Ingham County Medical Society

September 2019

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President's Perspective

A, B, C...DTaP?

As students head back to preschool, K-12 classes and even college campuses this fall, now is the time to make sure our patients are fully immunized against vaccine-preventable diseases.

Michigan is among the states with the lowest childhood immunization rates in the nation. As of January 2019, only about half of Michigan two-year-olds were completely immunized with the full recommended pediatric vaccines series, according to the Michigan Care Improvement Registry. As a result, Michigan sees hundreds of cases of whooping cough, mumps, and chickenpox each year, despite the availability of safe and effective vaccines to prevent them. Michigan is also among the 30 states in 2019 to experience the largest measles outbreak in more than 20 years.

In addition to ensuring that younger children are vaccinated according to the routine recommended schedule, now is also the time to make sure your college-aged patients are aware of the importance of full meningococcal vaccination- including two

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President's Perspective continued...

separate vaccines: one for MenACWY plus another for Meningitis B. Meningitis B accounts for nearly 50% of all meningitis cases in persons 17 to 22 years of age and college students are at particular risk because of the communal setting at most colleges and universities. Even when the disease is diagnosed early and adequate treatment is started, 5% to 10% of patients die, typically within 24 to 48 hours after the onset of symptoms. Left untreated, up to 50% of cases may die.

A physician's strong recommendation is the number one predictor in whether a parent accepts vaccines for their child. We need to make sure that we are educating our patients and their parents about this critical way of protecting themselves, their families, their childrens' classmates, and their entire communities.

Visit CDC's website for more information on promoting childhood immunizations.

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Mid-Michigan Annual Endocrine Symposium
September 26-27, 2019
MSU Radiology Auditorium

Join physicians and other allied health professionals in East Lansing next week and earn *12 AMA PRA Category 1 Credits™ in topics encompassing best practices and cutting-edge clinical advances in thyroid cancer and endocrine care.

The event kicks off with the new John Crockett Annual Thyroid Symposium (JCATS) meeting on Thursday morning. The first symposium of its kind to be held in the Lansing area, this meeting is named in recognition of late Doctor Crockett, a senior radiologist at MSU, as well as the area's expert on thyroid ultrasonography.

The JCATS agenda includes updates on US TIRADS and ATA guidelines for thyroid nodules and cancers; diagnosis and surgical referral for hyperparathyroidism; and surgical updates for parathyroid disease.

During the Thursday luncheon, Ved Gossain, MD, ICMS Past President and Emeritus Chair of the MSU Department of Endocrinology, will reflect on the lessons he's learned over his 50 years in practice.

The 36th Annual David Rovner Endocrine Symposium (ADRES) will kick off on Thursday afternoon. Established in 1975, this meeting quickly became a popular local educational event and, in 2017, was named after Doctor Rovner, who founded the meeting, the MSU Endocrinology Division and the first MSU Endocrinology Fellowship Program.

Topics in the afternoon include diabetic emergencies; inpatient endocrine glitches; measuring calcium in the clinic and the hospital; and safety issues on metformin use.

ADRES continues Friday, September 27. The morning agenda includes treatment options for prediabetes; detection of diabetes in the dental office; non-surgical treatment options for obesity; and whether to wait before surgically treating obesity.

Attendees are welcome to attend any or all of the sessions for one fee of $75 (click here to register online). Residents and students are invited to attend at no cost but advance registration (including Thursday lunch) is required for planning purposes.

Click here for the full meeting agenda and more information.

** Michigan State University is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Michigan State University designates this live activity for a maximum of 12 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

MDHHS: Severe Respiratory Pulmonary Disease From E-Cigarette/Vaping

The Michigan Department of Health and Human Services (MDHHS) is currently investigating six cases of severe pulmonary disease associated with e-cigarettes/vaping/dabbing- the age range of the cases is 19-39 years. All cases have been in the Lower Peninsula and most of the individuals have been hospitalized for severe respiratory illness (across 25 states, 215 possible cases of severe respiratory disease associated with e-cigarette/vaping use have been reported through August 27).

