MSDC

January/February 2009 • Vol 16, No 1

NEWSLINE

Published monthly for members of the Medical Society of the District of Columbia

D.C. Court of Appeals Affirms MSDC Position on the District's Peer Review Statute

Late last month, the Medical Society was successful in the D.C. Court of Appeals in defeating a constitutional challenge to the District's long-standing peer review statute. Dr. Blythe had sued MSDC and others regarding a peer review performed by the Society at the request of Greater Southeast Community Hospital. The case was initially heard in D.C. Superior Court where MSDC prevailed on summary judgment. Dr. Blythe appealed and raised three issues.

First, he appealed the trial court ruling denying his motion to compel discovery with respect to the peer review process. Second, Dr. Blythe argued that the trial court abused its discretion in granting the Society's motion to strike the testimony of Dr. Blythe's independent expert. Third, and most importantly, Dr. Blythe argued that the District's peer review statute is unconstitutional. Had Dr. Blythe prevailed on the last point, peer review would have come to an immediate halt at MSDC, professional societies and in District hospitals. This was a very important case for MSDC to defend, and the Society commends the outstanding legal work done by Hartell & Kane. A copy of the judgment is available by contacting MSDC.

PRESIDENT'S LETTER

Doctors Must Band Together as Never Before

Well, 2009 is going to be a pivotal year for medicine. As everyone is aware, health care has finally become a major political issue in American politics. As the economy collapsed, Americans have focused more on the issues and concerns of health care costs and accessibility. Never before has it been more important for doctors to have voice through organized medicine. Without a political voice, the dramatic changes being considered will adversely affect how you practice medicine and how you are able to care for your patients. Several failed models (Medicare, Canadian, Hawaiian, British, Medicaid, Massachusetts, S-CHIP, etc.) are being considered as part of sweeping reforms which will adversely affect the quality and accessibility of health care for generations to come. The goal of dramatic expansion of government run health care, with no reasonable expectation of how to pay for it, puts the entire system at risk. The same old unproven arguments are being used in fantasy projections of how to pay for the health care reforms – elimination of waste, elimination of fraud and abuse, unproven benefits of technology (EMR), pay for performance, best practice parameters, and so on. Legislators brush off the issues of patient safety and quality of care as some propose the dramatic expansion of scope of practice of non-physician providers as a way of providing cheaper health care. Yet, none of the proposals seriously take on the issue of the billions of dollars wasted on the medical liability crisis that strangles medicine. States are cutting Medicaid reimbursements and the federal government wants to cut Medicare reimbursements. These actions will dramatically affect patient care and access of patients to physicians.

How does MSDC & AMA benefit me? Here are some victories (well worth your dues):

- CareFirst battle on FEHBP – MSDC won.
- Medicaid battle – reimbursement rates to double in April 2009
- Medicare battle – average DC physician saved $9500 in 2008, new battle pending in 2009
- Scope of Practice infringements defeated in 2008
- MSDC awarded CMS incentive payment for electronic health records pilot
- Medicare transition problems resolved related to Trailblazers to Highmark conversion
- Limited adverse events reporting to "never events"
- Limited Board of Medicine medical malpractice disclosures

What about the local situation here in DC in 2009?

- Medicare cut of 22% effective January 1, 2010 - on going battle.
- Medicaid budget reductions – in VA proposed cut in reimbursements to providers.
- Legislative proposals in the areas of Occupational Therapy, Polysomnography, Addiction Medicine,

(See BAND TOGETHER, p. 2)

Inside

February Provider Town Hall Meeting

–with–

Dr. Julie Hudman

WHEN: Thursday, February 26, 2009

TIME: 2:00pm – 4:00pm

TOPICS:
1. **PERM** (Payment Error Rate Measurement) and **MIP** (Medicaid Integrity Program) Audits
2. Communication exchange between DHCF and Providers
3. Q & A with key DHCF Staff

WHERE: Mary's Center for Maternal and Child Care
2355 Ontario Road, NW
(Bright Pink Building)

RSVP: Please contact Adrienne Cooper at:
(202) 442-9050
adrienne.cooper@dc.gov

There is ample meter parking.
Should you choose to park in a garage,
Colonial Parking, located at 18th Street
(in the heart of Adams Morgan) is two streets away.

http://www.ecolonial.com/location.pl?location=462

(BAND TOGETHER, from p. 1)

Psychology, Dentistry, Podiatry, Massage Therapy, Nursing, Naturopathic Medicine – most of which deal with the expansion of scope of practice.

