, and millions of them finding value at the expense of their owner’s income creates efficiency and competence that governments run with the taxpayers’ money cannot match.

Its health plans have allowed the government to be a price regulator for several decades. Now, the Affordable Care Act (ACA) increases government involvement in medicine. So I will give you a brief description of the ACA to help you understand what government-run health care is, which I will separate into its two broad types, single-provider and single-payer health care systems.
The Affordable Care Act

The ACA, almost 1,000 pages long, is difficult to read, so the following is a short description of some of its major aspects. First, to make health care more affordable, people with low and moderate incomes who do not get health insurance from an employer are eligible for government aid to help pay for their health insurance. Those between 100 percent and 400 percent of the federal poverty level can have subsidies paid directly to the health insurer to lower their monthly premiums. If individuals choose not to use all or part of their allowed subsidy, the remaining value can be received as a tax credit when they file their federal tax return. Families will get larger amounts than individuals.

Overall, the higher the income, the lower the subsidy will be. The major method of driving down costs is health care exchanges. These online marketplaces, or “stores,” were created by state and federal governments and require every insurance company to design plans that meet specific requirements and to present them in the same way. Some think it will be as easy to compare health insurance plans as it is to compare cans of beans in the supermarket.

Second, there will be penalties for those who don’t have health insurance. While there are a few groups of people who will be exempt, such as American Indians, starting in 2014, individuals will be fined by the Internal Revenue Service for not having health insurance, and the same is true for businesses not providing full, affordable health insurance in 2015. This allows another major change to be enacted, that individuals not be denied or pay more for their health insurance because of pre-existing conditions. Before the ACA, individuals with an existing health condition who were able to get health insurance were charged higher premiums to offset treatment costs.

With the ACA, everyone will pay an average premium, whether they are healthy or unhealthy. Also, premiums will be closer for young and old individuals. This means that premiums for young people will be more than they were in the past. Lastly, if anyone wants to buy health insurance, they can get it. It is guaranteed as long as a few guidelines are met; for example, people in Pennsylvania cannot get health insurance offered only in Ohio.

While change was needed, the question now is whether the changes of the ACA were a good way to reform health care. There has been considerable focus on the ACA mandates, but I also have concerns about one of its linchpins. I know firsthand the complexity of out-of-pocket payments and don’t think government-run marketplaces will allow informed decisions about cost for health insurance.

While online comparisons of monthly premiums, copays and deductibles are helpful, one health insurance plan may provide only a few physical therapy visits each year while another allows many. One plan may allow a lengthy stay in a rehabilitation facility for recovery after injury while another denies it. One plan may allow most medications at low cost while another denies them. These are only examples of the differences that are possible. While you can do without power windows in the car you are buying, can you do without the medication needed for your good health? So you may not find out what the health insurance plan you purchased at a low cost is really going to cost you until it is too late.

Unquestionably, government involvement in the markets has increased over the past several years. And in addition to the government being inefficient and incompetent in running markets, giving politicians the reins to our health care will increase their temptation to use their power to garner votes, pander to special interest groups, or put more money into the pockets of those already fleecing the health care system. So next, let me give brief descriptions of single-provider and single-payer health care systems.

Single-provider system

A single-provider, government-run health care system is espoused by some as a way to provide health care to everyone. Examples are the health care systems in Great Britain and Japan. But we in America don’t need to go to another country to see what a government-run, single-provider health care system is like. We have one right here in America, the VA Healthcare system.

A single-provider health care system makes it easy to standardize services. Similar care can be delivered to all, from the health records, to the qualifications of the physicians, to its administration, to the infrastructure. Some advocate a single-provider health care system as a way to guarantee health care for all Americans. Being a citizen, a resident or possibly just being within the country’s borders would entitle one to health care. There also are savings with a single, large provider that come from economies-of-scale.

Like Wal-Mart, such a provider has the opportunity to negotiate better prices for supplies than smaller organizations. And employees, like doctors,
nurses and therapists, can be paid less because there is diminished competition for their services. Lastly, the system can be easily monitored. For example, compliance can be mandated and activity can be scrutinized within a single system.

Disadvantages of a single-provider health care system include loss of competition and the resulting efficiencies. Clinicians in such a system are not given incentives to work harder, and often they do not. Less care is provided. Another disadvantage is diminished choice. If one is dissatisfied with their care, there are fewer options and alternatives. The biggest savings of a single-provider health care system can come from controlling costs with rationing as health care costs can be kept down with a budget that can be set and adhered to. For example, the total cost for total hip replacements can be set at the beginning of the fiscal year. When it is spent, further total hip replacements can be halted until the end of the fiscal year. Care also can be rationed with strict criteria set for delivery of health care. For example, dialysis for kidney failure can be limited to those younger than a specified age.

**Single-payer system**

A single-payer health care system has many providers but eliminates all of the health insurance companies but one: government. In such a system, providers remain much the same as in our current health care system. They still must compete for patients and be efficient to remain profitable. And they maintain their own governance. An example is the Canadian health care system.

Advantages include simplification of the complex and bureaucratic systems of the way providers are paid. Instead of hundreds of payers, each with their own rules for payment, there is one. Individuals no longer have to endure the difficulties of shopping for a health insurance company.

In addition to the potential for rationing as with single provider health care systems, a disadvantage of single-payer health care systems is the lack of competition in administrating the insurance company.

Dr. McMahon will discuss solutions to problems with the American health care system in part two of this installment. Dr. McMahon, who specializes in orthopedic surgery, is in active clinical practice in Pittsburgh and the South Hills and can be reached at (412) 431-7342.
Society News

PAMED Alliance, Foundation offer scholarships

The Pennsylvania Medical Society (PAMED) Alliance, in conjunction with the Foundation of PAMED, is offering multiple $2,500 scholarships to Pennsylvania residents attending an accredited Pennsylvania medical school full-time as a second- or third-year student. Applications must be postmarked by Feb. 28, 2014.

In addition to the application, candidates must submit two reference letters, verification of medical school enrollment on school letterhead; and an essay describing the applicant’s vision for the future of Pennsylvania medicine.

For an application, call the Foundation at (717) 558-7852, or visit Student Financial Services at www.foundation-pamedsoc.org.

Windows XP, Office 2003 support ending

Windows XP and Office 2003 will go out of support April 8, 2014. Microsoft provides support and updates for its programs for a minimum of 10 years. After April 8, there will be no security updates, free or paid assisted support options or online technical content updates from Microsoft. The HIPAA Security Rule requires the secure protection of your data.

Please take appropriate measures to upgrade your systems and ensure the protection of your data.

Medical interpreter training offered

The Office of Health Equity for the Pennsylvania Department of Health is offering free medical interpreter training for three Allegheny County Medical Society (ACMS) members from April 9 to 11, 2014, at the Allegheny County Department of Human Services office in downtown Pittsburgh.

Interpreters or individuals who would like to become qualified medical interpreters (must speak another language in addition to English) should attend. Total training time is 15 hours and is fully consistent with the standards set by the National Board of Certification for Medical Interpreters (NBCMI); however, it does not comply with certification of medical interpreter prerequisites for Spanish interpreters effective Dec. 31, 2013. Fully bilingual persons with 1 year experience interpreting in a health care setting who complete this training and that of the Health Federation of Philadelphia’s Interpreter Training Program should be well-positioned to pass both written and oral NBCMI exams.

Space is limited to 25 participants per class; up to three members of the ACMS are permitted to attend free of charge, thanks to funds provided by the Refugee Health Program. Please contact Reese Clark at (717) 547-3313 or theclark@pa.gov for more information.

ACMSF awards two medical student scholarships

The Allegheny County Medical Society Foundation (ACMSF) has awarded two scholarships of $2,000 to medical students from Western Pennsylvania. The students are: Kathlene T. Babalola of Pittsburgh; and Nicholas J. Farber, of Monroeville; both attend the University of Pittsburgh School of Medicine.

Babalola is considering a specialty in obstetrics and gynecology, while Farber plans to specialize in urologic surgery.

EMS opportunity announced

EMS agencies currently are able to submit an application for Mission: Lifeline EMS Recognition. Mission: Lifeline Recognition is the only American Heart Association (AHA) program that includes a measure of system performance, moving quality improvement for hospitals to include EMS involvement. The application period opened Jan. 1 and will close Feb. 28. The guidelines and application are available at: http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/@ml/documents/downloadable/ucm_458942.pdf.

