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Spring 2015

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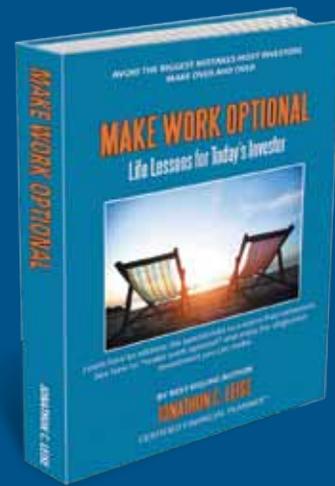
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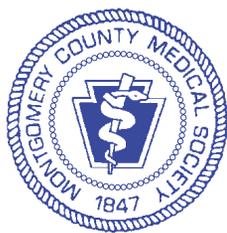
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MCMS Physician is a publication of the Montgomery County Medical Society of Pennsylvania (MCMS). The Montgomery County Medical Society's mission has evolved to represent and serve all physicians of Montgomery County and their patients in order to preserve the doctor-patient relationship, maintain safe and quality care, advance the practice of medicine and enhance the role of medicine and healthcare within the community, Montgomery County and Pennsylvania.



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The Healthcare Buffet

Is There Enough Food to Feed the Masses?



On a recent red-eye flight from San Francisco to Philadelphia, I heard the question that I dread hearing every time I fly: “Is there a doctor on the plane?” I responded and was faced with a 45-year-old woman who was having a “spell.” I could not detect anything obviously wrong before the pilot asked whether he should divert the plane to Chicago. . . . Fortunately, the patient improved on her own, and we were able to continue the flight as planned.

This example raises a situation that physicians are being asked to address more and more. How do we balance the needs of the individual patient vs. the needs of society at large? In many cases, the issue is being addressed for us by insurance companies as they restrict our use of procedures and force us to use certain drugs that they can obtain more cheaply. Given this environment, we must ask: What is our responsibility to our patient? How much responsibility should the physician bear in terms of cutting costs?

A Balancing Act

Physicians face a great conflict in medicine when trying to manage the needs of the individual vs. the needs of the population. Should we sacrifice care to the individual so that more care is available for others? I have often used the analogy that healthcare is like an all-you-can-eat buffet, but with a limited supply of food. The people at the front of the line want all they can eat. However, if they get all they can eat, there will be no food left for the people at the back of the line. Alternatively, if the restaurant restricts food to the people in the front of the line so that people in the back of the line will have food, it no longer is an all-you-can-eat buffet. Obamacare has complicated the matter further by inviting more people to stand in line in the restaurant, without making provisions for more food with which to feed them.

So what can be done? First, we need to get more “food.” We as a society need to make the profession more attractive. Meaningful use, MOC, ICD 10, SGR, etc. — all serve to do the opposite. They damage physician morale, cause early retirements, and take time away from helping patients. I am not clear what bureaucratic process they serve, but they do not help physicians to take better care of our patients. Second, we need to change patient expectations. We need to stop advertising that healthcare is an “all-you-can-eat-buffet”. Pharmaceutical, hospital, and legal ads all suggest that patients will or should have wonderful outcomes. Anything less implies a mistake. These ads tend to ignore the costs and other realities of the situation. Medical care cannot solve all problems, for all people, all of the time, and someone has to foot the bill.

Patient Satisfaction: Real or Fiction?

I define patient satisfaction as what happens when reality meets or exceeds patient expectations. With the societal expectation of all you can eat and the reality of a limited food supply, how can we ever hope to satisfy all of our patients? Furthermore, people at the front and the back of the line have different expectations. We can't have it both ways, and society as a whole must make a decision. As we move towards population medicine, it must be explained to the public that healthcare can no longer be “all you can eat.”

As physicians are being asked more and more to practice population medicine, I would argue that we need to remain cognizant of our primary responsibility to the individual patient who sits in front of us. It is unrealistic to expect physicians to serve two masters. That does not mean that we should not cut costs where we can, but ultimately it is the individual patient to whom we owe our allegiance. ■

Mark Lopatin, MD

Chairman, Montgomery County Medical Society

www.montmedsoc.com

I would love to hear from you. If you have suggestions, general comments or ideas for future issues, please email Mark Lopatin, MD, or the MCMS Executive Director Toyca Williams, montmedsoc@verizon.net.



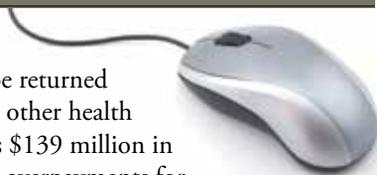
Feature

Obtaining Your Mcare Refund

Website Explains Process for Obtaining Your Mcare Refund

www.McareRefund.org

Last fall's Mcare settlement requires that \$200 million be returned to physicians, hospitals, and other health care providers. This includes \$139 million in refunds for prior assessment overpayments for 2009, 2010, 2011, 2012, and 2014.



- Who is eligible to receive refunds?
- How are refunds calculated?
- Are physicians required to remit their refund to another person or entity that paid the assessment, such as a medical practice or hospital?
- What should physicians and medical practices do over the next few months to protect their interests?

These are some of the questions the Pennsylvania Medical Society (PAMED) answers in a new website, www.McareRefund.org, which debuted April 1.

The first round of refund checks are tentatively scheduled to be sent to physicians in the first quarter of 2016.

To ensure that they make informed decisions and receive payment of refunds that they are entitled to keep, physicians need to understand several possible scenarios and actions that could arise from those situations.

For example, a person or entity that paid the assessment for the physician may make a claim on that refund. The claim period has started and runs through Aug. 19. Physicians will be notified of a claim through the mail – tentatively scheduled for the fall of 2015 – and will be directed to a website where they must choose whether a claimed refund should be paid to them or have Mcare pay the claimant.

A person or entity that paid your assessment also may ask you to fill out an assignment agreement if it did not make a claim on the refund. . . . required forms from Mcare. The assignment agreement forms is now available on the Mcare web site.

The www.McareRefund.org website that PAMED created is designed to give physicians and medical practices the proper information to help them understand these scenarios and make the best decision.

PAMED also has a webinar on www.McareRefund.org that provides an overview of the Mcare refund process. ■

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One Thing Certain in Healthcare – Change It's Up to You to Shape It



Jay Rothkopf, MD
Editor

It's hard to believe. No, not that spring is finally here (although I'm sure I'm not alone in thanking God that it is), but that 2015 is a third of the way done. It sounds cliché—the passing of time and all that—but time does pass, and with it comes change. And there can be no doubt, more change is upon us. It's a familiar theme, and one that continues to define the practice of medicine.

Team-based care. It's the wave of the future, but how should teams be run, and more importantly, who should lead them? In multiple states, legislatures have chosen to grant certified registered nurse practitioners (CRNP) the right to see patients without physician collaboration, and now Pennsylvania stands ready to join them. Many arguments exist both for and against, but the question remains—is this the solution that is best for our patients? Our cover story this issue takes a balanced look at both the benefits and risks of an expanded scope of practice. It's a difficult subject, but one that deserves a rigorous debate.

Next, we take a look at the problem of accumulating debt. Many physicians begin their careers saddled not only with student loans, but additional expenses, both business and personal. In an original article directed toward young physicians, contributing author Dr. Carl Manstein shares his thoughts on the management of debt, and how to avoid several common pitfalls.

Being sued for malpractice is both stressful and frightening, not to mention physically and emotionally draining. The PHP program, administered through the Foundation of the Pennsylvania Medical Society, has the resources to help you through it. Many physicians have benefitted from PHP, and it's important to know that you're not alone.

Physician employment by hospitals and healthsystems is becoming more common, not only in our state but across the U.S., and with it, new challenges have arisen. In this issue, we explore the resources available through PAMED to help employed physicians not only maintain their autonomy, but also to advocate for their patients without fear of reprisal, or losing the relationship upon change of circumstance.

June is fast approaching, and with it, our Annual Dinner, where we will honor 11 members who've been in practice for

50 years. We then profile Dr. William Lander, a MCMS board member who has practiced for more than 60 years, and one of only two board members to date who have served as president of the Pennsylvania Medical Society. We also recognize physicians who have practiced 25 and 10 years. Our own MCMS President Dr. James W. Thomas has reached his 25th year of practicing medicine. Congratulations to all those who have reached these important professional milestones.

We then turn to an issue that has garnered a great deal of attention: vaccinations. With feared diseases such as measles making a return, it is more important than ever to educate the public. Dr. Steven Shapiro, a long-practicing pediatrician with Abington Health, discusses the importance of receiving vaccines. This is vital to not only protecting our children, but the community as a whole, and we hope you find it a worthwhile read.

Other features include the profile of three Abington neurologists who are using the latest technology to increase practice revenue, a feature on coding and documentation, a few tips to get through a sometimes challenging allergy season and an update on meaningful use attestation. Finally, we end with a political update, a welcome to new members, and a farewell to ones we have lost.

It's another full issue, but that's the way we like it. As always, I want to point out that this publication is for our readers, and we welcome contributions from our community. If you have something you'd like to say, let us know, and we'll work with you to make it happen. If there's something you'd like to see us discuss, same rule applies—drop us a line, and we'll do our best.

They say spring is a time of renewal, of change. I agree, but it's up to us to shape that change, to help steer events where we'd like them to go. We might not always be successful, but we should never give up.