As a result, CDC and FDA are working with state partners to investigate all associated cases to determine the etiology of these illnesses. MDHHS has provided this update to all hospital emergency departments, healthcare providers, hospitals, medical examiners, clinics and EMS providers. MDHHS is also requesting that providers report patients with severe pulmonary disease associated with e-cigarettes/vaping/dabbing, with or without THC (tetrahydrocannabinol), to their local public health department.

Clinical presentation: Symptoms experienced by confirmed cases include cough, shortness of breath, chest pain, fatigue, and fever. Other reported symptoms include weight loss, nausea, abdominal pain, and diarrhea. In previously reported cases, symptoms generally worsened over a period of days to weeks before hospital admission. Chest radiographs have shown bilateral opacities (often in the lower lobes) and CT images have shown diffuse ground glass opacities. Some cases have improved with systemic steroids; some required endotracheal intubation (click here for a copy of the CDC's "case classification" criteria).

Management: Currently, it is unknown what is causing and contributing to the symptoms. Infectious etiologies should be ruled out, at a minimum by respiratory viral panel and influenza PCR or rapid test information. Further testing may be indicated e.g., urine antigen for Streptococcus pneumoniae and Legionella, sputum cultures if a productive cough, bronchoalveolar lavage (BAL) cultures if done, blood cultures, fungal tests or culture, or HIV-related opportunistic respiratory infection tests, etc. Aggressive supportive care is warranted, and in severe cases, it is recommended that pulmonary and critical care specialists are consulted.

How Can You Help with Prevention and Investigation Efforts?
Report all patients with severe pulmonary illness associated with use of e cigarettes, vaping devices, or dabbing devices to the *Ingham County Health Department*.

The following information should be reported: patient's name, date of birth (if unknown, age), city/town of residence (or county if known), reporting provider's name, phone number and email.

If available, please collect and hold all devices or substances used, including electronic nicotine delivery systems, vaping or dabbing devices and substances/solutions from the patient so that they can be sent for laboratory testing if requested by public health (if public health determines that the devices or substances should be tested, they will contact you and will handle collections and sending of products to the lab).

We Want to Hear from You!

Sometimes, it is easier to find out about what is going on at the state and national levels than about what is going on locally. And locally is where we live!

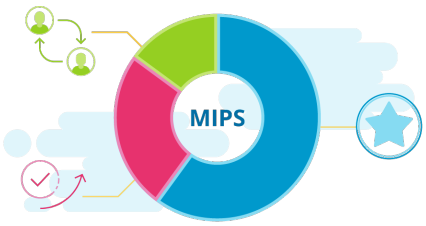
This newsletter is for you about you. Please let us hear from you about what you like and would like to see improved or modified in future editions. Also, please send us your news and opinions, ideas, tidbits, articles or anything that you think might add value to medicina.

Click here to contact us by email or call the ICMS office at 517-336-9019.

Thank you for helping us to make this a more worthwhile resource for you and other physicians in Ingham County!

September 30 Deadline to Submit a MIPS Targeted Review Request

If you participated in the Merit-based Incentive Payment System (MIPS) in 2018, your performance feedback, which includes your MIPS final score and payment adjustment factor(s), are now available for review on the *Quality Payment Program website*. The MIPS payment adjustment you will receive in 2020 is based on your final score. A positive, negative, or neutral payment adjustment will be applied to the Medicare paid amount for covered professional services furnished under the Medicare Physician Fee Schedule in 2020.



If you believe an error has been made in your 2020 MIPS payment adjustment factor(s) calculation, you can request a targeted review until September 30, 2019 at 8:00 PM (EDT).