2014 Clinical Update in Geriatric Medicine set

The Clinical Update in Geriatric Medicine will be held March 27-29 at the Marriott City Center in Pittsburgh. This award-winning course has been a popular and respected resource for more than 21 years. It is jointly sponsored by the Pennsylvania Geriatrics Society – Western Division (PAGS-WD), University of Pittsburgh Institute on Aging, and University of Pittsburgh School of Medicine Center for Continuing Education in the Health Sciences. The program is designed by course directors Drs. Shuja Hassan, Judith Black and Neil Resnick, along with the PAGS-WD planning committee.

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The program features 40 state-of-the-art sessions taught by top experts, with each lecture, symposium and breakout session designed to provide evidence-based “pearls for practice” that can be immediately incorporated into the realities of daily practice. Highlights of this two-day conference include:

- A symposium on geriatric neurology and psychiatry including assessment of capacity/decision making, anxiety and depression, the difficult patient, non-pharmacologic treatment of dementia, and delirium;
- Breakout sessions which allow participants to pose specific clinical management questions to experts in the area of GI, pain medicine, dermatology and radiology;
- Updates in geriatric pharmacology to include how to practically implement evolving standards such as the Beers criteria;
- Lectures on geriatric cardiology by the ACC’s Chair of Geriatrics.

Distinguished guest faculty include: Daniel Forman, MD; Sharon K. Inouye, MD, MPH; Corita R. Grudzen, MD, MSHS, FACEP; and Barbara J. Messinger-Rapport, MD, PhD, FACP, CMD. Distinguished local faculty also will enhance the program.

Conference credits include a maximum of 19.5 AMA PRA Category 1 credits™; with other health care professionals awarded 1.9 continuing education units (CEUs). An application for CME credit for AAFP has been filed with the American Academy of Family Physicians (determination of credit is pending); social work credits are offered (19.0 hours of social work); and nursing credits are a maximum of 18.75 contact hours (the maximum amount of continuing education credit granted).

Registration is now being accepted at https://ccehs.upmc.com/liveFormalCourses.jsf. For detailed credit information, contact UPMC center for continuing education in the health sciences at (412) 647-8232, or email ccehsconfmgmt101@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 email npopovich@acms.org. Apply for membership on the ACMS website at www.pagswd.org.

**12th International HELP conference slated**

The national Hospital Elder Life Program (HELP) conference will be held in conjunction with the Clinical Update conference March 27-28, 2014. Designed by course directors Sharon Inouye, MD, MPH, and Fred Rubin, MD, this two-day international conference educates HELP teams regarding strategies for delirium prevention, using HELP to improve hospital-wide care of the elderly, and creating a climate of change.

Expert clinicians and experienced members of the HELP sites will share evidenced-based information and clinical insights on selected topics regarding the influence of HELP, delirium updates and the larger policy implications of care for the elderly. Updates on collaborative papers, expansion of the
program and innovative site projects also will be presented.

For more information, please contact Krystal Golacinski, UPMC Center for Continuing Education in the Health Sciences, at (412) 647-7050, or email ccehsconfmgmt101@upmc.edu.

Practice Managers meet

ACMS Practice Managers Section presented, “Resolution for the New Year: Moving from Manager to Leader” Jan. 16 at the ACMS building. The presenter was Joe Mull, M.Ed., of Ally Training & Development. Topics included exploring the qualities and characteristics of high-performing leaders and understanding the ongoing behaviors they use to succeed. More than 30 attended the program.

Practice Managers will meet again Thursday, March 20, at ACMS.

POS meeting held

The Pittsburgh Ophthalmology Society Membership Meeting was held Jan. 9 at ACMS. The speaker was Asheesh Tewari, MD, presenting on “Current Treatment Strategies for Diabetic Macular Edema.” Dr. Tewari also spoke about “New Techniques for Repair of Complex Retinal Detachment.”

POS will hold its Annual Meeting Friday, March 21, featuring Warren Hill, MD, as the Thorpe Lecturer; Rob Noecker, MD; and Michael Ip, MD.

Joint Effort update from PMSA

From 2011 to 2013, Pennsylvania Medical Society Alliance (PMSA) and Allegheny County Medical Society Alliance (ACMSA), along with other counties in the state, took action as advocates in the interest of both patient and physician. ACMSA, at the Annual Meeting 2012 held at the Pittsburgh Golf Club, joined visiting Donna Rovito, president, PMSA, in the PAMED/PMSA effort urging legislation to allow Pennsylvania physicians freedom for expressions of sympathy to families of those patients with unfortunate outcomes. The patient/physician advocacy actions sought to lift existing liabilities for physicians. We are pleased that the campaign of written communication, phone calls, emails to and visits with state legislators has been successful.

Legislation protecting physician apologies was signed by Gov. Tom Corbett Oct. 25, 2013, thanks in large part to physician advocacy. The legislation prevents most physician apologies from being used against them in a medical liability lawsuit. The new law went into effect Dec. 24, 2013.

On behalf of PAMED and PMSA, also ACMS and ACMSA, we offer profound thanks for your interest, effort and your important participation in affecting change to keep humanity in the doctor/patient relationship!

2013 Year in Review:

Disaster relief

A monetary donation was sent by ACMSA to the Brother’s Brother Foundation for designated use to help victims of Hurricane Sandy.

Health education

The Henry the Hand project is a public health program promoting individual hygiene among third- and fourth-graders in Allegheny County schools. ACMSA this past year visited three locations with the HTH “hands-on” discussion-demonstration presentation, including games and prizes for enthusiastic kids, grades three and four. At home and in the neighborhoods, the children often become little ambassadors for clean hands after Henry’s happy lessons are learned!

Carnegie Science Center

ACMSA participated as sponsors of and judges for the Pittsburgh Regional Science and Engineering Fair. PMSA published in their newsletter and website a printed summary of decades and decades of ACMSA’s long and strong commitment and partnership with Carnegie Science Center.
ACMS member named president of PAD

Justin J. Vujevich, MD, has assumed presidency of the Pennsylvania Academy of Dermatology and Dermatologic Surgery (PAD), a 360-member, physician-led society that promotes improved patient care through medical knowledge and experience of dermatology and dermatologic surgery.

Dr. Vujevich will serve as president from January-December 2014.

Dr. Vujevich is currently the director of Mohs surgery at Vujevich Dermatology Associates, PC, Pittsburgh. He has been a member of the PAD Board of Directors since 2008. He attended medical school at Northwestern University; conducted cosmetic dermatology research at the University of Miami Department of Dermatology; and completed his dermatology residency at the University of Pittsburgh Medical Center.

Dr. Vujevich completed a Mohs surgery fellowship at the Texas Medical Center in Houston, before returning to his native Mt. Lebanon.

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.

Free Online CME Activities. Sponsor: Pennsylvania Medical Society. For information, visit www.pamedsoc.org/mainmenucategories/cme/cme-activities.


In Memoriam

William M. Mitro, MD, of Donora, died Saturday, January 4, 2014.

Dr. Mitro graduated in medicine from St. Louis University and served his residency at St. John’s Hospital in Pittsburgh.

He practiced medicine in Pittsburgh for 58 years and was a charter member of the medical staff at St. Clair Hospital, South Side Hospital, and long-distinguished General Practice in Beechview, Pa.

Dr. Mitro was a veteran of World War II, serving as captain from 1945-1947.

He is survived by his wife, Bea Sachs Mitro; a brother, Myron Mitro; a sister, Florence (Tom) Sveda; children William (Sue) Mitro, Mary Ann (Jay) Stern, Kathy Mitro and Jack (Margaret) Mitro; five grandchildren; two great-grandchildren; and many nieces and nephews.

Deceased is his first wife, June Kinnee Mitro.

A memorial service was held January 9, 2014, at William Slater II Funeral Service in Scott Township.
AN ELEGY WRITTEN IN THE MORGUE OF A TEACHING HOSPITAL
WITH APOLOGIES TO THOMAS GRAY

Here lies Mr. Clinical Medicine
Done to death by his kith and kin
They being Technology, Clickology
Corporate hospital methodology
Dedicated to voracious quantity
And proclaiming the appearance of quality
Treated by an army of ultra speciality
Taught to look at blood chemistry
Computed Tomography, MR angiography
And then to confront the patient for symptomatology
Alas! Between guidelines, and expert opinion
He fell into trial lawyers’ dominion
Government regulation, insurance formulation
Corporate coding froze his circulation!