Let's get to it. ■

Enjoy your spring,

Jay Rothkopf, MD
Editor



Coping with Malpractice Litigation

The phone rings in the middle of the night. Mark Lopatin, MD, has to decide whether to tell a frail, 79-year-old patient with Parkinson's disease complaining of a fever whether to stay in bed, take Tylenol and drink plenty of fluids, or venture out into the cold night to his local emergency room. The decision should be easy, but Dr. Lopatin, who has dealt with malpractice litigation, says it is not.

Six out of every 10 physicians practicing today have been sued for malpractice at least once, according to the Foundation of the Pennsylvania Medical Society's Physicians' Health Programs (PHP). "The effects of malpractice on the individual should be taken seriously," says Medical Director Jon Shapiro, MD. "As physicians, it represents a major area of stress, because we so often link who we are to what we do."



Kathleen Chanler, a principal in Post & Schell's Professional Liability Practice Group in Philadelphia, agrees. "When a physician is named personally as a defendant in a malpractice suit, it's often a difficult experience for them," she says. "Physicians enter the profession for altruistic reasons, and then find themselves entrenched in an adversarial litigation process that involves lawyers, depositions, and courtrooms, which ultimately takes them away from time with their patients."

According to the PHP, a malpractice suit is business to many lawyers and judges—just part of their jobs. To the physician, a medical liability suit questions his or her professional competence. The outcome of the suit can affect the physician's self-esteem and his or her standing among colleagues and in the community. Judges with numerous cases on the docket and attorneys who participate in multiple malpractice cases can afford a certain detachment, but it contrasts sharply with how the physician is affected.

"If you are facing the litigation process, you can turn to the PHP for information and support," says Dr. Shapiro. "PHP staff are available by telephone to discuss your feelings on the case, refer you to someone who can give you more information about the legal system, and help you gain a better perspective on the claim or suit.

"Adaptive strategies can keep the suit from becoming a catastrophe," Dr. Shapiro adds. "It helps to be able to talk to someone who has endured a common experience to realize you are not alone. That's the benefit of organized medicine." Dr. Lopatin, like most physicians, has faced malpractice litigation. He said the legal battle was traumatic. "My career and my license were at stake," he says. "Counseling was key to getting through the experience. I've learned that the sun will come up the next day, and it is up to me as to how I will receive it."

Joining PAMED and getting involved with advocacy efforts regarding malpractice reform helped Dr. Lopatin feel like he was taking back some control. His participation as chair of the Montgomery County Medical Legal Committee provided him with further understanding of how the legal system works.

As for Dr. Lopatin's patient who called in the middle of the night? He stayed warm in bed and felt better by morning—a testament to the physician's initial instincts. "I like to use this example when discussing how defensive medicine impacts decision-making, because the patient is actually my father," Dr. Lopatin says. "Had he not been a close relative, I absolutely would have sent the patient to the emergency room."

More work needs to be done to address the political intricacies of malpractice liability in Pennsylvania. "In the meantime, it's important to remember that PHP can help physicians learn to deal with the anxiety and ultimately survive the pressure by turning the negative stresses of a lawsuit in a positive direction," Dr. Shapiro says.

The Foundation of the Pennsylvania Medical Society provides programs and services for individual physicians and others that improve the well-being of Pennsylvanians and sustain the future of medicine. Visit the Foundation at www.foundationpamedsoc.org. ■

For counseling or referral service, call the Physicians' Health Programs toll-free at (800) 228-7823 or email php-foundation@pamedsoc.org.

The Most Effective Approach to Patient Care...

TEAM-BASED CARE

BY JAY ROTHKOPE, MD, EDITOR

20 STATES ALLOW CRNPs TO PRACTICE INDEPENDENTLY



Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Iowa, Maine, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington, and Wyoming

(Source: American Association of Nurse Practitioners)

With full implementation of the Affordable Care Act (ACA), millions of previously uninsured Americans stand to gain coverage and are expected to utilize healthcare services. This new level of engagement poses significant challenges, not the least of which is access. One of the solutions being proposed in numerous states across the nation involves granting certified registered nurse practitioners (CRNPs) the right to treat patients autonomously, without physician oversight. In Pennsylvania, proposed legislation by State Sen. Pat Vance (D-Cumberland), would allow for the severing of collaborative agreements between physicians and CRNPs. It's an issue that has stoked strong passions on both sides, leading to a vigorous and ongoing debate. Arguments continue to be made for and against, but one thing is certain: the influx of new patients will continue to drive changes in how doctors and nurses provide care.

So how best to solve this problem? The suggestions are myriad and vary, and attempting to discuss them all is beyond the scope of this article. Instead, several common themes—among them training, access, cost, patient satisfaction, malpractice, and collaboration—will serve as the basis for discussion.

MEDICAL EXPERTISE	Primary Care Physician	Nurse Practitioner	Nurse Anesthetist	Optometrist	Psychologist
Length of Graduate Education	4 years	2-4 years	2-3 years	4 years	4-6 years
Years of Residency and/or Fellowship	3-7 years	NA	NA	Not required	1 year
Total Patient Care Hours Required Through Training	12,000-16,000 Hours	500-700 Hours	500-720 Hours	1 year Clinical Rotations	1 year Clinical Rotations

Information compiled by the Pennsylvania Medical Society, Pennsylvania Physician, Winter 2015

Training and Patient Safety

One of the arguments often made by CRNP leadership is equating their skill set and competency with that of physicians. While all can agree that nurse practitioners are highly educated and qualified individuals, the breadth of their training and experience diverges from physicians in both duration and scope. To obtain an MD or DO degree, one must first complete four years of undergraduate education, followed by admission to a medical school for four more years of both clinical and non-clinical post-graduate coursework. This is then followed by three to as much as seven years of residency, and for some, an additional one to three years of fellowship. In total, a newly minted attending physician has completed a minimum of 12,000-16,000 hours of supervised patient-care training.

In contrast, CRNPs receive two to four years of graduate level education, followed by 500-720 hours of patient-care training. Although this provides a strong foundation and broad scope, as the numbers bear out, it does not equal the rigorous curriculum completed by physicians. Despite claims by the Pennsylvania Coalition of Nurse Practitioners that CRNPs can provide up to 90 percent of the same services as a family practice physician and up to 25 percent of that of a specialist, it is hard to see how, given the above statistics. Substituting this opinion for proven fact is not in the best interest of our patients, and risks creating a lower tier of primary care in our state. It may also ultimately drive up costs, as a less fully-trained provider might be more inclined to order more tests, or make use of specialist referrals to make up for gaps in knowledge.

Access to Care Questioned

CRNP leadership has asserted that independent practice is the solution to lack of access in rural and underserved areas. However, the numbers do not seem to bear this out. On a national level, one study showed the rural distribution of nurse practitioners

is about 25 percent. Another showed that in terms of providers, more family practice physicians (46,981) see patients in rural areas than CRNPs (14,351). In a 2012 paper using 2010 NPI data, the American Nurses Association identified 106,113 CRNPs nationwide. Of those, fewer practiced in a rural vs. urban setting (2.8 vs. 3.9 per 10,000) population. Although being in a state with independent CRNP practice did increase the likelihood of serving in a rural area, the increase did not reach statistical significance. It is also worth pointing out that nearly half of CRNPs select subspecialty training,

Continued on page 10

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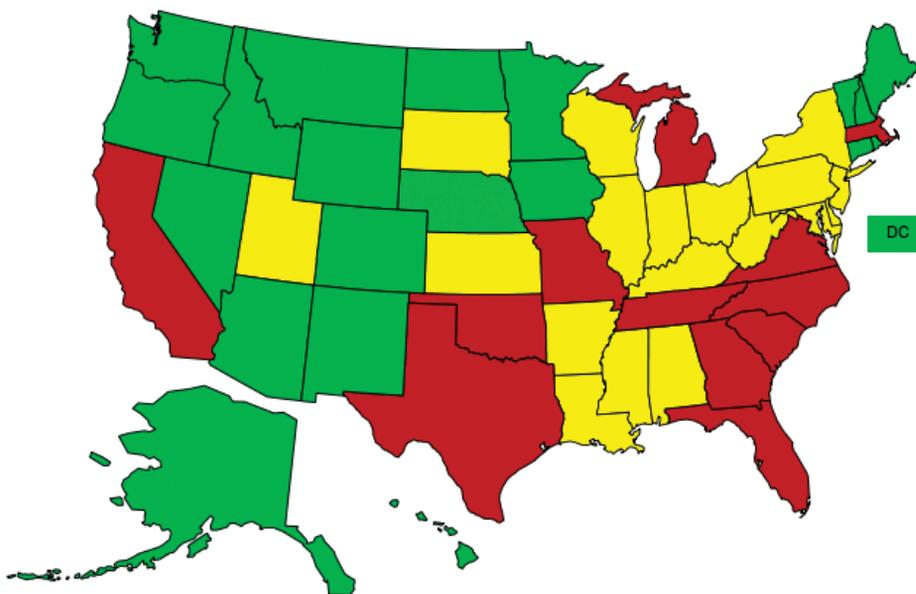
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2015 NURSE PRACTITIONER STATE PRACTICE ENVIRONMENT



FULL PRACTICE

State practice and licensure law provides for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribing medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

REDUCE PRACTICE

State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care.

RESTRICTED PRACTICE

State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care.

rather than primary care, as their career choice. This is not a criticism of CRNPs, but rather an acknowledgment of the breadth and scope of primary care and the difficulty in caring independently for a diverse and medically complex population.