I encourage all of you to hit the MSDC Web site www.msdc.org or contact MSDC and see what is going on. It will be both enlightening and shocking. Health care reform is essential and important. But it must be done properly and with the full input of physicians. Yet, many in the halls of power believe that a health care revolution done by Congressional staffers, Councilmember staffers, government bureaucrats, non-physician providers, and think tank gurus — all of whom have never treated a single patient, know more than those who have been treating patients for an entire career.

More than ever, organized medicine needs you as much as you need it. Without members and membership dollars, our effectiveness is diminished. We all have financial concerns, but your dues payment is one very critical and important bill that should not end up in the office budget cutting bin! I assure you, groups that want to control how you practice, what you charge, access to care, and the quality of care you provide your patients are going to mount a full assault on the practice of medicine and we all better be prepared. There is no more important time than right now. The fate of medicine is honestly in your hands. If we all don't join together, and support our society, medicine will change in ways you may not even imagine.

Your dues are a critically important first step. For those interested, please get involved, stay in touch by email or on the MSDC Web site, join a committee, or join the Board. Use you voice before you lose it completely.

Peter E. Lavine, M.D.
President

New Money-saving Member Benefit for MSDC Members Insured by ProAssurance National!

Your membership in the MSDC rewards you with dollar savings wherever possible. To that end, MSDC has negotiated a NEW immediate savings for you, as well as a potentially substantial savings in the year to come.

MSDC negotiated a $50 immediate loss prevention seminar fee savings for you when, as an MSDC member, you attend any of the 2009 seminars. So, for only $50, you get the benefit of solid risk management information, 2.0 hours of CME credit, and—potentially—up to 5% premium credit off your professional liability premium for full attendance. MSDC's corporate partner for coverage is ProAssurance National Capital Insurance Company (formerly named NCRIC, Inc.). Please watch your mail for a brochure listing upcoming loss prevention seminars!

MSDC and AMA Win Legal Victory for Physicians in Privacy Court Case

Physicians have won a major victory for preserving their privacy in the recent ruling by the D.C. Circuit of the United States Court of Appeals. Consumers' Checkbook, a non-profit organization that provides information to consumers, had filed a suit to require the Department of Health and Human Services to publicly disclose records of individual physician Medicare payments. The group alleged that this information would allow patients to make more informed decisions about the qualifications of individual physicians based on how often they provided particular medical services to Medicare patients.

Believing that public disclosure and use of this information could be misleading, the American Medical Association (AMA) and the Medical Society of the District of Columbia successfully fought to protect patients and preserve physician privacy. The court found that physicians have a significant right to privacy, and there is no public interest in the disclosure Consumers' Checkbook sought. The court clearly found that the release of personal physician payment data does not meet the standard of the Freedom of Information Act, which is to provide the public with information on how the government operates.

Every physician who works with Medicare will benefit from the MSDC/AMA legal victory to preserve physicians' privacy and protect patients and the general public from potentially misleading information. MSDC and the AMA continue to make good on our commitment to help physicians, through advocacy, focus on what they do best—care for patients.

Early Career Physicians Agree to Goals for a Young Physicians' Section

On January 29th, 2009, six young DC physicians, of diverse specialties, *Doctors Hind Benjelloun, Kayla Pope, Adair Parr, Christian Shults, Janine Van Lancker, and Elisabeth Wells* met with three former MSDC Presidents, Doctors Daniel Ein, Victor Freeman and Eliot Sorel to explore the notion of *reviving the MSDC Young Physicians' Section*.

After brief introductions and an overview of MSDC's history by Dr. Sorel, the group plunged into the core of the agenda, identified and discussed the following start up priorities for a *revived MSDC YPS*:

- communications-listserve ASAP
- policy, legislative advocacy
- career & leadership guidance/mentoring
- financing of YPS activities
- social & professional networking
- annual social gathering of all Residents, Fellows and Young Practicing Physicians
- fostering MSDC, AMA collaboratives

The upcoming *AMA National Advocacy Day in Washington this March*, an *educational program on health policy in May* and a possible gathering of all DC Residents and Fellows later this year were discussed. The group, with assistance from MSDC and the AMA Residents & Fellows Section will develop a data base on all young physicians in DC. All young physicians are invited to join the MSDC YPS and help us help you enhance your professional career. If you are interested in health policy, career development, networking or advocacy, this is the section for you. Please contact Barbara Allen at allen@msdc.org for further details.