Venkataraman Krishnaswami, MD, FACC, FACP
Clinical Professor of Medicine,
University of Pittsburgh School of Medicine

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February 2014
Dear Editor:
I totally agree with Donald Middleton’s comments in the January 2014 Bulletin of the Allegheny County Medical Society article: “Retiring but not shy: an EHR commentary.” It’s unfortunate for family medicine that we lost a great teacher and practitioner who is retiring because of his frustrations with EHRs. The problems that Don and the rest of us have grappled with are all too common with these systems. Some comments regarding EHRs need reiterating.

- The EHR interferes with communication between physicians and allied health personnel who struggle to check off one box after another in a needlessly complicated EHR note.
- Medication lists are often incorrect, especially if the hospital computer is a different system than the office computer.
- Needlessly long and unreadable notes with reams of repetitive data make office notes essentially incomprehensible.
- The computer becomes the object of the office visits, placing a division between the personal interaction that we need to have with patients.
- Just completing a brief office or hospital visit can take so long that “cutting and pasting” previous notes has become all too commonplace.
- The time spent just to complete the day’s worth of office entries frequently intrudes on time better spent elsewhere.
- Many of the important intricacies of the patient visit cannot be added to the EHR because there is no coinciding drop-down list.
- EHRs are proprietary and cannot communicate information with different health systems, many times across the street from each other.

The practice of medicine has been invaded by the Information Technology business. This invasion unfortunately has been embraced by both the government and insurers alike. And, of course, neither have any idea of what goes on in the exam rooms or how to deliver cost-effective and compassionate medical care. Medicine should use technology as a tool, not be negatively directed by it.

And, most important, there is no consensus that EHRs improve quality.

Marc J. Schneiderman, MD
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A novel device for epinephrine self-injection: Auvi-Q® auto-injector

For parents and children who suffer from severe allergies, anaphylaxis is a constant and stressful threat. Scrutinizing food labels and avoiding buffet tables become normal, day-to-day lifesaving precautions. Although data on its incidence are imprecise, anaphylaxis is estimated to affect up to 2 percent of the population.¹

Epinephrine is the initial drug of choice for the emergency treatment of anaphylaxis. It is recommended that patients at risk for anaphylaxis carry an epinephrine auto-injector (EAI).² Despite the importance of EAs, there are several limitations and barriers associated with their use. These barriers include low rates of carrying, underuse in anaphylaxis, incorrect injection technique and unintentional injections by patients or caregivers.³⁻⁷

A survey to assess the use of self-administered epinephrine among families of food-allergic pediatric patients found that only 55 percent of families had unexpired epinephrine on hand at the time of the survey.⁴ Additionally, only 32 percent of participants could correctly demonstrate the use of their EAI.⁴ A similar study sought to determine the rate of correct EAI device demonstration by medical staff.⁵

Researchers found that only 2 percent of doctors were able to demonstrate all six administration steps correctly, with 16 percent self-injecting into their thumb.⁶ Incorrect use and unintentional injection is not only common, but can be fatal. In 2012, a teenage boy passed away from anaphylaxis after ingesting walnuts.⁶ Although the school had an available EpiPen® and trained staff in administration, the staff member administering the EpiPen® was holding it upside down and inadvertently injected himself.⁶ In addition, from 1994 to 2007, 15,190 unintentional injections from EAs were reported to U.S. Poison Control Centers.⁷

Continued on Page 62
With severe food allergies among children becoming more and more frequent, it was only a matter of time before a more user-friendly EAI was made available.

Auvi-Q® product development

The EpiPen® has been used to treat anaphylaxis for more than 25 years. Competing EAIs (e.g., Adrenaclick® and Twinject®) have tried and failed to challenge its dominance of the market share.8 Auvi-Q® is a newly FDA-approved EAI that was developed by a set of twin brothers, Evan and Eric Edwards.

The Edwards brothers grew up with serious food allergies that required they carry an EAI everywhere they went.8 As the brothers grew older, they decided to create a new epinephrine device, one with the patients' perspective at the forefront of the design. Their idea was 15 years in the making, but culminated in a $230 million licensing deal with Sanofi-Aventis. The unique EAI alternative, Auvi-Q®, made it to pharmacy shelves nationwide in 2013.8

Auvi-Q® product information

Auvi-Q® is a compact, rectangular device, about the length and width of a credit card and as thick as a smartphone.9 It features step-by-step voice instructions to guide users through the injection process. Upon each user action, green and red LED lights accompany the audio prompts for additional user guidance. When the outer case of the device is removed, the voice instructions begin, and first instruct patients to pull off the red safety guard.9

After the outer case and the red safety guard are removed, the injection is automatically triggered once the device is pressed firmly against the middle part of the outer thigh. A 5-second, voice-instructed countdown accompanies the injection. The needle injects and retracts automatically to help prevent accidental needle sticks.9

The shelf life of Auvi-Q® is 18 months; its battery life is designed to last several years. The epinephrine injection of Auvi-Q® works independently of its electronic features.9 If the battery dies or if the voice instructions do not work for any reason, it will still operate. In the absence of audio, there are written instructions printed on the device. Auvi-Q® is currently only available in the English language. Auvi-Q® should be injected into the middle of the outer thigh, through clothing if necessary.9 Similar to the EpiPen®, Auvi-Q® is available as a single-use injection in two dosage strengths, 0.15 mg (patients weighing 33 to 66 lbs) and 0.3 mg (patients weighing more than 66 lbs). Auvi-Q®, like EpiPen®, is prescription-only and packaged with two auto-injectors and a single training device.

Primary literature

A randomized, single-blind, three-sequence crossover study compared peak and total epinephrine exposure between epinephrine injected with Auvi-Q® and EpiPen®.10 Seventy-one healthy adults aged 18 to 45 years old were randomly assigned to receive a single injection of epinephrine 0.3 mg with Auvi-Q® in one period and with EpiPen® in the other two periods. Blood samples were obtained before and 14 times during the 6 hours after the dose. Auvi-Q® and EpiPen® had similar peak and total epinephrine exposure, were bioequivalent, and had similar safety profiles.10

A second study was done among health care professionals to validate the sharps injury prevention features of Auvi-Q® and to obtain feedback on
features of Auvi-Q® compared with Twinject® and EpiPen®. 11 Twenty-eight health care professionals experienced with using the EpiPen® or Twinject® were included. Participants provided feedback via a post-test questionnaire and gave ordinal preference rankings for the Auvi-Q®, EpiPen® and Twinject®. All 28 participants ranked Auvi-Q® first in overall preference to the EpiPen® and Twinject®. Most participants ranked Auvi-Q® first in terms of perceived safety (n = 27; 96 percent), ease of use (n = 26; 93 percent), ease of training patients in use (n = 26, 93 percent), preferred size (n = 22; 79 percent) and preferred shape (n = 19; 68 percent). 11

A large, multicenter, simulated-use study evaluated whether adults, caregivers and children with and without experience using an EAI had a preference for the current design of Auvi-Q® or the current design of EpiPen®. 12 Participants were given a scenario that involved anaphylaxis and were instructed to simulate use of an EAI. They received and tested each device individually according to the randomization assignment. After testing both devices, they completed a survey to indicate their preferences. For experienced and inexperienced participants in all 3 groups (n = 693), Auvi-Q® was preferred over EpiPen® for method of instruction, preference to carry and device size (all p < .001). 12

Summary

Auvi-Q® is a novel EAI approved for the treatment of anaphylaxis. It is bioequivalent to the EpiPen® and has a similar safety profile and cost. Auvi-Q® has a number of unique features that include compact size, voice instruction and automatic needle retraction. Studies have shown Auvi-Q® is preferred over the EpiPen®. It is important for health care professionals to familiarize themselves with this novel device.

Dr. Wojtusik is a PGY2 pharmacy resident at UPMC St. Margaret. Dr. Higbea is a PGY1 pharmacy resident at UPMC St. Margaret. They can be reached at wojtusikap@upmc.edu and higbeaam@upmc.edu, respectively. Heather Sakely, PharmD, BCPS, provided oversight for this article and can be reached at sakelyh@upmc.edu.