Historically, family practice physicians have cared for uninsured or underinsured patients for years. While the numbers vary, the estimated 32 million Americans who entered the insured pool under the ACA will not suddenly result in a ‘paradigm’ shift that forces physicians to suddenly ‘acknowledge’ them. The assertion by the Pennsylvania Coalition of Nurse Practitioners that independent practice will eradicate this issue seems somewhat disingenuous when reviewing these facts. In addition, the nursing profession itself is projected to have a shortage of 260,000 by 2025, which begs the question of why CRNP leadership is pushing for expansion of scope, rather than for legislative steps to alleviate this burden?

These are important questions that need to be answered.

So what needs to be done about the issue of access? In the 2014 legislative session, Pennsylvania lawmakers passed Act 198, which established the Patient-Centered Medical Home Advisory Council. With a focus on team-based care rather than provider autonomy, a patient centered medical home (PCMH) encourages integration and collaboration, and allows all to practice to the full extent of their training and licensure. The Pennsylvania Coalition of Nurse Practitioners acknowledges this, yet still wishes to see collaborative ties with physicians severed. Why? One of the issues most commonly cited

is cost. Another is that forcing nurse practitioners to be supervised by a physician adds an unnecessary layer of time and money to nursing practice, without demonstrated improvements to patient safety or outcomes. Let’s take a look at some of those claims.

Cost, Patient Satisfaction, and Outcomes

CRNP leadership has often asserted that independent nurse practitioners result in lower overall costs, improved patient satisfaction, and better outcomes. Many studies have attempted to address this, yet the issue remains one of high complexity. There is data to suggest that in the appropriate setting, nurse practitioners can lower costs, but the claim that removing physicians from oversight of the patient care team saves substantial healthcare dollars is a disputed one. It might seem obvious that shorter wait times, longer periods of patient-provider interaction, and generally caring for a healthier population would produce data showing superior metrics for NPs vs. physicians, but that is like saying Florida is warmer than Pennsylvania. It’s comparing apples to oranges.

Putting it another way, it is easy for CRNPs dealing with less paperwork, regulation, and fewer government mandates to claim that they can spend more time with their patients, reduce costs, and improve satisfaction and outcomes. It is a compelling argument, but one that leads back to the same question: how is eliminating the team’s most highly-trained member—the physician—ultimately in the best interest of the patient?

It is worth pointing out that collaboration does not necessarily mean direct, ‘hands-on’ oversight for every

patient encounter. Under current law, CRNPs can function nearly independently, yet have a direct pipeline to a physician should the need for backup or referral arise. It would seem that repealing this requirement would lead to an increased burden on the patient, and potentially even put them at risk. Rather than having a physician available with whom to discuss a potential concern, a nurse practitioner might feel compelled to send that patient to the emergency department or, as previously mentioned, request an unnecessary specialist consult, thus driving up costs for the entire system. Instead, allowing CRNPs to practice to the fullest extent of their training license, while still under the supervision of a trained physician, maintains both autonomy and patient safety.

In addition, a 2012 study by the American Medical Association found that a clear majority—76 percent of patients—prefer their health-care team be led by a physician, a position supported by the Hospital and Healthsystem Association of Pennsylvania (HAP).

The take home point is simple: when it comes to the data, so many ‘studies’ exist that supporters of both sides can easily find evidence to support their view. In light of that fact, it becomes hard to see how changing the law will provide the benefits claimed with any degree of freedom from bias. Indeed, it would appear that further fragmentation--rather than a retreat from it--could be the result. It’s also why one must look at the whole picture, not just individually chosen metrics.

Malpractice

Severing of collaborative agreements between physicians and CRNPs will likely alter the field of malpractice, most notably the extent of liability and the issue of cost. Currently, CRNPs pay lower premiums than physicians in the same specialty for coverage, but without physician oversight, this could easily change. Across the nation, courts have differed in regards to how much fiduciary responsibility a nurse practitioner carries when

collaborating with a physician, but with independence, any dilution of risk between a CRNP and supervising doctor will quickly disappear.

While on the surface, this may serve to increase vigilance on the part of advanced practice nurses, it also potentially puts patients at risk. Although a plethora of anecdote is not evidence, multiple case reports exist in which nurse practitioners have been found liable for diagnostic and treatment errors in the same manner as physicians. With independent practice, these numbers are likely to increase, which may result in higher insurance premiums for CRNPs and added costs across the healthcare spectrum. Plaintiff’s attorneys are unlikely to shy away from ‘mining’ a new source of potential claims, which could add to the problem of defensive medicine and abrogate savings in provider reimbursement.

In other words, when lawsuits go up, everybody pays. CRNPs will be no exception.

Successful Collaboration

Collaboration is a process by in which a nurse practitioner works with one or more physicians to deliver healthcare within a CRNPs scope of practice. When implemented effectively, collaboration reduces costs, improves access, and maximizes the complementary skills of both the physician and advanced-practice nurse. In both primary care and specialty groups, successful models of collaboration abound. From small practices to large organizations, physician-led, team-based care continues to work for our providers and patients. While we should always search for areas of improvement, severing collaborative agreements will harm the team, right at the time we need to preserve it.

Working together, physicians and nurse practitioners are the future of team-based care. Both bring unique, complementary skills to the patient encounter, and play a vital role in managing health and disease. Today, with the ACA moving forward, it’s time to strengthen the team—not destroy it. ■

WHAT IS COLLABORATION?

Collaboration is a process in which a nurse practitioner works with one or more physicians to deliver healthcare services within the scope of the practitioner’s expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by the law of the State in which the services are performed.

In the absence of state law governing collaboration, collaborations is a process in which a nurse practitioner has a relationship with one or more physicians to deliver healthcare services. Such collaboration is to be

evidenced by nurse practitioners documenting the nurse practitioners’ scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. Nurse practitioners must document this collaborative process with physicians.

The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner. ■

Source: Centers for Medicare & Medicaid Services 42 CFR 410.75 (c)

Frontline Groups 100% Committed to MCMS

Is your practice among an elite group that is 100 percent committed to the Montgomery County Medical Society? You can be . . .

Frontline practices – three or more physicians in a group – stand on the front line of the medical profession by making a commitment to 100 percent membership in the Montgomery County Medical Society and the Pennsylvania Medical Society (PAMED). MCMS continues to provide a forum for physicians to work collectively for the profession, patients and practice.

The Montgomery County Medical Society says thank you.

MCMS Frontline Groups as of March 2015

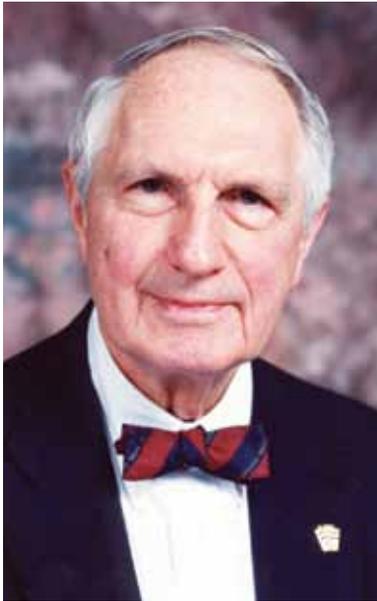
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| <ul style="list-style-type: none"> ■ Abington Medical Specialists ■ Abington Memorial Hospital-Division of Cardiothoracic Surgery ■ Abington Neurological Associates Ltd ■ Abington Perinatal Associates PC ■ Abington Reproductive Medicine ■ Academic Urology-Pottstown ■ Advocare Main Line Pediatrics ■ Annesley Flanagan Stefanyszyn & Penne ■ Armstrong Colt George Ophthalmology ■ Berger/Henry ENT Specialty Group ■ Cardiology Consultants of Philadelphia-Blue Bell ■ Cardiology Consultants of Philadelphia-Lansdale ■ Cardiology Consultants of Philadelphia-Norristown ■ East Norriton Women's Health Care PC ■ Endocrine Metabolic Associates PC ■ Endocrine Specialists PC ■ ENT & Facial Plastic Associates of Montgomery County ■ Gastrointestinal Specialists Inc. ■ Green & Seidner Family Practice ■ Hatboro Med Associates ■ Healthcare for Women Only Division ■ King of Prussia Medicine ■ LMG Family Practice PC | <ul style="list-style-type: none"> ■ Lower Merion Rehabilitation Associates ■ Main Line Gastroenterology Associates-Lankenau ■ Marvin H Greenbaum, MD, PC ■ Neurological Group of Bucks/Montgomery County ■ North Penn Surgical Associates ■ North Willow Grove Family Medicine ■ Northern Ophthalmic Associates Inc ■ Otolaryngology Associates ■ Patient First-East Norriton ■ Patient First-Montgomeryville ■ Pediatric Associates of Plymouth Inc. ■ Performance Spine and Sports Physicians PC ■ Respiratory Associates Ltd ■ Rheumatic Disease Associates ■ Rheumatology Associates Ltd ■ Rittenhouse Hematology ■ Suburban Geriatrics ■ The Philadelphia Hand Center PC ■ Thorp Bailey Weber Eye Associates Inc. ■ Tri County Pediatrics Inc. ■ TriValley Primary Care/Lower Salford Office ■ TriValley Primary Care/Upper Perkiomen ■ William J Lewis, MD, PC |
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Through your membership, MCMS Frontline members and practices receive special recognition and benefits:

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- Additional discounts and services from county and state endorsed vendors.
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For more information on how your practice can become a Frontline practice, e-mail montmedsoc@verizon.net or call (610) 878-9530 or (855) PAMED4U.

Meet Your County Medical Society Leaders



Even at the tender age of 90, William W. Lander, MD continues to thrive in his family practice and actively participates on the MCMS Board of Directors, including a term as president in 1990. Dr. Lander, who also served as president of the Pennsylvania Medical Society in 2005, recently reminisced about his military service and early medical career.