You may wish to request a targeted review if:

- You feel there are errors or data quality issues for the measures and activities you submitted
- You have eligibility and special status issues (e.g., you fall below the low-volume threshold and should not have received a payment adjustment)
- You feel are being erroneously excluded from the APM participation list and not being scored under the APM scoring standard
- You feel a targeted review is warranted for any other reason (contact the Quality Payment Program directly to determine if you need to submit a targeted review request).

You can access your MIPS final score and performance feedback and request a targeted review by visiting the *Quality Payment Program website*. Log in using your HCQIS Access Roles and Profile System (HARP) credentials (the same credentials that allowed you to submit your MIPS data). Please refer to the QPP Access User Guide for additional details, including if you do not have a HARP account or role.

When evaluating a targeted review request, we may require additional documentation to support the request. If your targeted review request is approved, CMS may update your final score and/or associated payment adjustment (if applicable), as soon as technically feasible. CMS will determine the amount of the upward payment adjustments after the conclusion of the targeted review submission period. Please note that targeted review decisions are final and not eligible for further review.

To learn more about the steps for requesting a targeted review, please review the following:
2018 Targeted Review Fact Sheet
2018 Targeted Review Frequently Asked Questions

If you have questions about your performance feedback or MIPS final score, or whether you should submit a targeted review request, please contact the Quality Payment Program by:

Phone: 1-866-288-8292/TTY: 1-877-715-6222
Email: *QPP@cms.hhs.gov*

Happy September Birthday!

Partha Mookerjee, MD	1	Jatin Rana, MD	13	Elizabeth Paull	21
Edwin Marinas, MD	1	H. McCoy, MD	14	Thomas Morley, MD	25
Homing Yian, MD	2	Jeffrey Kovan, DO	14	Kenneth Stringer, DO	25
Seung Hwan Chung	3	Mark Gugel, DO	14	Erin Sarzynski, MD	25
Walter Baird, MD	5	Heather Laird-Fick, MD	14	Thomas Archambeau, MD	27
Debra Duxbury, MD	5	Craig Lewis, MD	14	Jessica Martin	28
Roberta Zapp, MD	8	Roger Paterson, MD	15	J. Clyde Spencer, MD	30
Subhash Gupta, MD	10	Larry Fitzsimmons, MD	15	Jalal Ahmed, MD	30
Randolph Pearson, MD	10	Marshall Spencer, MD	16	Tannur Oakes	30
I. Zachary Dyme, MD	11	Mark Lebeda, MD	16	Elizabeth Ronchetto	30
James Mayle, MD	11	Kaitlin Herdman	17		
Dana Duren, DO	12	David Rovner, MD	20		
Christopher Foucher, MD	12	Adam Kadri	20		
Ernesto Quiachon, MD	13	John Mitchell, MD	21		
Mohamed Elnabtity, MD	13	Kripa Thakur, MD	21		
Churlsun Han, MD	13	John Shinners	21		

Contact Congress: Stop Surprise Medical Billing of Your Patients

Unanticipated, or surprise, medical bills can arise when patients reasonably believe the care they received would be covered by their health insurer but it was not. Such situations may include when a patient receives care in an emergency from physicians or facilities who have not been contracted by their health insurance company; or when a patient receives scheduled care from an in-network physician at an in-network facility but other participants in the episode of care, whom the patient did not have an opportunity to choose, are not in their insurer's network.

Currently, Congress is considering multiple pieces of legislation that aim to address the issue of surprise billing. There is broad agreement that any legislation should protect patients from the failure of their health insurer to provide an adequate network of physicians. Patients who experience true "surprise bills" should be responsible only for the cost-sharing amounts that would have applied if their provider had been in-network.

While out-of-network physicians are willing to forgo the ability to balance bill patients for amounts not covered by their patient's insurance company, there must be a fair mechanism for settling disputes between physicians and plans over the appropriate payment amount. At no point should negotiated, discounted in-network rates be used as a benchmark to determine fair payment to out-of-network physicians, and at every point commercial data from independent sources should inform the payment standard.