Table 2. Comparison of EpiPen® versus Auvi-Q®. 8, 12-13

<table>
<thead>
<tr>
<th></th>
<th>EpiPen®</th>
<th>Auvi-Q®</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indication</strong></td>
<td>Emergency treatment of anaphylaxis</td>
<td></td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
<td>Patients greater than or equal to 30 kg (66 lbs): 0.3 mg Patients 15 to 30 kg (33 lbs – 66 lbs): 0.15 mg</td>
<td></td>
</tr>
<tr>
<td><strong>Route of Administration</strong></td>
<td>Intramuscularly or subcutaneously into the anterolateral aspect of the thigh, through clothing if necessary</td>
<td></td>
</tr>
<tr>
<td><strong>Voice Instructions</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Automatic Retractable Needle</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>33/8” high, 2” wide, 5/8” thick</td>
<td>~5” tall, 3/4” diameter</td>
</tr>
<tr>
<td><strong>Cost (two-pack)</strong></td>
<td>$317.40</td>
<td>$332.58</td>
</tr>
<tr>
<td><strong>Prescription Assistance Program</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Mobile App</strong></td>
<td>No</td>
<td>Yes</td>
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</tbody>
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References


Care is Your Business, Change is Ours

The healthcare environment is changing. Physicians must focus on providing the highest quality care with intense competition for their time. Medical practices face increased challenges tied to changes to regulation, insurance protocols, cost-management and revenue management.

Houston Harbaugh has over 30 years of experience in helping physicians and medical practices manage change through contract negotiations with hospitals and payors; contract management; advocacy and new practice start-up counsel. We have provided critical support in practice mergers and acquisitions. And we have provided sound advocacy on issues ranging from HIPAA compliance to medical staff and peer review matters.

Every challenge a medical practice can face, we have seen. We have helped practices of all size and structure meet these challenges. And we know what is ahead. Houston Harbaugh: Your voice in medical practice management.
Legal Summary

The ACA and the ... Fair Debt Collection Practices Act?

Beth Anne Jackson, Esq.

The case: In Bradley v. Franklin Collection Serv., Inc. No. 13-12276 (11th Cir. Jan. 2, 2014), the 11th Circuit Court of Appeals recently highlighted the importance of collection policies and patient agreements regarding payments, dismissing claims regarding one health care provider’s account, but not the other. In this case, the collection agency added a percentage of the patient’s balance as a “collection fee” when the account was referred for collection. One health care provider’s agreement with the patient allowed it to impose “costs of collection,” while the other’s provided that the patient agreed to pay “reasonable collection fees.” The court held that the agreement to pay “costs of collection” did not permit the collection agency to add a percentage fee to the patient’s balance, only actual costs of collection. The collection agency’s actions, therefore, violated the federal Fair Debt Collection Practices Act (FDCPA).

Import: One trend that the Affordable Care Act will accelerate is the prevalence of high-deductible plans. As more and more health care costs are transferred to patients through high deductibles, providers who are not prepared with appropriate collection policies, notices and agreements may not only lose the ability to collect patient balances expeditiously, but also may find themselves in violation of Pennsylvania’s version of the FDCPA, the Fair Credit Extension Uniformity Act (FCEUA). Unlike the FDCPA – which applies only to collection agencies – the FCEUA also applies to the creditor: your practice. Managed care contracts and governmental health care program regulations also affect how you may collect from patients. The best way to address the problem of unpaid patient account balances is twofold: (A) Avoid the accumulation of patient debt by implementing practices to collect payment due at the time of service (including copayments and amounts that will be applied to the patient’s deductible, if that information is available); (B) Utilize forms and agreements that allow you to collect balances in accordance with applicable laws, regulations and contracts. For the latter, seek the services of a qualified attorney to ensure compliance.

Ms. Jackson is the sole member of Beth Anne Jackson, Esq. LLC, a law firm that serves the legal needs of health care practitioners and facilities in southwestern and central Pennsylvania. She can be reached at (724) 941-1902 or bjackson-law@verizon.net. Her website is www.jacksonhealthlaw.com.

Reference
1. If you miscalculate and the patient overpays for a given date of service, be sure to return the overpayment to the patient once all outstanding claims are paid. Overpayments by Medicare or Medicaid must be returned within 60 days to avoid potential False Claims Act liability.
A four-quarter schedule for medical billing management

The first three months of the year are a good time to make sure your administrative systems are functioning as efficiently as possible so that your medical practice can perform to the levels you want. This means maximizing productivity and profitability.

Maintaining a high-quality billing operation is a critical component of this process that requires constant attention. One of the best ways to approach management of your medical billing operation is to understand that it is well worth an investment of time and resources up front to ensure that throughout the year, you are achieving revenue goals.

A good way to manage this process is to do what any well-run enterprise does, and that is to break the year into its four quarters and follow a four-quarter medical billing timeline. Here is what we would recommend as an annual schedule to stay on top of the key management imperatives for a billing department to reap maximum revenues and assure integrity of processes:

1st quarter (ends March 31): Winter wrap-up

Look back at the prior year and prepare for the year’s challenges.

Update CPT codes: Survey the CPT and HCPCS manuals with your physicians. Ensure their understanding of every definition change, deleted codes and new codes. Ensure that all updates are appropriately loaded into EMR/PM software before entry of any current-year data.

Update fee schedule: For the top 3 to 5 payers for your practice, obtain the new year’s reimbursement for all services. Ensure that fees are appropriate; re-set fees as needed.

Forecast revenue: Capture the prior year’s production by CPT and by payer and apply the new reimbursements. Then, estimate production for the new year. Look at the numbers by provider and/or by location. Does the practice need to adjust provider schedules? Open or close a location? Study the reimbursements by payer; what is changing at the payer level that will affect revenue?

Plan staffing and education: After understanding the revenue forecast and CPT changes, determine if your staffing is still sufficient. Does everyone have the knowledge they need to do their best?

Review and adjust workflows: Are all billing processes working effectively and efficiently? Walk through the operation and note areas that need improvement – or documentation.

2nd quarter (ends June 30): Spring into action

Based on the first quarter’s findings, implement the staffing and workflow modifications.

Staff training/Cross training: Payers constantly change billing and reimbursement guidelines. Staff usually require regular training to ensure complete understanding, especially for writing insurance appeals. Having one-on-ones with each staff member allows management to uncover individual training needs. Don’t forget to create a backup plan for each person, so when people are out ill or on vacation, no billing tasks are ignored or overlooked. HIPAA refreshers also are critical.

Update billing guides: For each payer, we keep a copy of the latest Local Coverage Determination or Medical Policy Bulletin for the most commonly billed services. That way, when staff is covering for a co-worker, they have operational support for all basic processes – for interacting with the payer and for optimal usage of the PM software.

Software feature implementation and/or improvements: Most of us utilize EMR and PM systems that have numerous valuable features; we often don’t have the time to implement all of them. Use these months to select at least one feature that you determine will provide a tangible benefit to your billing operation. If you can’t find one, just ask your billing team.

Continued on Page 68
3rd quarter (ends September 30): Summer slide-through
Make sure that revenue is on track. Cover all your bases even when short-staffed.

Mid-year analysis of forecasting accuracy: Most practice managers watch the numbers closely every month. But, if the analyses are not shared with the billing department, take the time to perform a “billing-centered” analysis. Are you collecting what you expected? For every service? For every payer? If the collection numbers don’t match what was anticipated, identifying the reasons for the mismatch may lead you to what in the billing operation needs to be adjusted.

Vacation coverage: This is the time to test how well your team integrated their cross training. Remember, summer-time is vacation time for payers, too. So, your practice may experience slower responses to your appeals. Keep an eye on the Aged A/R to ensure attention is paid.

4th quarter (ends Dec. 31): Fall forward
As the year winds down, it's time for billers to harvest all available knowledge about new diagnosis codes. We expect that 2014 will be one of the most challenging we've seen in a while, as ICD-10 is integrated into providers' awareness, EHRs and PMs.

ICD updates: Ensure that all providers and billing staff fully understand ICD coding, and that all systems are updated completely and accurately.

Encounter form updates: Whatever format the providers use to report the codes they select for billing, ensure that those systems or forms are completely revised and understood by all. This is the source for your claims which need to be correct upon initial submission.

Collection processes, especially self-pay: With the trend being that patients carry higher deductibles and copayments, it's critical that your billing operation include clearly thought-out policies and procedures for collecting patient-due account balances. Take the time to obtain legal counsel to write a policy that meets state and federal fair debt collection guidelines. Obtain input from the practice's principals to ensure that your billing office is implementing the policy according to the practice philosophy.

Follow your medical billing management plan
By having a plan in place like this, at the end of each quarter, you will know what you were able to accomplish and what still may need to be addressed in the next quarter. At that point, you can make adjustments.