Name: William W. Lander, MD

Specialty: Family Medicine, Internal Medicine

Currently Practices: Main Line Health in Bryn Mawr

Years in Practice: 62

Medical School: University of Pennsylvania School of Medicine

Residency: Bryn Mawr Hospital

Hometown: Forest Hills, New York

Residence: Villanova

Family: Wife Nancy passed away in September 2012; 3 sons Bill of New Hampshire, David of Rosemont and John of Berwyn

PROFESSIONAL BACKGROUND

When I was eight years old, my father, a priest in the Episcopal Church, moved us to Rosemont in Montgomery County for a better education. I graduated from the Episcopal Academy in 1943. I played on all sorts of athletic teams.

Because of World War II, we were advised to sign up for service in a military branch that we prefer rather than being assigned to a branch in the regular draft. I joined the Naval V-12 Program (college program designed to provide the Navy with a continuous supply of officers) and was sent to Ursinus College—near home!

I graduated from Ursinus in 1946, completing enough credits for my diploma in 24 months. Following graduation, I was sent to Bainbridge Naval Hospital for the summer and then received orders to go to University of Pennsylvania School of Medicine. I had one semester at Penn gratis from the U.S. Navy and received a “senatorial” scholarship for the rest of my medical education.

A UNIFORM BUT NO PAY

I met a delightful lady at Ursinus, who lived near Penn. Nancy left Ursinus and waited for me to graduate from Penn. We were married three days after graduation. I started my internship at Bryn Mawr Hospital in June 1949. There was no pay, but they gave us a uniform! My wife was our sole income producer, working at the Insurance Company of North America. But when they learned that she was pregnant, they “allowed” her to leave—therefore no income.

At that point, I re-enlisted in the Navy for \$50 a month and left Bryn Mawr at the end of July 1950. The Korean “War” had started. I was sent to the naval hospital on Long Island. After one week at the naval hospital, I received orders to go to Camp Pendleton, Calif., to join the 1st Marine Division.

KOREAN LANDINGS

After two weeks at Camp Pendleton, we boarded ship and sailed for 13 days to Japan, where we

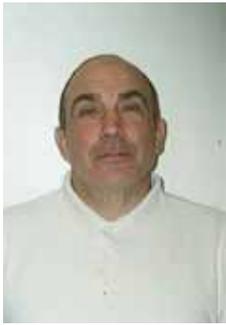
“staged” to go to Korea. We went in on the 14th wave of Marines landing on Inchon—an interesting adventure for anyone not trained in combat. Our second Korean landing followed on the other coast and then the 1st Marines Division went into a now cold North Korea. The Chinese came swarming in, surrounded us, and cut us off from other elements of the Marines. Enough of that—it’s more difficult to tell that part of my life.

Eventually we went back to California, where I received orders to Pennsylvania and the Philadelphia Naval Hospital. I was there only for a few months when I was assigned to a Marine recruiting detail until finally being discharged.

EARLY CAREER AND ORGANIZED MEDICINE

I started a one-year medical residency at Bryn Mawr Hospital and then went into solo practice in the Bryn Mawr area. In those days, you were required to be a member of the Montgomery County Medical Society and the Pennsylvania Medical Society. I was a member of the AMA, too. Eventually I became president of the Bryn Mawr Hospital medical staff (two years) and some time after that the AMA started the hospital medical staff section, and I went to that meeting. MCMS called me to come to a meeting to report on the new section. And the rest is history.

That history includes many leadership roles within PAMED and MCMS—serving as president for both organizations and chairman of the MCMS Board of Directors. He became the second president of PAMED from Montgomery County in 2005, following the 1885 presidency of Hiram Corson, MD. His involvement in organized medicine is massive and just as long as his 62 years of practicing medicine. He has served on various boards and commissions within the AMA, PAMED, MCMS and Bryn Mawr Hospital medical staff. For 25 years, he served as the head of Bryn Mawr Hospital’s Family Medicine Service. ■



Physician Provides Roadmap to Financial Freedom

BY CARL MANSTEIN, MD

Much has been written about medical students and residents incurring enormous debt due to onerous tuitions. It is not uncommon for many medical students to have debt, more than \$100,000, upon graduation. Whether a young physician has \$10,000 or \$100,000 of debt, there are some strategies to help eliminate it in the least painful and most economically efficient manner.

Generally speaking, personal debt is bad; so you should try to pay it down as quickly as possible. For the young surgeon starting his or her practice, that might seem like an impossibility with all of the pressures that come with “working for a living.” Simply put in four words: Don’t Spend Your Money. What does that mean? A certain degree of austerity and discipline is necessary to allow you to achieve financial freedom of debt.

There is little that some could have done to prevent incurring debts to pay for education. Unfortunately, medical school tuitions now exceed the median income for families in the United States. An essential first step to prevent falling deeper into a hole is to avoid acquiring more debt. You must be careful not to get caught into a trap of buying new cars, homes or even office lasers. The length of physician training and residency leaves new graduates hungry for some of the finer things of life. Unfortunately, attempts to satiate unfulfilled delayed gratification can lead to a never-ending cycle of debt and repayment.

Know the basics

- Savings equals income minus spending. If you spend more than you make, there is negative savings, otherwise

known as debt. This is the predicament in which many medical students and residents find themselves. Sometimes there is little you can do about this while a student is in training. The goal is to reverse the trend when you began practicing.

- Wealth is equal to the summation of years of savings. If you are able to save money every year, over a relatively short period, there is an accumulation of dollars, which represents wealth.

General tips to managing debt

- Establish a budget and stick with it. Having a plan for saving for retirement, funding for children’s tuitions, and paying off debt requires dedication to a concept that over the long run provides security for everyone. Putting away \$100 a month in each one of these three areas beginning the first month that you start practice initiates an exercise of fiscal restraint that will serve you well over the long haul. By year three of practice, increase it to \$200 a month; by year five, \$300 a month; and by year 10, \$500 a month. The secret is to have a plan and be compulsive about following it. If you are fortunate enough to start putting away \$500 a month the day your child is born by the time he or she is ready to college, you will have \$100,000. Unfortunately that only buys two years worth of tuition at a private university.

- Rate of contribution to a savings plan is far more important than rate of return on the investments. People worry far too much about which stock or mutual fund to buy, rather than the more basic principle of just putting the money away. If the dollars aren’t saved, they can’t be invested in the first place.

- Pay off debt that is carrying the highest interest rate first. Even if you owe twice as much on a low-interest loan, paying off the higher interest loan (such as a credit card bill) is the better investment. Paying off a credit card bill that commands 18 percent interest is the equivalent of earning 18 percent rate of return on an investment. Remember that the stock market historically averages a 9 percent rate of return (over a 20-year period). Paying off high-interest loans essentially gives you twice the return that the stock market does; particularly recently with the market having been up, down, and all around.

- It is usually cheaper to buy than to lease. This is particularly true when it comes to acquiring a car or a home. For certain types of office equipment, the argument could be made to lease; but generally buying is the way to go. No matter what the argument is, buying a car is always cheaper than leasing one. The secret is that you have to keep a purchased car for a minimum of seven years to make this work. If you are the kind of person who must drive a new model Mercedes, then understand that the choice you are making will have grave consequences in your ability to eradicate your debt.

- If you are a buying a house and you need a 30-year mortgage to finance it, then you have bought “too much” house. The often heard argument is, “I could never afford to live in my house without a 30-year mortgage.” That is exactly the point. You should never buy a house that cannot be comfortably financed with a 15-year mortgage. When you are financing your home purchase, figure out what is the difference in total payout on a 15-year and 30-year mortgage. Taking the 15-year

mortgage is the least expensive way to own the home when borrowing money from the bank.

- People always say, “I need my mortgage for a tax deduction.” This is madness and faulty logic. It is much cheaper to pay off your house than to think you are getting some kind of “discount” on your tax bill by carrying a mortgage and making those monthly payments for the next 30 years. Remember that wealthy people don’t have mortgages. Mortgages were designed so that banks could make money.

- Avoid the temptation to plunge into an expensive marketing scheme early in your practice. There have not been any good studies that indicate that fancy advertising campaigns for physicians actually increase your bottom line. A well-run marketing strategy may cost as much as \$100,000 a year. This is money that could be better spent paying down tuition loans or credit card bills. There is also the lost opportunity-cost of not having that money to invest in retirement accounts or children’s college tuition programs.

- The single worst investment that many physicians make is owning a vacation home. Unless you are a zillionaire, owning a vacation home is a terribly inefficient way to spend your money. You have to be able to distinguish between the good feeling that you get inside saying that you own two properties versus the truly secure feeling you may have when you can say you are debt-free. Having a mortgage on a vacation home makes no financial sense at all. Figure out how much it costs to maintain a vacation home for mortgage, insurance, maintenance, etc. Then call the most luxurious hotel at your favorite resort and ask them how much is the rent for the most expensive suite during the time period you wish to be there. The hotel will always be cheaper. For those of you who say, “I rent out the property for the time I am not there to cover my expenses.” I say then “you are merely being a landlord.” This is a poor excuse to justify owning a second home when you need renters to finance the vacation property.

There is no easy solution to managing debt. It takes discipline and perseverance. Young physicians must be careful not to fall into an ongoing cascade of increasing debt. Achieving financial independence is difficult on that path. Two truths: It is always easier to buy than to save. Spending money is always easier than not spending. After more than 30 years of practicing, if you develop disciplined habits in managing your debt, you can reap outstanding rewards. ■

Carl H. Manstein, MD, MBA, CPE, is a graduate of Abington High School, Amherst College, Temple University School of Medicine and LaSalle School of Business. He completed his plastic surgery residency at Duke University and is certified by the American Board of Plastic Surgery.