DC Council Begins New Year with a Flurry of Health Related Legislation

The Council of the District of Columbia re-convened in early January and took up where it left off in 2008. Last year, a number of changes were proposed to the Health Occupations Act, but were lumped together in an omnibus bill. At the direction of David Catania, Chairman of the Council's Committee on Health, the legislation was divided up into 10 separate bills, all of which were introduced in January. Hearings on all 10 bills were heard in late January and early February, and at press time, the bills are awaiting mark-up later this month before going to the full Council. MSDC submitted comments on two of the ten bills, one having to do with polysomnography and the other related to the scope of practice for podiatrists (see related article). Copies of all legislation, health-related and otherwise, are available by contacting MSDC.

MSDC to File Amicus Brief Protecting Role of Expert Witnesses in Malpractice Cases

Late last month, the District of Columbia Court of Appeals handed down a troublesome verdict in a medical liability case. Originally decided in favor of the defendant physicians, the plaintiff had alleged that several physicians were negligent in diagnosing and treating her breast cancer. The plaintiff appealed to the Court of Appeals which handed down a 56-page verdict in favor of the plaintiff/ appellee. It is that verdict that is being appealed by the defendant physicians. MSDC will be filing an Amicus brief later this month as the Court of Appeals verdict threatens expert witness testimony in medical malpractice cases. What the court ruled was that, in this case, a plaintiff's expert witness could state what the standard of care was without offering an opinion that the standard was actually breached. The Court ruled that the jury could then determine whether or not the standard was breached. The decision reads in part "…whether there was a breach in the standard of care, was an issue the jury was competent to handle without the need for expert witness that went beyond what the expert offered in her deposition…" Copies of the Appeals Court verdict and the MSDC Amicus brief are available by contacting MSDC.

MSDC MARKETPLACE

Downtown: Premier medical office space in a premier building, 2141 K. St, NW Washington DC. 4000 square foot, new, beautifully decorated office space available for sublet five days a week. Large offices, exam rooms, waiting area. Mini-Ct for sinuses. Beautiful furniture, paintings, fish tank, the works. Reasonable rent. Call 301-718-7979 or fax to 301-718-7747

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2440 M Street, NW - Medical Building: I have a newly renovated 3000 square foot office space, configured to share with two additional physicians. My internal medicine boutique practice will be state of the art, with electronic medical records/electronic practice management/electronic prescriptions, digital chest x-ray, interpretive EKG, etc. Parking available in the building. Contact Charles J. Bier, M.D., (W) 202-333-7003, (M) 202-498-0731, or e-mail: drbier@bigplanet.com.

Check out all classified ads at: http://www.msdc.org. Click on Classified Ads.

Would you like to place an ad? Contact Barbara Allen for details, e-mail allen@msdc.org, phone 202-466-1800, ext. 103. MSDC members may post ads at no charge!

Society Continues to Address Physician Drug Dependence Issues

By Peter Cohen, M.D. Chair, MSDC Physician Health Committee

Drug dependence, a disease that afflicts all members of society, does not spare physicians. The Physician Health Committee of the Medical Society of the District of Columbia (PHC) plays an important role in assisting physicians who suffer from this illness. The PHC's role in intervention, monitoring, and advocacy, is vital both for public welfare and physician health. Education of the general public and medical community is an integral component of the PHC's activities.

Members of the PHC are available for "outreach" programs aimed at individual practitioners, hospitals, medical staffs, credentialing committees, medical negligence carriers, and the general public. We hope that all affected (and potentially affected) groups will take advantage of this important mission. In discussing drug dependence, we stress several significant facts.