You and your staff will have a better sense of day-to-day priorities by following a larger plan so that as you make both major and minor medical billing management decisions, you are more likely to have all of the information you need to make an informed decision.

Most importantly, by being better organized, your medical billing systems will better deliver maximum practice revenues.

Donna J. Kell is CEO of The Kell Group, LLC, a medical billing and consulting firm with offices on the South Side of Pittsburgh. She can be reached at dkell@kellgroup.com.

Serving the legal needs of health care practitioners and facilities
- Regulatory - Stark, Anti-Kickback, HIPAA, EMTALA
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- Operational issues and policies
Each year, the Allegheny County Medical Society Foundation (ACMSF) recognizes outstanding individuals and community organizations for the contributions they have made to the health care needs of the Pittsburgh community and beyond. The 2013 ACMSF award winners featured here will be honored at the ACMSF Gala and community awards ceremony Saturday, March 8, 2014, at the Omni William Penn Hotel. Allegheny County Medical Society (ACMS) encourages you to attend this wonderful affair and to celebrate Pittsburgh’s world class medical community.

Nathaniel Bedford Award for Outstanding Primary Care Physician

Thomas P. Wein, MD, is the 2013 recipient of the Nathaniel Bedford Award for Outstanding Primary Care Physician. Presented by ACMS since 1975, the award recognizes a primary care physician for long-term provision of care and exemplary dedication to their patients.

Dr. Wein specializes in internal medicine and geriatrics. He graduated from Temple University School of Medicine in 1976 and fulfilled his residency at Montefiore Hospital, serving as chief medical resident in 1978. Dr. Wein is in private practice and has been an associate of Health Center Associates since 1979. In addition, he is affiliated with UPMC Shadyside Hospital and Magee Women’s Hospital of UPMC. Dr. Wein also has served as a clinical instructor at the University of Pittsburgh School of Medicine and is currently serving as clinical assistant professor of medicine at the medical school.

A member of ACMS and the Pennsylvania Medical Society (PAMED) since 1979, Dr. Wein also has been a longtime member of the American College of Physicians. Dr. Wein has participated in numerous committees over the years including, but not limited to, the Allegheny University Ambulatory Medical Practices Quality Assurance Committee; Utilization Review Committee at Montefiore Hospital, UPMC; Quality Assurance Committee at Montefiore Hospital; CMI Risk Management Committee at UPMC; and Health Information Management Committee at Magee Women’s Hospital of UPMC.

A longtime patient who nominated Dr. Wein for this award wrote, “I have been under Dr. Wein’s care for over three decades and during this journey he has demonstrated impeccably high standards of care that have always been and continue to be delivered with a warm and gentle demeanor. He has shown exceptional dedication to me as a patient which exceeds above and beyond the call of duty.”

The nomination letter goes on to list several of Dr. Wein’s attributes, including his compassionate bedside manner, thorough attention to detail, genuine empathy, selfless devotion to his patients, outstanding communication and listening skills, and charming sense of humor.

“Dr. Wein is more than an outstanding primary care physician,” says Dr. Wein’s nominator. “He is a model that all PCP’s should strive toward: A true humanitarian, a gifted physician, a great communicator, and a man who I consider a friend.”

Benjamin Rush Individual Award

Robert Nelkin, president and chief professional officer of the United Way of Allegheny County, has been selected as the 2013 Benjamin Rush Individual Award winner. Established in 1947, the award recognizes an individual who is not a practicing health care professional, who devotes time, skills and resources to assisting others and who advances health care delivery.

Mr. Nelkin’s nearly 45-year career stems from his passion for positive change and focus on advocacy for children, youth and people with disabilities. Since taking the helm at United Way in 2007, he has been leading efforts to address critical issues in the community affecting struggling families, frail seniors, striving schoolchildren and young adults with disabilities.

Continued on Page 70
Mr. Nelkin has worked with Allegheny County Medical Society on many public health initiatives, including Healthy Start to reduce infant mortality; Tobacco Free Allegheny to reduce tobacco use; fitUnited to improve childhood wellness; and the Chronic Disease Self-Management Program.

Mr. Nelkin oversees the implementation and continuing expansion of PA 2-1-1 Southwest, a free resource that connects people with community, health and disaster services in 11 counties across Southwestern Pennsylvania. Mr. Nelkin also has overhauled United Way’s granting process, requiring evaluations, building relationships and obtaining measurable results for future funding.

Mr. Nelkin previously served as Director of Human Services for Allegheny County, where he led an initiative to improve community health; and Director of Policy Initiatives at the University of Pittsburgh Graduate School of Public Health and the Jewish Healthcare Foundation.

“The focus on prevention and his understanding of the numerous factors that affect health care have fueled his approach to improving the health of our communities,” says Arthur J. Rooney, past chairman, United Way of Allegheny County. “While Bob has been the driving force behind countless successful programs advancing health care, his work has also resulted in system-wide change and new public policy approaches based on research or best practices.”

Physician Volunteer Award

James M. Rossetti, DO, is this year’s recipient of the 2013 Physician Volunteer Award. Established in 2001, this award recognizes a physician for the donation of their time and talents for charitable, clinical, educational or community service activities, either domestically or internationally.

Dr. Rossetti, specializing in hematology and oncology, graduated from Lake Erie College of Osteopathic Medicine in 1996. He completed his residency in internal medicine at St. Francis Medical Center and fulfilled a fellowship at Western Pennsylvania Hospital in hematology and oncology.

A member of the Division of Hematology/Oncology at Western Pennsylvania Cancer Institute at West Penn Hospital, Dr. Rossetti also is clinical assistant professor at Temple University School of Medicine and adjunct clinical instructor at Lake Erie College of Osteopathic Medicine.

Dr. Rossetti has been an active and dedicated volunteer with the Leukemia and Lymphoma Society (LLS) – Western PA and West Virginia Chapter, since 2003 when, as an oncology/hematology fellow at the Western PA Cancer Institute, he volunteered and presented his first educational program for LLS.

Dr. Rossetti has since served as a member of the chapter’s Medical Advisory Committee, Advisory Board and Executive Committee. He currently serves on the LLS Board of Trustees. Dr. Rossetti was the first LLS board member to offer his assistance in reaching out to underserved communities. His strong interest in health disparities among minority populations led to LLS hosting its first health disparities educational program for the African American community. In addition, he visited local churches and organizations as a volunteer promoting health care equality and emphasizing local resources to help those in need.

“Dr. Rossetti gives so much of his time and resources to LLS in the hopes of finding a cure,” says Chelsea Trimble, campaign manager, LLS. “Dr. Rossetti’s passion and drive is contagious and has helped to motivate many to support our organization or to get involved with the society.”

Dr. Rossetti continues to fulfill speaking engagements for the society and is an avid fundraiser and participant in several of the society’s community awareness events including Light the Night Walk and its stationary bike event, Race to Any Place. In 2012, he recruited and led a team of his staff to fundraise on behalf of the LLS. Dr. Rossetti’s team raised more than $50,000 for LLS’s mission.

“Dr. Rossetti’s enthusiasm and passion to provide the best treatments to every blood cancer patient is inspiring,” says Brittany Murray, campaign manager, LLS. “He is always willing to participate in events, generate excitement among other medical professionals, and share his dedicated history with LLS to hopefully encourage more people to support our efforts.”

In addition, Dr. Rossetti also holds several appointments at Western
Pennsylvania Cancer Institute including chairman, Patient Life Committee; assistant director, Hematology/Oncology Fellowship Program; chairman, Cancer Committee; coordinator, Hematology Subspecialty Education; and assistant director, Cell Transplantation Program.

Richard E. Deitrick Humanity in Medicine Award

Alfred P. Doyle, MD, is the 2013 recipient of the Richard E. Deitrick Humanity in Medicine Award. The award honors a physician who has improved the lives of patients by caring for them with integrity, honesty and respect of their human dignity, and serves as a role model for other physicians.

Dr. Doyle, who specializes in oncology and hematology, graduated from the University of Pennsylvania School of Medicine in 1954, and completed a residency program at Bellevue Hospital in New York City. He served as a captain in the U.S. Army and eventually was stationed at the VA Hospital in Aspinwall, Pa. By the mid-1960s, Dr. Doyle moved to Sewickley, where he began practice in internal medicine. He completed his specialty boards in hematology and oncology in the early 1970s and has continued to practice in those specialties for 40 years.