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CELEBRATING THE 3 Ps: PHYSICIANS, PATIENTS AND PASSION

BY TOYCA D. WILLIAMS, DEPUTY EDITOR

Join MCMS Physicians for the Annual Membership Dinner June 3

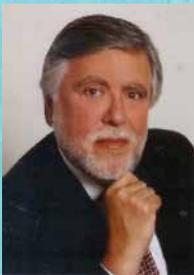
This community is fortunate to have many knowledgeable, as well as nurturing, practicing physicians and healthcare providers who care for Montgomery County patients on a daily basis. Many of those physicians are members of the Montgomery County and Pennsylvania medical societies and are committed to advocating for the needs of the profession and the practice. Each year, MCMS pays tribute to those physicians who have reached a noteworthy professional milestone – 50 years of practicing medicine.

MCMS will honor 11 physicians who have practiced medicine for 50 years during its 2015 MCMS Annual Membership Dinner, June 3, William Penn Inn in Gwynedd. In addition to a welcoming ambiance, excellent food and great music, Dr. Erin Lally will share intimate details about her passion outside of medicine. She bravely scaled Mt. Everest during her senior year of medical school and practiced a bit of medicine along the way. You are invited to honor our physicians as well as hear her amazing story.

Additionally, MCMS will recognize those physicians who have practiced 25 years as well as our young physicians who have practiced for 10 years.



Hack R. Chung, MD is an attending psychiatrist at Brooke Glen Behavioral Hospital in Ft. Washington. He has been practicing psychiatry since 1969 and has been with Brooke Glen for more than 30 years. Born in Korea, Dr. Chung received his medical degree from Yonsei University in Seoul, Korea. Dr. Chung is licensed in Pennsylvania, Ohio, and New York. In addition to MCMS, Dr. Chung holds memberships to the Pennsylvania Medical Society and American Psychiatric Association. Dr. Chung has his own private practice as well as a full case load during the day at Brooke Glen.



Walter I. Hofman, MD, an expert in forensic pathology known throughout the United States as well as in Canada, is

Montgomery County's coroner. He is the only board-certified forensic pathologist coroner in Pennsylvania. A medical graduate of the University of Basel, Switzerland, Dr. Hofman is board certified in anatomic, clinical and forensic pathology. He has personally performed more than 10,000 autopsies, issued more than 17,000 death certificates and examined more than 20,000 bodies. He retired as chairman of Laboratory Medicine at Roxborough Memorial Hospital, Philadelphia, full clinical professor of pathology at Temple and associate clinical professor at the University of Pennsylvania Medical Schools. In addition to serving as MCMS secretary and a delegate to the PAMED Annual Business Meeting, he is a past chairman and current member of the MCMS Medical Legal Committee and is a consultant to Pennsylvania Highmark Blue Shield.

Bruce D. Hopper, MD is a retired obstetrician and gynecologist who has been a member of the medical society for 38 years. The Upper Darby native was affiliated with Bryn Mawr and Paoli Hospitals. He received his medical degree from Jefferson Medical College. In addition to the Pennsylvania Medical Society, he is a member of the PA Section of the American Congress of Obstetricians and Gynecologists.



Marvin H. Kromash, MD is a retired pediatrician who has been a member of the medical society for 39 years. The Philadelphia native was affiliated with Hospital of University of Pennsylvania and Pottstown Memorial Medical Center. He received his medical degree from Hahnemann Medical College in Philadelphia. In addition to the Pennsylvania Medical Society, he was a member of American Academy of Pediatrics.

Thomas D. Mull, MD was a board certified anesthesiologist who has been a member of the medical society for 39 years. The West Chester resident practiced at Bryn Mawr Hospital. He received his medical degree from the University of Pennsylvania Perelman School of Medicine. He is a member of the Pennsylvania Medical Society and the Pennsylvania Society of Anesthesiologists.

Thomas C. Sansone, MD, FACS was an urologist who has been a member of the medical society for 42 years. The Villanova resident practiced at Bryn Mawr Hospital and was a former chief of urology. He received his medical degree from the University of Pennsylvania Perelman School of Medicine. He is a member of the Pennsylvania Medical Society and the Urological Association of Pennsylvania.



Philip S. Schein, MD, widely regarded as an international authority on the treatment of cancer, is the president of the Schein Group, Inc., which provides consultative services to the pharmaceutical industry. Dr. Schein, an Asbury Park, N.J. native, received his medical degree from Upstate Medical University and holds multiple honorary doctorates. He is board certified in internal medicine, hematology and medical oncology. As the

former chairman and CEO of U.S. Bioscience, he took three drugs through development and regulatory approval in the United States, Europe and Canada. Dr. Schein has held major positions in the field of medical oncology, serving as president of the American Society of Clinical Oncology, and serving as chairman of the Food and Drug Administration's Oncologic Drugs Advisory Committee. He has served as a member of the Board of Directors on the American Board of Internal Medicine, where he chaired the Medical Oncology Committee. Dr. Schein has authored more than 350 articles and texts relating to basic and clinical cancer research and drug development, been awarded 11 patents and serves on numerous biotechnology/pharmaceutical scientific advisory boards. He is a recipient of numerous scientific and medical awards including the Harvey W. Wiley Medal from the FDA. He has been a member of the medical society for 22 years.



Robert C. Schmutzler, MD, FACS is a general and laparoscopic surgeon at Abington Memorial Hospital. He is one of 11 surgeons with Abington's Surgical Care Specialists. The board certified general surgeon has been a member of the medical society for 43 years. Additionally, he is a fellow with the American College of Surgeons. Dr. Schmutzler received

his medical degree from Temple University School of Medicine and completed his surgical residency at Abington Memorial Hospital.

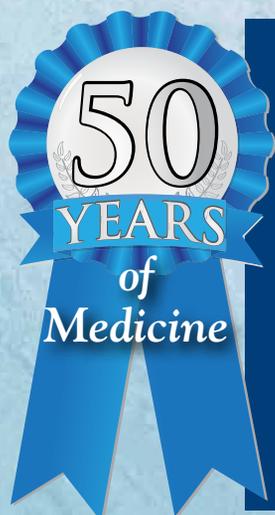
Joel L. Schwartz, MD was a board certified child, adolescent and adult psychiatrist, as well as certified psychoanalyst. The Philadelphia native has been a member of the medical society for 40 years. He received his medical degree from Hahnemann Medical College in Philadelphia. Dr. Schwartz has been the Chairman of the Department of Psychiatry at Abington Memorial Hospital. He is an author and professional speaker who has written several books, including *Laughter is the Best Medicine*, *Noses are Red* and most recently, *To Pee or Not to Pee*. He is the recipient of the Herman Belmont Award for Excellence in Teaching Child and Adolescent Psychiatry and has been one of the Philadelphia Magazine's Top Docs several times. In addition to being a member of Pennsylvania Medical Society, he is a life distinguished fellow with the Pennsylvania Psychiatric Society.



Carol P. Webber, MD was an obstetrician and gynecologist who has been a member of the medical society for 46 years. The Chester Springs resident received her medical degree from the Woman's Medical College in Philadelphia. She is a member of the Pennsylvania Medical Society.

Richard D. Weiss, MD was a board certified radiologist who received his medical degree from Temple University. The Harrisburg native has been a member of the medical society for 31 years. He practiced for many years with the Radiology Group of Abington. For his entire career, he held an adjunct teaching position at Temple University School of Medicine and held a teaching position in the physician assistant program at Arcadia University. He was a member of the American College of Radiology as well as the Radiological Society of North America.

Continued on page 18



NAME	CITY	SPECIALTY
Hack R. Chung, MD	Ft. Washington	Psychiatry
Walter I. Hofman, MD	Merion Station	Pathology
Bruce D. Hopper, MD	Devon	Obstetrics & Gynecology
Marvin H. Kromash, MD	Pottstown	Pediatrics
Thomas D. Mull, MD	West Chester	Anesthesiology
Thomas C. Sansone, MD	Villanova	Urology FACS
Philip S. Schein, MD	Bryn Mawr	Oncology
Robert C. Schmutzler, III MD	Abington	General Surgery
Joel L. Schwartz, MD	Ft. Washington	Psychiatry
Carol P. Webber, MD	Chester Springs	Obstetrics & Gynecology
Richard D. Weiss, MD	Elkins Park	Radiology



F. Thomas Harkins, MD



Jonathan T. Wolfe, MD



Kenneth S. Resnik, MD



Allen Chiang, MD



Lana B. Patitucci, MD



Kevin G. Lax, MD



Mark Lopatin, MD



Abashta T. Johnson, MD

NAME	CITY	SPECIALTY
Matthew Carl Acker, MD	Meadowbrook	Anesthesiology
Mihaela Biscoveanu, MD	Bala Cynwyd	Endocrinology
Anthony F. Bonagura, MD	North Wales	Internal Medicine
Fernando B. Bonanni, Jr. MD	Warminster	General Surgery
Avraham N. Cohen, MD, FACS	Cherry Hill, NJ	Ophthalmology
Dominick M. Giuffrida, DO	Norristown	Obstetrics & Gynecology
F. Thomas Harkins, MD	Flourtown	Emergency Medicine
Kevin G. Lax, MD	Furlong	Cardiology
Amara A. Lieberman, MD	Wynnewood	Dermatology
Lawrence S. Mendelson, MD	Wayne	Cardiology
Kenneth S. Resnik, MD	Newtown Square	Dermatopathology
Steven Barnet Schwartz, MD	Sinking Spring	Neurological Surgery
Evan J. Thomas, MD	Wyndmoor	Psychiatry
James W. Thomas, MD	North Wales	Radiology
Jonathan T. Wolfe, MD	Plymouth Meeting	Dermatology