When the minimum payment from the payer for out-of-network care is insufficient, an independent dispute resolution (IDR) process should be developed to determine a fair payment by the health insurance company for the care provided. The IDR should be structured with clear factors that an arbiter, familiar with health care billing, must consider when deciding such as the complexity of the case, the experience of the physician, and the rate that physicians charge for that service in the area.

Such an IDR, or appeals, process was included in legislation adopted by the House Committee on Energy and Commerce. Congress should continue to improve this proposal by requiring the independent third party to consider additional information, such as charge data, when determining the appropriate payment amount.

To ensure that patients are completely protected, benefits should be assigned to the physician or other providers so that they may pursue payment for services provided directly with the insurer without further involving the patient. This is to ensure that games that have been played by insurers, such as making periodic payments directly to the patient, are not allowed and that the patient is fully kept out of the middle.

Congress should ensure that patients are reasonably able to access the benefits their health plans promised when they signed up for coverage. Insurers must also ensure that their provider directories are accurate and up-to-date so patients can make informed decisions about their care.

Key talking points on surprise billing legislation should include:

- Establishing benchmark rates that are fair to all stakeholders in the private market; benchmark rates should include actual local charges as determined through an independent claims database.
- Establishing a fair and independent dispute resolution (IDR) process to resolve disputes about payments from insurers to unaffiliated providers for services rendered out of network to their beneficiaries.
- Protecting patients from out-of-network billing and preserve patient access to hospital-based care by holding insurers accountable for addressing their own contributions to the problem.

Visit the *MSMS Action Center* today to email Congress and ask them to support surprise billing legislation that protects the patient and holds insurers accountable.

Does Trial Lawyer Advertising Pose a Growing Risk to Public Health?

What would you do if you saw a TV ad about a lawsuit against a drug company over a medication prescribed by your physician that you were currently taking? In 2017, the U.S. Chamber Institute for Legal Reform (ILR) asked that question of 1,335 adults—500 of whom were currently taking or had taken one of 12 prescription drugs frequently targeted by personal injury lawyers. Nearly half of the survey respondents said they would definitely or probably stop taking the drug immediately after seeing the ad. When shown an actual TV lawsuit ad about a drug they or a household member had taken, more than half said they would reduce the dosage to below the prescribed amount.

The malignant effects of attorney advertising are significant enough that the American Medical Association (AMA) House of Delegates adopted a policy during its 2016 annual meeting: The AMA would advocate to require warnings in attorney ads, cautioning patients to not stop taking their medicines without discussing it first with their healthcare providers.

Predictably, attorneys have a different view. When interviewed about the AMA's new policy, Philadelphia plaintiffs' lawyer Max Kennerly told Legal Newsline (an ILR publication) that the warnings are unnecessary: "Attorney advertisements are one of the that the public learns about new dangers of drugs and medical devices." Although Mr. Kennerly lists medical malpractice and

(cont)

Trial Lawyer Advertising *continued*

also stated, "I don't know of a single instance of a patient stopping a medication and being hurt because they saw an attorney's advertisement."

Contrary to Mr. Kennerly's statement, ILR's study notes that MedWatch, the U.S. Food and Drug Administration's Safety Information and Adverse Event Reporting Program, received reports that 31 patients quit taking prescribed blood thinners after seeing litigation advertising and then suffered injuries that included stroke, pulmonary embolism, paralysis, and death. These incidents occurred between September 2014 and December 2015. Another 61 reports through December 2016 described patients who had stopped taking blood thinners in response to attorney ads and suffered injuries that included cardiac arrest, stroke, deep vein thrombosis, transient ischemic attack, and death.