In a nomination letter submitted by Norm Mitry, president/CEO of Heritage Valley Health System, Dr. Doyle is described as a dedicated, compassionate practitioner who places his patients’ needs first. His histories and physicals are the “stuff of legend.” Patients frequently praise his methodical and thorough evaluations. His colleagues universally laud him as a keen intellect who continually studied to stay abreast of the latest and best therapies. He is known as the “physician’s physician,” called upon by his peers to help solve medical mysteries.

Dr. Daniel Brooks, vice president of Community Health Services at Heritage Valley Health System, adds, “Dr. Doyle has a voracious approach to maintaining and applying current knowledge in clinical practice and has a lifelong commitment to evidence-based, research-supported medical oncology care. He is the standard bearer for the objective, relentless pursuit of clinical quality.”

“I’ve always thought of myself as a ‘foot soldier’ in the ranks of many far more distinguished colleagues, and this nomination to receive the Richard E. Deitrick Award came as an amazing and wonderful surprise,” said Dr. Doyle. “Reading about Dr. Deitrick’s pleasure in sharing extended time with his patients while engaged in a busy OB-GYN practice, and while serving the community in valued diverse functions, including presidency of the Allegheny County Medical Society, elicits high esteem and respect.”

Ralph C. Wilde Award for Outstanding Physician

Richard L. Simmons, MD, is this year’s 2013 recipient of the Ralph C. Wilde Award for Outstanding Physician. The award recognizes a physician who embodies the characteristics of skill, compassion and dedication to the ideals of the medical profession in their clinical care of patients, as teachers, profession leaders and humanitarians.

Dr. Simmons, who specializes in general and transplantation surgery, graduated in medicine from Boston University in 1959. He served his residency at Columbia Presbyterian Medical Center and served fellowships at Columbia University, American Cancer Society, Massachusetts General Hospital and Harvard Medical School.

Dr. Simmons served in the U.S. Army Medical Corps as an investigator in the Division of Surgery at Walter Reed Army Institute of Research in Washington, D.C., and for a time in 1967, he served as chief of the U.S. Army Surgical Research Team in Vietnam.

Currently, Dr. Simmons is distinguished service professor of surgery at the University of Pittsburgh School of Medicine, where he also is chairman emeritus of the Department of Surgery. He also serves as medical director of UPMC Health System and medical director and chairman of the Institute for Quality and Medical Management. He continues to serve the Department of Surgery as vice chairman of Surgical Research and an adviser and mentor to several research programs.

Dr. Simmons was elected to the Institute of Medicine of the National Academies in 1994. He was chairman of the surgical forum committee of the American College of Surgeons, and in 2001, the organization dedicated the Annual Volume of the Owen H. Wangensteen Surgical Forum to him. He has served as president of the Society of University Surgeons, the American

Continued on Page 72
Society of Transplant Surgeons and the Surgical Infection Society.

Dr. Simmons has trained close to 300 residents. He also has edited or co-authored 15 books and has written or co-authored more than 1,200 articles for professional journals, primarily on transplantation, immunology and surgical infections. The Institute for Scientific Information has awarded him a certificate as a “Highly Cited Researcher.”

Dr. Simmons was awarded the Medawar Prize for lifetime achievement in transplantation by the International Transplantation Society in 2004. In addition, he received the Thomas Starzl prize in Surgery and Immunology from University of Pittsburgh Medical Center in 2005 and a Lifetime Achievement Award from the Society of University Surgeons in 2011.

“Dr. Simmons is an outstanding mentor whose extensive knowledge in transplantation, research and patient safety has changed the medical field,” says Susan Stuart, president and CEO, Center for Organ Recovery and Education. “He is a visionary leader who has greatly improved patient safety and helped develop Pittsburgh into a health care powerhouse by recruiting some of the region’s top medical professionals.”

**Benjamin Rush Community Organization Award**

Aerotech Inc. is the recipient of the 2013 Benjamin Rush Community Organization Award. Established in 1947, this award recognizes a company, institution, organization or agency successfully addressing a community health issue.

Under the direction and leadership of Stephen J. Botos, president and CEO, Aerotech Inc. has made Intraocular Lenses (IOL), artificial lenses implanted in the eye, available to those suffering from cataract-induced blindness. Though adopted in the developed world in the 1970s, IOL availability was not within reach of millions of blind people in the developing world because of a lack of skilled surgeons, inadequate health care distribution systems and the high cost of the lenses imported from Western countries. Cataract blindness, although easily treated and restored, was basically a death sentence for victims in India and beyond.

Aerotech’s involvement with the IOL industry began in 1975. Aerotech and Mr. Botos, who served as CEO and principal mechanical engineer at the time, successfully worked to create the first IOL fabrication machine utilizing Aerotech precision motion technology. As Aerotech’s technologies continued to advance, they were applied to improving the manufacture of state-of-the-art lenses and IOL fabrication. Aerotech’s technology can now produce lenses that can correct astigmatism and require no polishing.

While progress was being made in the United States regarding IOL fabrication, others on the other side of the world were leading a revolution in eye care in the 1970s. Two doctors, Dr. Fred Hollows from Australia, and Dr. Govindappa Venkataswamy (Dr. V) in India, began their careers fighting to get help to victims of infectious eye diseases. From Australia, Dr. Hollows’ efforts took him to other countries including Nepal, where in the late 1980s, he noticed a very high incidence of cataract-induced blindness. Similarly, Dr. V, who established Aravind Hospital in the late 1970s, turned his attention toward the same problem. In the early 1990s, Dr. Hollows established a pioneering fabrication facility in Nepal utilizing Aerotech’s precision motion technology, making IOLs available and affordable.

Dr. V, an ophthalmologist, understood the magnitude of the cataract problem in India. Although nearly 12 million people in India are blind, an estimated 80 percent are curable cases. Although curable, what stood in Dr. V’s way was the cost of the imported IOLs. In 1994, a representative group from Aravind Hospital visited Aerotech. Under the leadership of Mr. Botos, Aerotech was able to make tradeoffs in equipment design to maintain sufficient IOL quality, but dramatically lower the equipment cost of manufacturing IOLs. A relationship was established between India and the United States that continues to this day.

“Steve Botos has shown unbelievable leadership in providing health care for persons living without economic resources,” says Donald Middleton, MD, professor in the Department of Family Medicine and vice president for Residency Education at UPMC St. Margaret. “Under Steve’s guidance, Aerotech has worked to improve vision around the world.”

Ms. Morton is a communications consultant. She can be reached at cmorton@acms.org.
Meet your new president:
Kevin O. Garrett, MD, FACS

Last month, Kevin O. Garrett, MD, officially became the 149th president of Allegheny County Medical Society. Dr. Garrett is no stranger to Pittsburgh. He grew up in Oakdale, Pa., and received his bachelor of science degree in chemistry from Carnegie Mellon University (CMU). He was introduced to the world of medicine when he worked in a hospital lab one summer as an undergraduate. It was that experience that convinced him to enter medical school upon graduation at CMU.

Dr. Garrett earned his medical degree at the University of Pittsburgh School of Medicine in 1987 and served his surgical internship and residency in general surgery at the University of Pittsburgh School of Medicine. Board certified in general surgery, Dr. Garrett practices at UPMC St. Margaret Hospital, where he serves as chairman of surgery. He will transition to UPMC Passavant this month. In addition, he is a clinical professor of general surgery at the University of Pittsburgh School of Medicine.

Dr. Garrett recently talked about the path that led him to becoming a surgeon, his concerns regarding the future of general surgery, his goals as ACMS president, along with an inside look at his family and interests outside of medicine.

Why did you choose general surgery and not a more specific surgical specialty?

I decided to go into general surgery because it was a fairly broad field that provided a lot of emergency and elective surgical opportunities. I spent three years in the research lab intending to stay academic, but I was really drawn to the clinical aspect of the specialty.

In 1995, a clinical general surgery opportunity arose at UPMC St. Margaret. I have been practicing general surgery for 18 years at UPMC St. Margaret. It has been a good place to work for general surgery and still is today. In February, I will transition to UPMC Passavant.

You serve as a clinical professor of general surgery at the University of Pittsburgh School of Medicine. Tell me about your experience as a mentor.