NAME	CITY	SPECIALTY
Nasrin Ashouian, MD	Pottstown	Nephrology
Allen Chiang, MD	Penllyn	Ophthalmology
Brooke Devenney-Cakir, MD	Gladwyne	Neuroradiology
Todd A Feathers, DO	Warminster	Physical Medicine & Rehabilitation
Deepakraj Gajanana, MD	Ft. Washington	Internal Medicine
Matthew R. Gerstberger, MD	Pennsburg	Family Medicine
Joshua M. Greene, MD	Wynnewood	Ophthalmology
Ahashta T. Johnson, MD	Philadelphia	Internal Medicine
Jean Marie Kane, DO	Jenkintown	Internal Medicine
Annie N. Kotto, MD	Elkins Park	Pediatrics
Lissa B. Levin Mizrahi, MD	Dresher	Internal Medicine
Hugo M. Linares, DO	Wynnewood	Ophthalmology
Benjamin Noh, MD	Lansdale	Emergency Medicine
Lana B. Patitucci, DO	Phoenixville	Otolaryngology
Stephen Jay Tai, MD	Phoenixville	Otolaryngology
Seema Balwantsingh Vasu, DO	Audubon	Family Medicine

STUDENT SCHOLARSHIPS WINNERS

MCMS awarded three scholarships to first-year medical students from Montgomery County.

Congratulations to John D. Arena, University of Pennsylvania Perelman School of Medicine; Alexis J. Lukach, University of Pittsburgh School of Medicine and Diana Z. Li, Temple

University School of Medicine. The students will be recognized at the annual membership dinner June 3, William Penn Inn, Gwynedd.

Thanks to contributions made to the MCMS Scholarship Fund, MCMS continues to fulfill its mission to invest in medical student education.



John D. Arena



Alexis J. Lukach



Diana Z. Li

If you want to invest in the future of medicine, send tax-deductible contributions to The Foundation of the Pennsylvania Medical Society with MCMS Scholarship noted on memo line, 777 E. Park Drive, Harrisburg PA 17105. For additional information, call MCMS, (610) 878-9530. ■



ICD-10: Five Tips on How Your Bank Can Help

BY LISA M. ENRIGHT, SENIOR VP, CITIZENS FINANCIAL BANKING

As healthcare providers across the nation prepare for the upcoming implementation of ICD-10, planning should factor in the financial impact on your practice. As you prepare for the conversion, the magnitude of the changes on your employees, your patients and your bottom line should not be underestimated. There are practical expenses – as well as potentially hidden costs – you should be planning for today.

These five tips will help you identify items you need to consider and actions you need to take in anticipation of expanding capital and increased cash flow flexibility that will affect your practice both before and following the October 2015 conversion. Like many aspects surrounding the transition, to be fully prepared, it is prudent to address finances three to six months in advance of October.

1. Understand Capital Needs – The complexity of the ICD-10 implementation will require software upgrades and extensive staff training in advance of the conversion. Your bank can construct term loans to address these capital expenditures.

2. Arrange Working Capital – Understand the average time it takes today to collect receivables, and expect the average time to lengthen significantly as practitioners learn the new codes. To backstop a longer receivables cycle, you should have access to three to six months of working capital reserves. Although you cannot control whether your payers will be ready and whether they are fluent in the new codes, an expansion of your working capital line of credit will help your practice manage available cash reserves through a period of delayed receivables. In advance of the conversion, talk to your banker about how to obtain or increase an existing line of credit.

3. Before You Meet With Your Banker – Compiling essential documents before meeting with your bank will expedite the credit review and result in a fuller discussion of the practice's financial needs. These documents should include tax returns for the prior three years for the practice and the principals, year-to-date interim financials, current

Accounts Receivable Aging Report and an updated personal financial statement.

4. Work with a Bank That Understands Your Needs – As the healthcare industry becomes more complex, it is important to work with a bank that understands the specialized financing requirements of healthcare practitioners. Some banks have specialized units dedicated to the healthcare professional. A knowledgeable banking partner who understands the full scope of your industry and operation – from posting and managing your receivables to establishing loans and lines of credit – can design financing plans that anticipate your short- and long-term needs.

5. Widen Your Cash Flow Window – Rather than writing checks to pay for monthly operating expenses, use a business credit card to stretch out payments. Some banks offer extended 50-day billing cycles that can provide additional cash flow flexibility. To avoid interest payments, pay your credit card bill in full each month. ■

Lisa M. Enright can be reached at (866) 440-4217 or at lisa.m.enright@rbscitizens.com. According to SNL Financial, Citizens Financial Group (CFG) is the 13th largest retail bank holding company in the United States with \$130.3 billion in assets as of June 30, 2014. For more information, visit Citizens Bank's website www.citizensbank.com.

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Twenty-three Year Old's Worst Nightmare Happened on Friday the 13th

Survivor of Stroke Wants to Help Others Like Him

To many, Friday the 13th evokes images of Jason Voorhees and all things unlucky, but to Brent Wylie, that date in 2011 was the day his life changed in ways he never anticipated.

It was the day Brent succumbed to a stroke at the age of 23.

"Having a stroke was not the last thing on my mind... it was something that never even entered my mind," remembers Brent. "It's all so surreal."

While walking to a night club to meet a friend, he noticed that his car key was missing from his key ring. That's when he started to retrace his steps and felt disoriented while searching. He'd had a mixed drink and several energy drinks and attributed his lightheadedness to that.

couldn't and then he heard someone say the word "stroke."

"I can't be having a stroke," he said, "I'm 23."

But he was confused about why he couldn't lift himself off the ground.

"I was arguing with them the whole time saying I was fine... that I was healthy — I had just had a physical! I told them that I didn't drink too much and I didn't do drugs. I'm sure I wasn't making things easy for them."

In the hospital, he waited for the doctors to tell him that what had just happened was anything but a stroke. The drink he had that night was mixed with a brand of vodka he'd never had. That's what he was hoping he could attribute his hospital visit to. But when his family flew in, he says, he knew it was bad.

"The doctors told me I needed a craniotomy because my brain was swelling and that would allow room for it to swell. After it was over, I looked in the mirror and I was shocked... devastated. I was still hoping someone would say I was fine and that I didn't have a stroke. I'm not sure how you're supposed to feel after a stroke, but I felt like myself. They still had to perform the craniotomy," said Brent.

Brent, now 27, has taken his LSATs and considered applying to law school. But his career focus has shifted to becoming a physical therapist. He will start the University of Delaware in 2016. "Becoming a physical therapist just started to make more sense. After I had the last seizure, which was just before I took the LSATs for the second time, I started to take that as a sign that maybe law school isn't for me," he reflects.

"I've had so many PTs and feel like I know so much — having been a patient — that I now want to be of good use to someone who may be in the same position I was once in." ■



He continued to search for his key, but called his roommate to ask for a ride back home to get his spare. He never made it to the club. "I fell right on the street in front of the club. It was crazy because no one asked me if I was ok. At no point did anyone come over and ask me if I needed help. I was being heckled, circled and cursed. People thought I was drunk, but I'd only had one drink. I couldn't move and couldn't roll over," recalls Brent.

Both his friend, who was coming to pick him up, and the EMTs pulled up, as if on cue. Brent tried to get up and

Information prepared and submitted by the American Heart Association, 1617 John F. Kennedy Blvd., Suite 700, Philadelphia, PA 19103. During May, American Stroke Month, the American Heart Association/American Stroke Association increases stroke awareness by educating Americans that stroke is largely preventable, treatable and beatable. While stroke is the no. 5 cause of death and leading cause of disability in the U.S., many Americans do not think of stroke as a major health concern. To learn more, visit www.heart.org/philadelphia or call (215) 575-5200.



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Advocacy at Work

PAMED Sets Advocacy Agenda for Employed Physicians

As your voice in Harrisburg, the Pennsylvania Medical Society (PAMED) is working tirelessly to make Pennsylvania a positive practice environment for all physicians. With the consolidation of physician practices and the increased employment of physicians by hospitals and health systems, PAMED believes it is essential to develop comprehensive legislation to safeguard the rights of employed physicians. These rights include the right to practice independently; the right to reasonably advocate for patient care without fear of discipline or reprisal; and the right to continue to care for patients without interruption of that care by the patient's change of employers.

PAMED is actively advocating on several fronts to support employed physicians across the commonwealth. PAMED urges you to join these efforts and support its work to represent your interests in Harrisburg and statewide.

Employed Physician Advocacy Priorities for 2015

Assuring Physicians' Clinical Autonomy

PAMED advocates that physicians employed by hospitals or health systems should retain their independent medical judgment in providing care to patients, and that the hospitals or health systems may not discipline a physician for reasonably advocating for a patient. A hospital or health system that violates a physician's clinical autonomy or retaliates against a physician for exercising rights afforded by this safeguard should be subject to licensure action by the Department of Health under the Healthcare Facilities Act.

Keeping Physicians in Charge of Medical Decision Making

To assure that physicians remain the leaders of patient care, PAMED will advocate for the requirement that hospitals and health systems that employ physicians must appoint someone who is responsible for monitoring and reporting to the Department of Health any actions or events that they believe in good faith constitute a compromise of the independent medical judgment of a physician. This individual would be appointed in consultation with the physician advisory committee of that institution and would serve on the physician advisory committee ex-officio, without a vote.