In an informational hearing on the subject in June 2017, the U.S. House of Representatives Judiciary Committee heard from practicing physicians whose patients had been negatively affected by attorney advertising—including one moving example of a patient who died because she stopped taking her prescribed anticoagulant after receiving a pamphlet in the mail from a plaintiffs' attorney targeting the medication. The committee also heard from a law professor who explained that much of the drug litigation advertising is funded by so-called "aggregators"—law firms that do not try cases but merely recruit plaintiffs. The aggregators then pass the plaintiffs to other law firms, often in jurisdictions far from the patients and their healthcare providers, where courts and juries are sympathetic to class action plaintiffs. The committee's final witness was a lawyer who counsels other lawyers on their ethical responsibilities. This witness felt that regulation of attorney advertising on drug litigation is unwise and unnecessary.

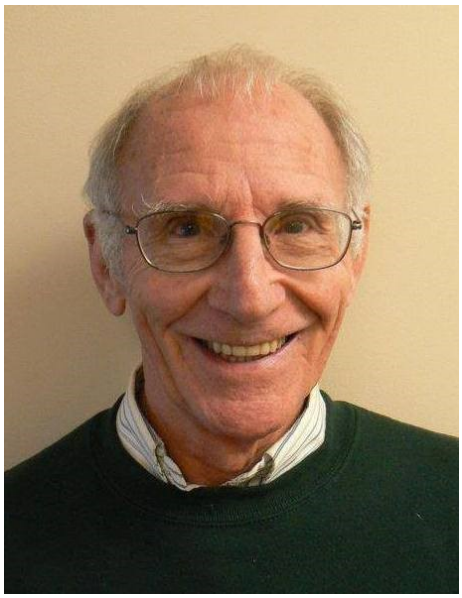
Lawsuit advertising continues to grow. The American Tort Reform Association issues periodic updates on trial lawyer ad spending. While not all of the ads are related to drug litigation, the expenditures are staggering. In the third quarter of 2018, trial lawyers spent $226 million to air ads on local broadcast networks, up $50 million from the second quarter of 2018. That figure includes 23,000 ads in New York City alone, at a cost of nearly $9 million in three months. Those figures do not include local cable, national cable, or national broadcast networks. The ILR estimates that trial lawyer advertising in 2017 amounted to $1 billion nationwide.

Physician advocates continue to grapple with trial lawyer advertising—including concerns that misleading advertising may affect the objectivity of potential jurors—as evidence mounts that deceptive ads hinder a physician's ability to provide effective treatment. Providers may wish to add the pernicious effects of attorney advertising to the factors influencing when and how to assist patients in following their prescribed therapies.

We will continue to monitor legislative developments and advocate on behalf of our members and the medical profession. Look for updates in future issues of *The Doctor's Advocate*.

Keep up to date on bills and regulations we're tracking in your state. Find our interactive Legislative Activity map at thedoctors.com/advocacy.

In Memoriam… Barry Saltman, MD



Long-time ICMS member Barry Saltman, MD, passed away September 9, 2019, at age 83.

Doctor Saltman was born July 5, 1936, in Toledo, OH, to William and Belene Saltman. A 1977 graduate of the MSU College of Human Medicine, he was a practicing physician in Mason, MI, for 30 years. He started the first medical clinic at Cristo Rey and upon retirement started Care Free Medical, based in Lansing.

He is survived by his loving spouse of 42 years, Suzanne Saltman; children, Lisa (Martha) Saltman, Lori (Gregory) Brasic, David (Mary) Saltman, Gaelin (Alex) Simson, and Ben (Lindsay) Hollister; 7 grandchildren; 5 great-grandchildren; brother, Chip (Norva) Saltman; and 2 nieces and 1 nephew. He was preceded in death by his parents and brothers Brad and Byron Saltman.

A celebration of Doctor Saltman's life will be held from 1:00 – 3:00 pm on Monday, September 23, 2019, in the Big 10 Room at the Kellogg Center on Michigan State's campus.

In lieu of flowers, please *donate to Care Free Medical* for the Barry Saltman Patient Fund.