Students and residents keep us vital, and there are exceptional people still going into medicine. It is quite reassuring to those of us who are more mature. They bring new information and perspective, and we as mentors provide valuable expertise and guidance. Teaching and mentoring at the University of Pittsburgh Medical School has been rewarding to me over the years. In addition, I have learned to refine my own thought processes and techniques by teaching them to others.

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You have been extremely active with the American College of Surgeons and the Southwestern Pennsylvania Chapter of the American College of Surgeons over the years, serving in several leadership roles. Tell me the roles in which you have served and the importance of being part of a specialty society.

I have been a member of the American College of Surgeons since 1995, serving as a governor from 2007 to 2013. I have also been active with the Southwestern Pennsylvania Chapter of the American College of Surgeons, serving as treasurer, council member and program chair.

As a governor of the ACS, I attended the annual meetings and participated in the governors meetings. It was during the time when the Affordable Care Act (ACA) was introduced that the ACS developed a rational approach to analyze it and form a response. It was a pretty interesting time.

The ACS also has an online document called “Being Well and Staying Competent.” I contributed to the module about the aging surgeon and how it ties in with workforce issues. One of the things we have seen across the nation is that as general surgeons retire, fewer and fewer surgeons replace them.

We are facing a shortage of physicians overall, but this trend seems to be magnified in primary care and general surgery. Why do you think this is true for general surgery?

There has definitely been a push toward specialities. This has been accelerated by limited resident work hours which has also limited autonomy, making residents feel less confident that they can function independently after five years of clinical training. This has actually been shown in a number of surveys. Specialty training provides additional supervision and a narrower scope of practice. As the population ages, we need competent specialists, but they seem to come at the expense of general surgeons who take night call and keep the emergency rooms open.

The subject of the aging surgeon is a double-edged sword. On one hand, we would like surgeons to continue working to meet the needs of the population. On the other hand, we need to assure that they remain competent, and this has to be individualized.

Why do you think being part of organized medicine is so important?

Workload, specialty organizations and the Internet are powerful competitors for organized medicine, but organized medicine can have influence in areas that affect all physicians. Paradoxically, membership in organized medicine is frustratingly low because too many physicians feel that they have no voice and we need to do a better job of being that voice.

Are there specific goals or issues that you would like to address during your presidency?

We need to do what we can to address workforce shortages. We need new ideas.

We need to drive the evolution of the EMR, not be driven by it. We are currently not the clients of the EMR vendors, and that needs to change.

We need to be more educated about the ACA to anticipate changes better. This is a moving target with executive orders, waivers and general chaos.

These are three issues that are much bigger than ACMS, but they certainly affect us locally and we must work together to address them.

Tell me a little bit about your family.

My wife, Jennifer, is a professional engineer and writer.

My son, Kevin, graduated from New York University with a degree in music production and technology. He is a singer/songwriter in a band called Noble Hunter that has recorded their second CD. Kevin is also a solo performer who does freelance work in the music industry. My daughter, Kelly, is in her first year at PRATT Institute in New York majoring in fine arts. My youngest, Megan, is still in high school. She has talked for many years about being a detective.

What are your interests or hobbies outside of medicine?

I take lessons on an electric bass, so I am an amateur bass player. I am also interested in art. I have taken some art classes that have been offered at Carnegie Museum and have carried on somewhat of an art background. I like to draw and paint, and I also enjoy reading history.

Do you have a final message for the ACMS membership?

Unite around the issues that face all physicians and reach out to nonmembers. Unity is strength.

Ms. Morton is a communications consultant. She can be reached at cmorton@acms.org.

“We need to do what we can to address workforce shortages. We need new ideas.”

Kevin O. Garrett, MD, FACS
Earn up to five hours of CME credit, free.
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The fourth quarter of 2013 was a busy one, with action on several measures of importance to physicians and patients. Following is a summary of some of the highlights.

**Apology bill**

Thanks in large part to physician advocacy, on Oct. 25, 2013, Gov. Tom Corbett signed into law legislation preventing most physician apologies from being used against them in a medical liability lawsuit. Pennsylvania Medical Society members sent more than 1,300 messages to the state legislature in support of this legislation over the course of the two-year campaign. The legislation, now Act 79 of 2013, will protect most physician apologies except for admissions of negligence, which will remain admissible. It removes a barrier to open communication between physicians and patients after a poor outcome, which is essential to maintaining the physician-patient relationship.

The new law does not take any legal right away from injured patients or impair their ability to file a personal injury action against a health care provider should they choose to do so. It also does not limit the amount that a patient can recover in such an action. The bill became effective Dec. 24, 2013. The Pennsylvania Medical Society (PAMED) has put together a short webinar that goes over the nuances of the new law. It can be accessed on the society’s website.

**Controlled substance database**

A bill that would create a controlled substances database, giving physicians better knowledge of prescriptions written for and filled by a patient, is one step closer to becoming law. The House of Representatives passed House Bill 1694 Oct. 21, 2013, by a vote of 191-7. The success was the result of two years of effort by PAMED and its members, who recognize the value such a database would have in reducing doctor-shopping and controlled substance abuse. Our “Pills for Ills, Not Thrills” campaign has played a major role in generating public support for the legislation.

On Nov. 18, Sen. Pat Vance (R-Cumberland) introduced her own version of the legislation, Senate Bill 1180. The bill differs in several respects from the House-passed bill, HB 1694. PAMED is now working to reconcile those differences and get a final product to Gov. Corbett’s desk to make this important tool a reality for Pennsylvania physicians.

**Physician Assistant bills signed into law**

Do you have a physician assistant (PA) with whom you have worked for some time, and who has impressed you with his or her competence? Has your confidence in that PA’s work reached the point where countersigning every one of his or her patient records has become an administrative burden rather than a necessity for patient safety? Could you be more productive, and do you believe patient safety would not be compromised if you were to countersign fewer of your PA’s patient records going forward? If you can answer yes to all of those questions, help is on the way.

On Nov. 27, 2013, Gov. Corbett signed two bills into law that will permit the PA countersignature requirement to be relaxed under appropriate circumstances. The measures, House Bills 1348 and 1351, had the support of PAMED and the Pennsylvania Society of Physician Assistants, and became effective Jan. 26, 2014.

Under the new laws, physicians will continue to be required to countersign 100 percent of PA patient records during the first 12 months of a PA’s practice post-graduation and licensing; during the first 12 months of a PA’s practice in a new specialty; and during the first six months of a PA’s practice in the same specialty under the supervision of a new physician. After that, the PA’s approved physician could choose to review on a regular basis a lesser number of patient records completed by the PA. The physician will...
select patient records for review on the basis of written criteria established by the physician and the PA. The number of patient records reviewed must still be sufficient to assure adequate review of the PA’s scope of practice.

That written agreement would then be submitted to the State Board of Medicine or State Board of Osteopathic Medicine for approval, the final step before the agreement would go into effect. It is important to note that entering into an agreement with your PA to countersign fewer than 100 percent of his or her patient records is purely optional. If a physician wishes to continue to review and countersign all of a PA’s patient records, he or she is free to do so.

However, in appropriate circumstances, physicians now have a way to improve their efficiency and productivity without jeopardizing patient safety. PAMED believes this legislation is a good example of how physician-led, team-based care can be streamlined, ultimately increasing access to care.

Child protection laws strengthened

On Dec. 18, 2013, Gov. Corbett signed into law a 10-bill package strengthening the state’s child abuse laws. The Jerry Sandusky scandal at Penn State University had revealed a number of weaknesses in Pennsylvania’s child protection laws, and caused the General Assembly to establish a Child Protection Task Force to review the state’s existing statutes and recommend changes. The task force, headed by Bucks County District Attorney Dave Heckler, released a 427-page report in November 2012 recommending a wide range of reforms, which found their way into more than 30 House and Senate bills.

While the 10 bills signed into law probably contain the bulk of the changes, there are still a couple more that will likely reach the Governor’s desk early next year. At least one of those will almost certainly have significance for physicians in their role as mandated reporters.

Many of the changes enacted don’t go into effect until Dec. 31, 2014, in order to give mandated reporters and others assigned new responsibilities an opportunity to be trained. The Pennsylvania Medical Society is already at work planning the necessary educational materials for our members. Among the coming changes, the new laws will broaden the range of persons who can be found guilty of child abuse, and significantly lower the threshold for the degree of injury, pain or impairment needed to trigger a report of suspected child abuse. These are important things for physicians, who are mandated reporters, to know.