Drug dependence in health care professionals is not new! More than a century ago, for example, Professor William Osler chronicled, in his *Inner History of the Johns Hopkins Hospital*, his observations of and concerns for his friend, Professor William Stewart Halstead; this excellent description of an opiate-addicted physician, recorded in a small locked black book that was not even opened until 1969, is classic, yet rarely taught to students of medicine:[1]

> The proneness to seclusion, the slight peculiarities amounting to eccentricities at times (which to his old friends in New York seemed more strange than to us) were the only outward traces of the daily battle through which this brave fellow lived for years. When we recommended him as full surgeon to the hospital in 1890, I believed, and Welch did too, that he was no longer addicted to morphia. He had worked so well and so energetically that it did not seem possible that he could take the drug and done so much.
>
> About six months after the full position had been given, I saw him in severe chills, and this was the first information I had that he was still taking morphia. Subsequently, I had many talks about it and gained his full confidence. He had never been able to reduce the amount to less than three grains daily; on this, he could do his work comfortably and maintain his excellent physical vigor (for he was a very muscular fellow). I do not think anyone suspected him, not even Welch.

Drug dependence is a *disease* and not a *moral failing*. As with other diseases, it has specific diagnostic criteria: Although science has not elucidated the mechanism(s) of every disease, the molecular biology of drug dependence is beginning to be understood.[2]

Criteria for Substance Dependence[3]

Substance dependence is a syndrome characterized by a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period (note that tolerance and symptoms of physical withdrawal are not necessary to make the diagnosis):

1. Tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or
   (b) markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance, or
   (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. Substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance…, use the substance…, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Finally, regardless of one's eventual mind-set, the following quotation is useful:[4]

> If we reject all cases of affliction which the improvidence of human beings has brought upon themselves, there will be but little room left for the exercise of mutual love and charity. God alone punishes. We, as we best can, must relieve. Neither must we be too curious in respect to causes and motives, nor too vexatious in our censorship. Hence I will state what I have observed and tried in the disease in question; and that not with the view of making men's minds more immoral, but for the sake of making their bodies sounder. This is the business of the physician.

If you are interested in learning more about the disease of drug dependence and the availability of the PHC to help you, your colleagues, and the public, please contact Barbara Allen at 202/466-1800, extension 103.

[1] C. DOUGLAS TALBOTT, KARL V. GALLEGOS, DANIEL H. ANGRES, *Impairment and Recovery in Physicians and Other Health Professionals,* in PRINCIPLES OF ADDICTION MEDICINE 1263, 1264 (Allan W. Graham and Terry K. Schultz, Editors, Second Edition, American Society of Addiction Medicine, Chevy Chase, MD, 1998).

[2] See, e.g., Edythe D. London, *et al., Morphine-Induced Metabolic Changes in Human Brain. Studies With Positron Emission Tomography and [Fluorine 18]-Fluorodeoxy-glucose,* 47 Arch. Gen. Psychiat. 73 (1990); Nora D. Volkow,

*(See **DEPENDENCE**, p. 6)*

Medical Society Opposes Inappropriate Expansion in the Scope of Practice for Podiatrists

Earlier this year, Councilmember David Catania introduced B18-0037, the Practice of Podiatry Amendment Act of 2009. The legislation proposes to amend the definition of the practice of podiatry as follows: "Practice of podiatry means to diagnose or surgically, medically, or mechanically treat, with or without compensation, the human foot or ankle, the anatomical structures that attach to the human foot, or the soft tissue below the mid-calf." The Medical Society has indicated to the Council that this legislation will put patients at risk. In a letter to members of the Committee on Health, MSDC wrote in part, "While the Medical Society is supportive of the vast majority of the changes contained in the 10 pieces of legislation currently before the Committee on Health, B18-0037, the Practice of Podiatry Amendment Act of 2009, will end up causing more harm than good, and therefore we oppose its passage. You have been a champion of patient safety – most recently in the area of adverse events reporting; but rather than enhancing patient safety, B18-0037 will needlessly put patients at risk. The procedures that would be allowed under the proposed legislation are complex and invasive ones currently performed by medical doctors, orthopaedic surgeons." Joining MSDC in opposition to the legislation is the American College of Surgeons and the American Academy of Orthopedic Surgeons. Copies of the Society comments and the legislation are posted on the Society web site.

(DEPENDENCE, from p. 5)

et al., Long-term Frontal Brain Metabolic Changes in Cocaine Abusers, 11 Synapse 184 (1992); Nora D. Volkow, *et al., Brain Glucose Metabolism in Chronic Marijuana Users at Baseline and During Marijuana Intoxication, 67 Psychiat. Research and Neuroimaging* 29 (1996).

[3] *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.* (Washington, DC: American Psychiatric Association, 1994).