Resolving Complaints When a Physician Reports Concerns about Clinical Interference

PAMED advocates that a mechanism be created to resolve complaints regarding interference or attempted interference with a physician's independent medical judgment.

Due Process Protections for Clinical Privileges

PAMED advocates that physicians who are terminated by a hospital or health system must be given due process according to medical staff bylaws before their clinical privileges can be adversely affected. PAMED asserts that physicians must have a private cause of action if their employment is terminated or otherwise subject to retaliation in violation of these safeguards.

Eliminating Restrictive Covenants

PAMED supports prohibiting employers from requiring a physician to sign a restrictive covenant that precludes the physician from competing with the employer if their employment is terminated. Elimination of restrictive covenants is crucial to assuring physicians are not limited in their ability to practice medicine despite prior employment agreements. ■

Information prepared by the Pennsylvania Medical Society. These priorities are critical to assuring that physicians remain the leaders in clinical decision making in hospitals and health systems. To join the efforts, please visit www.pamedsoc.org/join or call 855-PAMED4U.

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Legislative Update

BY SCOT CHADWICK,
LEGISLATIVE COUNSEL, PAMED

As is often the case at the start of a fresh two-year term of the General Assembly, there isn't much to report in the form of newly enacted legislation. In fact, an April 2 search of the legislature's website for statutes enacted so far this year reveals "no records found." Don't be fooled, though. There is a lot going on, and much of it is healthcare. Following are some key early developments in what promises to be an interesting year, as Pennsylvania's new Democrat governor, Tom Wolf, interacts with conservative Republican majorities in the state House and Senate.

2015-2016 State Budget

Pennsylvania's annual budget process began with a proposed spending and revenue plan delivered by the governor in an address to a joint session of the General Assembly on March 3, and those expecting Gov. Wolf to offer an initiative very different from those of his Republican predecessor were not disappointed.

Overall, Wolf's proposal would increase state spending by 2.7 percent (actually more than 8 percent if you include education spending), to be paid for with a variety of tax increases, including a raise in the state income tax from 3.07 percent to 3.7 percent, and a boost in the sales tax from 6 percent to 6.6 percent. The sales tax would also be expanded to include many services, though physician/patient office encounters are excluded.

Wolf's proposal offers \$8.5 million to expand the state's loan forgiveness program for primary care physicians, more than doubling the current appropriation. He also recommends that the program be moved from the Department of Health to the Pennsylvania Higher Education Assistance Agency, commonly referred to as PHEAA.

Other significant healthcare items include a \$2.5 million increase for behavioral health services and a \$5 million increase to the Department of Drug and Alcohol Programs (DDAP) to address heroin and opioid addiction. PAMED works closely with DDAP on drug abuse issues.

The budget proposal also contains \$3.8 million to reopen closed state health centers; \$3 million for healthcare innovation, to fund a multi-payer payment and health delivery system transformation; and \$100,000 for a new registry to compile health data from people living in Marcellus Shale drilling areas. PAMED supports the establishment of such a registry.

Importantly, the budget appropriates \$2.147 million to the Achieving Better Care by Monitoring all Prescriptions (ABC-MAP) program. That's the official name for the newly enacted statewide controlled substance database. The database is supposed to be up and running by June 30 of this year, but that timetable has been jeopardized by a lack of funding in the current year state budget.

Additionally, the budget contains \$2.7 million to continue the operation of the Pennsylvania Healthcare Cost Containment Council (HC4), which was unfunded in the current year budget but continues to operate under a gubernatorial executive order.

While it is encouraging to see so many proposed healthcare-related spending increases, it must be noted that Pennsylvania's state constitution requires revenues to match spending, and House and Senate Republican leaders have reacted negatively to Gov. Wolf's recommended tax increases.

House and Senate budget hearings have now been completed, and work will soon begin on crafting the new revenue and spending plan, which is due by the end of the fiscal year on June 30.

Medical Marijuana Legislation on Center Stage

Legislation to legalize medical marijuana didn't make it to the governor's desk last year, dying in the state House after receiving Senate approval. However, Sen. Mike Folmer (R-Lebanon County) has reintroduced the measure, now Senate Bill 3, and it has already been the subject of House and Senate public hearings this year.

PAMED testified at the hearings, repeating our position that the FDA should relax marijuana's status as a Schedule I drug to facilitate testing of a substance that seems to have some promise in treating children with epileptic seizure disorders, nausea in cancer patients, and other conditions. PAMED also believes the state should fund pilot studies that the Department of Health laid the groundwork for last year. However, until solid research results are in hand, the Society believes legalization would be premature.

Looking at the bill's specific provisions, there are a number of reasons for concern. The bill's scope is very broad, and goes well beyond the legalization of cannabidiol, the non-psychoactive component of marijuana that seems to help some children with seizure disorders.

SB 3 would also legalize THC, the psychoactive component of marijuana, to treat cancer, epilepsy and seizures, ALS, cachexia/wasting syndrome, Parkinson's disease, traumatic brain injury and post-concussion syndrome, multiple sclerosis, Spinocerebellar Ataxia (SCA), post-traumatic stress disorder, severe fibromyalgia, and any other condition authorized by the Department of State.

This is despite a review in the February *Journal of Developmental & Behavioral Pediatrics*, the official journal of the Society for Developmental and Behavioral Pediatrics, stating that a growing body of evidence links cannabis to "long-term and potentially irreversible physical, neurocognitive, psychiatric, and psychosocial adverse outcomes."

The bill would permit the medical use of marijuana edibles, presumably including THC-laced brownies and candy bars, raising concern over the risk of diversion and unintended harm. This has been a problem in states that have legalized medical marijuana, as evidenced by a 2011 study in Colorado that concluded that "diversion of medical marijuana is common among adolescents in substance treatment."

The bill would authorize up to 65 growers and another 65 processors, far more than would seem necessary to provide marijuana-based products to a defined subset of patients with specifically enumerated conditions. Further, this creates more than 4,000 possible ways a specific medical marijuana product could get from grower to processor to dispenser, raising questions about product consistency.

The bill would permit physicians, CRNPs, podiatrists, nurse midwives and physician assistants to all "recommend" medical marijuana to patients, the antithesis of a go-slow, cautious approach warranted by legislation legalizing a Schedule I, non-FDA approved substance.

Yet another problem relates to physician liability. The bill provides that the Commonwealth can't be held liable for any deleterious outcomes resulting from the medical use of cannabis by a registered patient, which makes sense given the paucity of scientific evidence supporting the safety and efficacy of medical marijuana. However, no similar protection is given to healthcare practitioners who will actually "recommend" non-FDA approved marijuana concoctions to their patients.

Despite these concerns, Senate approval is again expected early this year. House action on the legislation is less certain.

Naturopathic Licensure Bill Advances

House Bill 516, which would provide for the licensure of naturopaths and grant them a formal scope of practice, was recently approved by the House Professional Licensure Committee.

The bill would permit licensed naturopaths to independently prevent, diagnose, and treat human health conditions, injuries, and diseases. They would be able to order and perform physical and laboratory examinations, and utilize invasive routes of administration for their tests.

PAMED opposes the bill for several reasons. The level of credibility that state licensure establishes could be misleading to the average Pennsylvanian by implying that naturopathy is equivalent to mainstream medicine. "Naturopathic medicine" is defined in HB 516 as "a system of primary healthcare." Patients may see unproven and possibly unsafe treatments by "naturopathic doctors" as a substitute for conventional medical care.

If there is doubt about whether the bill allows naturopaths to perform a particular test or treatment, the question would likely be resolved in their favor, as Section 102 (4) specifically calls for the act to be "liberally construed."

Additionally, there is no requirement in HB 516 that naturopaths collaborate with or refer complicated medical cases to a physician.

The bill would also create logistical headaches for the state. Fewer than 100 naturopaths would qualify for licensure under this bill, requiring the State Board of Medicine to establish and maintain the necessary infrastructure for a mere handful of people. The vast majority of Pennsylvania naturopaths would remain unlicensed after the bill is enacted, adding confusion and providing little, if any, protection to the general public.

The committee improved the bill slightly by deleting language that would have authorized licensed naturopaths to order diagnostic imaging studies, though that change is insufficient to warrant a change in PAMED's opposition. ■

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Meaningful Use Attestation Is Complete, Now Breathe a Sigh of Relief – Or Can You?

BY PENNSYLVANIA MEDICAL SOCIETY'S PRACTICE SUPPORT TEAM

Numerous eligible professionals have been working diligently to meet Meaningful Use (MU) measure objective thresholds, whether by using the Flexibility Rule or by attesting to the stringent requirements of Stage 2 in 2014.

The Pennsylvania Medical Society (PAMED) has received quite a bit of feedback from our membership regarding the MU program, and some potential problems and issues they are experiencing:

- Attestation rejections related to information within the PECOS system not aligning with the information within the EHR Incentive Program Registration and Attestation System
- EHR payment adjustment being assessed although attestation was successful
- Prepayment audit letter received only after two days of submitting Stage 2 attestation

Let's take a moment to discuss each of these topics.

1. Attestation rejections due to PECOS mismatch with EHR Incentive Program Registration

According to the Centers for Medicare and Medicaid Services (CMS), providers who received this rejection would need to contact their local Medicare Administrative Contractor (MAC) Enrollment department as information within the PECOS system does not match what is listed in the EHR registration and attestation system.