**Physician Leadership Day held at Capitol**


Two bills that would help build a stronger framework for our health care teams have been introduced by Sen. Judy Schwank (D-Berks) and Rep. Baker. The bills, SB 1083 and HB 1655, propose a Patient-Centered Medical Home Advisory Council at the Department of Public Welfare to help nurture the growth and development of patient-centered care in the Medicaid program.

**Healthy Pennsylvania**

On Sept. 16, 2013, Gov. Corbett announced his Healthy Pennsylvania package of initiatives, and while his take on Medicaid expansion has grabbed all the headlines, the plan contains a number of other pro-physician, pro-patient measures.

Among those proposals, the governor endorsed increased medical student debt forgiveness, a long goal of the Pennsylvania Medical Society. According to a 2012 report, the mean debt for graduates from the class of 2012 was nearly $167,000, not including premedical educational debt, driving many graduates away from primary care to higher-paying specialties. The governor also proposed additional funding to increase the number of in-state primary care residency slots, a move that could help the growth of the physician population in medically underserved areas.

Corbett also publicly announced his support for the establishment of a statewide controlled substance database and the proposed apology law. Not long afterward, the House passed a controlled substance database bill and the legislature enacted the state’s new apology law.

Finally, the governor also announced his advocacy for health care technology and telemedicine. PAMED strongly supports the development of a statewide health information exchange (HIE), and is pleased that the Corbett administration and legislature are moving forward with this initiative.

PAMED will be working aggressively with the governor and legislature over the coming months to advance this positive package of health care measures.
THE NEW WORLD OF HEALTH CARE IS COMPLICATED.
ARE YOU PREPARED?

Allegheny County Medical Society members:

The new world of Health Care ushered in by the Patient Protection and Affordable Care Act (ACA) has created uncertainty and confusion for most people. There are new regulations and requirements. Individual and employer mandates. Penalties for not purchasing coverage. On Exchange and Off Exchange access. As an Allegheny County Medical Society member, you have help.

Talk to USI Affinity, the ACMS’s endorsed insurance broker and partner. Our benefits specialists are experts in Health Care Reform. We can help you choose a health plan that provides the best coverage and value while ensuring you will be in compliance with complex new IRS and Department of Labor regulations. We’ll also provide you the kind of world class service and support you need to make sure you get the most out of your health care benefits after you buy.

You can also check out the NEW Allegheny County Medical Society Insurance Exchange, a convenient and secure online portal where you can find competitively priced insurance coverage for all your needs, including a wide variety of medical and dental plans.

To learn more, contact USI Affinity today!
Call 800.327.1550, or visit the ACMS Insurance Exchange at www.usiaffinityex.com/acms
ACMS selects vendors for quality and value. Contact our Endorsed Vendors for special pricing.

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What does ACMS membership do for me?
Pennsylvania breast density law: ‘What did they do now?’

What happened in Pennsylvania?

On Nov. 1, 2013, Gov. Tom Corbett signed the Breast Density Notification Act (PA Act 86 of 2013), making Pennsylvania the 13th state to pass legislation of this type. Effective Jan. 30, 2014, this law specifically dictates that every Pennsylvania patient who undergoes a mammogram MUST receive notification of their breast density. Medical societies (including the Pennsylvania Radiological Society) raised concerns with our legislators and governor as to what commotion this legislation might create and pointed out that there is currently no mechanism in place to handle the anticipated increase in anxiety that patients would likely experience. In spite of these concerns, the law passed and Pennsylvania physicians are now faced with (yet another) legislated medical practice.

The breast density law’s ‘required’ language

Currently, every patient undergoing a mammogram is required to receive written results, as dictated by the Mammography Quality Standards Act (MQSA) legislation from the 1990s. With the new Pennsylvania breast density legislation, these “results” will be augmented to include specific language about a patient’s breast density. Specifically, the new law requires the following language:

“This notice contains the results of your recent mammogram, including information about breast density. If your mammogram shows that your breast tissue is dense, you should know that dense breast tissue is a common finding and is not abnormal. Statistics show many women could have dense or highly dense breasts. Dense breast tissue can make it harder to find cancer on a mammogram and may be associated with an increased risk of cancer. This information about the result of your mammogram is given to you to raise your awareness and to inform your conversations with your physician. Together, you can decide which screening options are right for you, based on your mammogram results, individual risk factors or physical examination. A report of your results was sent to your physician.”

Several concerns immediately present themselves. Consider the following sentence from this language:

“Dense breast tissue can make it harder to find cancer on a mammogram and may be associated with an increased risk of cancer.”

Of course, this statement is not “new information,” but by emphasizing this to the patient, it is likely to create increased anxiety. The paragraph continues:

“Together [with your physician], you can decide which screening options are right for you…”

This legislated language is clearly putting the onus for further dialogue squarely on the shoulders of physicians and, in most cases, the primary care physician.

Things don’t necessarily end there! Because the breast density law dictates the above language, many mammography facilities will choose to supplement the required language to further explain and calm the recipient patients. The end result? Patients now will receive a significantly lengthier, written explanation than they were previously accustomed to receiving.

What to expect from patients

With all the new additional written information patients will receive, they are likely to have new concerns and a heightened sense of anxiety. Many patients may express greater concern about whether they could have “undetected” breast cancer and may experience “decreased faith” in their screening studies. Since breast density can vary from year to year, some patients may experience panic from this perceived “change from last year.”

Some patients might insist on additional imaging studies, which may not be reimbursed by their insurance carrier. Other patients might experience “avoidance behavior” in regard to
Further imaging studies – either overtly declining or, less consciously, “missing” appointments. The bottom line is that patients are likely to have far more questions and concerns than ever before about their mammogram results and its implications. Combined with the fact that about half of all women over 50 years old have “dense” breasts, this could easily translate into a high volume of unanticipated phone calls and office visits to their physicians to address their concerns.

What should physicians do?

Many physicians might find that they are receiving frequent calls from patients, inquiring about their (“newly identified”) breast density. Patients may ask specific questions about breast density, the implications for breast cancer detection and what other studies are needed. Indeed, some physicians could be inundated with a voluminous number of telephone calls, which they simply do not have the resources to handle.

There is no current consensus on the best way to image women with “dense” breasts. In most cases, no additional imaging studies are required. Other times, Screening Breast Ultrasound, Breast MRI, 3-D Mammography (Tmosynthesis) and/or molecular imaging might be considered. Usually, these additional imaging studies will NOT be reimbursed by the patient’s insurance carrier unless there are other indications besides “dense breasts.”

In navigating the impact of this new legislation, patients are going to require greater empathy, education and patience from their physicians. It might behoove your office to take some proactive steps in anticipation of the fallout from this legislation. A “cheat sheet” or “handout” with useful information for patients about breast density and where to go to learn more (see resource box), is a good first start. Reacquaint yourself with current breast cancer screening guidelines and which imaging studies are appropriate for which patients. Alert your office staff about the required language in the new legislation and educate them about what to anticipate from patients and how to respond. Consider creating a “triage pathway” for how such calls will be handled by your office.

Final thoughts

The Pennsylvania breast density legislation will create new challenges for patients and physicians. In anticipation of the impact from this legislation, physician practices should consider taking proactive steps to be better prepared to manage the likely influx of questions from concerned patients. While a certain “adjustment period” is inevitable, being advocates for our patients is the best way to help this process proceed more smoothly.

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Useful breast density resources

**PA 2013 Act 86** (Breast Density Notification Act)
The recently passed PA law
http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2013&sessInd=0&act=86

**American College of Radiology – Breast Density Patient Brochure**
An excellent 2-page resource about breast density and breast cancer screening
http://www.acr.org/NewsPublications/-/media/180321AF51AF4EA38F-EC091461F5B695.pdf

**Breast Density.Info**
California-based organization with information for patients and physicians
http://www.breastdensity.info/

**Recent Diagnostic Imaging Article “Breast Density Notification Laws Unclear On Delivery and Goal”**
http://www.diagnosticimaging.com/

**American Cancer Society – Breast Cancer Screening Guidelines**
Information for patients and physicians
http://www.cancer.org/healthy/information-for-healthcare-professionals/acsguidelines/breastcancerscreeningguidelines/index

**American College of Radiology Resources for Physicians on Breast Density Notification**
http://www.acr.org/Advocacy/eNews/20131004-Issue/ACR-Offers-Resources-to-Physicians-on-Breast-Density-Notification

**IBIS Breast Cancer Risk Evaluation Tool**
http://www.ems-trials.org/riskevaluator/
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