[4] In his review of Darrel W. Amundsen, *Medicine, Society, and Faith in the Ancient and Medieval Worlds,* Johns Hopkins University Press, Baltimore, 1996 (Eric J. Cassell, 336 New Engl. J. Med. 883 (1997)), Cassell called attention to Amundsen's final chapter—The Moral Stance of the Earliest Syphilographers—quoting Thomas Sydenham's reply, in 1673, to those who believed that syphilis should not be treated, in order to frighten the unchaste or punish the afflicted.

2009 Medicare Physician Payment Rates: What to Expect in Your Practice

Factors Affecting 2009 Rates

In July 2008, the U.S. Congress passed a law that provided an average 1.1 percent increase in Medicare physician payment rates for 2009. This payment update is far from the only change affecting 2009 rates, however. Payment changes will vary by service, specialty and locality based on the following factors:

- The **1.1 percent update** is an across-the-board increase from the 2008 payment rates that applies to all Medicare physician payment schedule services. It does not apply to physician-administered drugs or clinical laboratory fee schedule services.
- This year will be the third year of a four-year transition to **revised practice expense relative value units**.
- Updates to the **geographic adjustment factors or GPCIs** for 2008 were phased in over two years, so additional changes in the GPCIs are occurring in 2009. In addition, the Medicare Improvements for Patients and Providers Act (MIPPA) that passed last July continued the floor of 1.00 on the physician work GPCI for 2009.
- The **budget neutrality adjustment** that was applied in 2007 and 2008 has been moved from the work relative values to the conversion factor for 2009. This has the effect of increasing payment rates for many services and decreasing rates for some services, and the change was strongly supported by organized medicine. Although the elimination of the work adjustment factor leads to a numerical reduction in the Medicare conversion factor, however, it does not reduce average payment rates as it is a budget neutral change.
- Some services will have revised **relative value units for physician work** based on a review of misvalued services.
- **Some services have been added to those that are subject to imaging payment cuts** stemming from the Deficit Reduction Act of 2005 which limits payments to no more than the comparable payment in hospital outpatient departments.

The combined impact of these various payment changes on your practice depends on your specialty, location and service mix. When all of the changes are averaged out across all physicians, most physicians will see a net increase in their Medicare rates, but some will see net decreases. Many other payers as well as Medicare Advantage plans link their rates to the Medicare rates, so payment impacts from the Medicare changes will likely be magnified. *(From the American Medical Association)*

MSDC
NEWSLINE
Published monthly for members of the Medical Society of the District of Columbia

MSDC Newsline is published by the Medical Society of the District of Columbia.

202-466-1800 (phone)
202-452-1542 (fax)

Editor:
K. Edward Shanbacker

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Medical Office Help Recently Trained

Founded over 12 years ago, the Training Futures office skills program added a medical terminology/billing and coding component in 2005 and has since been instrumental in filling almost 200 medical office positions in the region. Qualified low-income individuals test into the six-month program and come away with skills in all aspects of Microsoft Office, customer service, filing, business math and medical office instruction.

In partnership with Northern Virginia Community College, the Training Futures curriculum provides up to 17 college credits for trainees, some for whom college has only been a dream. NVCC's medical education faculty delivers 35 hours of health care sector training during the first few months of core Training Futures' training. The sessions include medical terminology, HIPAA confidentiality standards, and an introduction to health care information technology, insurance billing and coding.

Following their core training, trainees are sent on three-week internships to local hospitals, doctors' offices and organizations. Internships give trainees the opportunity to gain valuable office experience, while allowing employers to test out potential new hires at no risk. When the current group of trainees graduate on Feb. 5, 2009, they will be prepared for a variety of entry-level administrative jobs, such as receptionists, billing/accounting clerks, administrative assistants, customer service/patient services representatives and medical records/file clerks, in health care and elsewhere.

Participating health care employers can participate in program activities by hosting free trained interns for three-week temporary assignments or by participating in job fairs to pre-screen up to 50 candidates for open positions in one morning. To find out more about Training Futures, please call 703-448-1630 or visit the Northern Virginia Family Service website at www.nvfs.org and click on the Job Training link. Graduates' resumes are available on the website for your review at **http://www.nvfs.org/trainingfutures_resumes/**.

Professional & Occupational Licenses – A Clarification

Recently, the District government sent out invoices for Basic Business Licenses. It is important to note that if you have a current District of Columbia medical license, you are not subject to the requirement for a basic business license.