When researching this problem, PAMED found a direct correlation to the revalidation process. Numerous practices having revalidated one or more providers within their group, however, had remaining providers yet to be revalidated, a

scenario that seemed to have caused the attestation to be rejected. Providers still in the revalidation process also would be rejected for a PECOS mismatch. According to CMS representatives, revalidation processing may range from 60-210 days. In some instances, the local MAC needed to “recycle the provider file” to correct the problem. This in turn, by the press of a button, corrected the problem, allowing the practice to resubmit its attestation. In other instances, the Electronic Funds Transfer (EFT) information for the group needed to be updated for those providers yet to be revalidated.

2. EHR payment adjustment being assessed despite successful attestation

Imagine being a successful user of MU and receiving your 2015 Medicare reimbursements reduced by 1 percent with remittance code N700, Payment adjustment based on Electronic Health Record. Your practice never received a letter from CMS advising that your provider was subject to a penalty, your attestations were successful, and you have documentation stating such. One of your providers was audited, but the result of that audit was favorable again with supporting documentation. So, how can your practice be getting assessed a penalty?

In order to get to the root of the problem, PAMED placed a call to the EHR Information Center (888-734-6433) and is awaiting further information on this issue. At this point, we do not have any clear-cut answers as to how and why this is happening. We do know that an informal review form should not be completed unless a penalty letter was received by the provider. This is an error on CMS' end which will need to be corrected. What is unfortunate is the administrative burden the practice's billing staff will face in reapplying the 1 percent corrected payments.

Meaningful Use Attestation is Complete

3. Prepayment audit letter received only two days after submitting Stage 2 attestation

We can only speculate that CMS has realized the difficulties physicians have had meeting the objective thresholds for Stage 2 due to the stringent requirements. Therefore, soon after providers submit attestation, audit requests follow. Some feedback PAMED has received from its members has been audit requests received two days after attestation to an audit request received hours after Stage 2 attestation.

Providers need to be certain to have all of their documentation ready and in hand to send to Figliozi and Company to support all the Core and Menu objectives. Any measures that were answered with a yes/no, screenshots, or reports from the EHR supporting that answer should be provided.

Let's take the example of Core Measure 11 — generate patient list by specific conditions. When attesting, the system simply states “generate at least one report listing patients of the eligible professional with a specific condition.” The provider must mark a yes or no. To support this measure in the case of an audit, the practice will need to show that a report was indeed run during the attestation period to support its answer.

MU continues to be a controversial issue and challenge for many providers. Those providers who choose not to participate due to the burdensome requirements and associated costs, as well as those providers who choose to participate to avoid the associated payment adjustments to their Part B fee-for-service reimbursements, must deal with aggravating issues like those listed above.

PAMED has the resources to help practices meet MU requirements, earn incentives, and avoid penalties.

One of the most common causes for a failed audit is insufficient documentation of the Security Risk Analysis (SRA). PAMED has a toolkit available to assist practices in the completion of the SRA. This toolkit and other HIPAA-related resources can be found at www.pamedsoc.org/hipaa.

PAMED has educational webinars on MU, available at www.pamedsoc.org/webinars. MU incentives and penalties also will be a topic at our spring practices manager meetings across the state. Learn more and register at www.pamedsoc.org/managermeeting. Watch your email inbox for the Daily Dose, PAMED's daily, all-member email, as it contains the latest news and resources to help you and your practice navigate the challenges you face, such as MU.

PAMED members who have questions about MU can contact our Practice Support Team at (717) DOC-HELP, that's (717) 362-4357. ■

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Documentation and Coding Audits Unearth Some Possible Quick Fixes



BY TRACEY GLENN, CPC, COC™, CPMA, CPPM, CEMC, CCS-P
DIRECTOR OF PRACTICE MANAGEMENT CONSULTING, PMSCO

As a certified coder and consultant, I am routinely asked to audit physician documentation and coding. In recent months, these requests have become more frequent as Medicare and commercial insurers have increased their scrutiny of the services being billed.

During an audit, the consultant looks to see if the documentation in the chart supports the level of service billed. In other words, if the physician billed a level 4 (99244, for example), the audit will determine if the documentation in the chart supports that billed code.

The level of service determination generally isn't the only audit outcome. In almost every case, the audit uncovers other errors that could impact practice revenue or be a possible malpractice risk.

The following are examples of coding and documentation errors found in actual charts in physician offices. Although the errors are not intentional, the consequences can be very real.

Get the Easy Stuff Right

Each practice should follow fundamental rules for coding and documentation. Although these basic rules are brought to the attention of physicians at many different venues, the same mistakes keep showing up in patient charts. Here are some examples that are easily correctable:

Using time when billing an evaluation and management (E&M) code

E&M code assignment is generally based on three components: history, exam, and medical decision-making. The combination of these three documentation elements drives the

code that is used. However, if accurately documented, the time that a physician spends with a patient can be used to pick the code level. This is extremely helpful in cases where the physician spends a lot of time just talking to a patient to counsel or coordinate care. There are specific guidelines for using time that are easy to master and put into practice.

Not billing for a service that is documented

During an audit, the entire note for the visit is audited. The documentation may state that the patient presented for a problem visit and some additional services were provided during the service. Many times we find that the office visit code is billed (99213, for example) but none of the additional service codes (urinalysis, lesion removal, etc.) are billed. By not billing for services provided, revenue is lost.

Encounters that cannot stand alone

Each documented encounter must tell the auditor and anyone who reviews the record a complete story. An auditor looks only at the date of service they are auditing. Information provided in prior encounters cannot be considered unless referenced by date in the encounter being audited. We see many, many subsequent hospital visits that state "Patient doing fine. Continue current course of care." This is not enough information to support the billing of even a 99231 and could cause a physician to have to return payment for this service.

Unclear documentation as to the type of patient visit Many times we have no idea if the patient is there as a new patient, established patient, or

consultation. If the note states "new pt ref by Dr. Smith," should the visit be billed as a new patient visit or as a consultation? As this is a common area of confusion, it should be made crystal clear what type of service is being provided. Another area of confusion is whether it is a new patient or an established patient. If the documentation does not specifically state that the patient is new to the practice, an insurer may change the new patient billing code to an established patient code during an audit.

Incomplete or incorrect documentation of a consultation

Correct documentation of consultations is a huge area of concern. Almost all payors are auditing consultations and there are strict rules for documentation within the patient record. It must be clear at the very beginning of the note that the patient is there at the request of another physician for an opinion about a specific problem. In other words, the opening sentence should say something like: "Mrs. Smith presents at the request of Dr. Jones for consultation on her stomach pain." There is no doubt that a physician requested this consult. There should also be documented proof that the opinion was sent back to the requesting physician. If there is not clear documentation that a visit is a consultation, an auditor can say that the encounter is a new or established patient visit and decrease the reimbursement for that visit.

Routine undercoding to stay in the "safe" zone Many physicians think they will avoid the specter of a payor by deliberately billing lower level codes

regardless of what services are performed. I routinely hear, "I bill a 99243 because too many 99244s may raise an audit flag." There are more risks and downsides to this strategy than many recognize. It is still considered fraud and there can be fines assessed for deliberately choosing a "safe" code. I've had physicians audited who only ever choose the level 3 code. An even bigger issue is that it costs the practice money. One example is an audit of 10 charts with a total charge amount of \$500. An audit showed that downcoding accounted for a total loss of \$125—25 percent of the total billed. In today's atmosphere of low reimbursement, a 25 percent loss of revenue is unacceptable.

Frustrating Process Errors

The best documentation and code selection can be a wasted effort if the rest of the process is not implemented correctly. Here are some examples we see frequently:

- The CMS 1500 form states that the patient is female while the documentation clearly states that the

patient is male, or vice versa.

- A 99211 code was billed after the physician saw the patient. A 99211 should only be used when nursing staff sees a patient.
- The date of service billed does not match the date of service documented in the patient's chart.
- A procedure is performed on the same day as an evaluation and management code, but no modifier appears on the claim form. The evaluation and management service must be modified with a 25 for both services to be paid.
- The physician documents two or more diagnoses, but only one is billed. If more than one diagnosis is documented, all should be billed. This is the best way to support medical necessity and the illness burden of the patients in the practice.
- The handwriting in the chart is illegible. Many records are very difficult to read, but can be deciphered with effort. However, too many charts are just flat-out unreadable. If audited, an unreadable record may be considered "unbillable."

Solutions

The best strategy, proven effective by thousands of chart audits, is to clearly and thoroughly document the services provided and then bill in accordance with that documentation. To check results and look for process errors, periodically perform a documentation audit of your own. A random sampling of charts on a regular basis for each physician or mid-level provider can offer insight into problems that may be occurring in the practice. There are many audit templates available to assist a practice in the process. Regular audit of charts, along with education, can help a practice to stay in compliance and realize the revenue that it's due. ■

Tracey Glenn is Director of Practice Management Consulting at PMSCO Healthcare Consulting. Located in Harrisburg, PA, PMSCO is a subsidiary of the Pennsylvania Medical Society. You can reach Tracey via email at tglenn@consultPMSCO.com. You can also visit the company's website at www.consultPMSCO.com.

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iPad Based App Generates Practice Revenue

BY DAVID WEISMAN, MD, JOHN KHOURY, MD, AND KANDAN KULANDAIVEL, MD

Three physicians with Abington Neurological Associates, a community neurology clinic, with support from Abington Memorial Hospital's Innovator's Circle grant, developed an iPad app that tests a patient's cognitive functions.

David Weisman, MD, John Khoury, MD, and Kandan Kulandaivel, MD, created The Philadelphia Cognitive Assessment (P-Cog), a cognitive test to diagnose and detect mild cognitive impairment vs. dementia and can be done within four minutes.

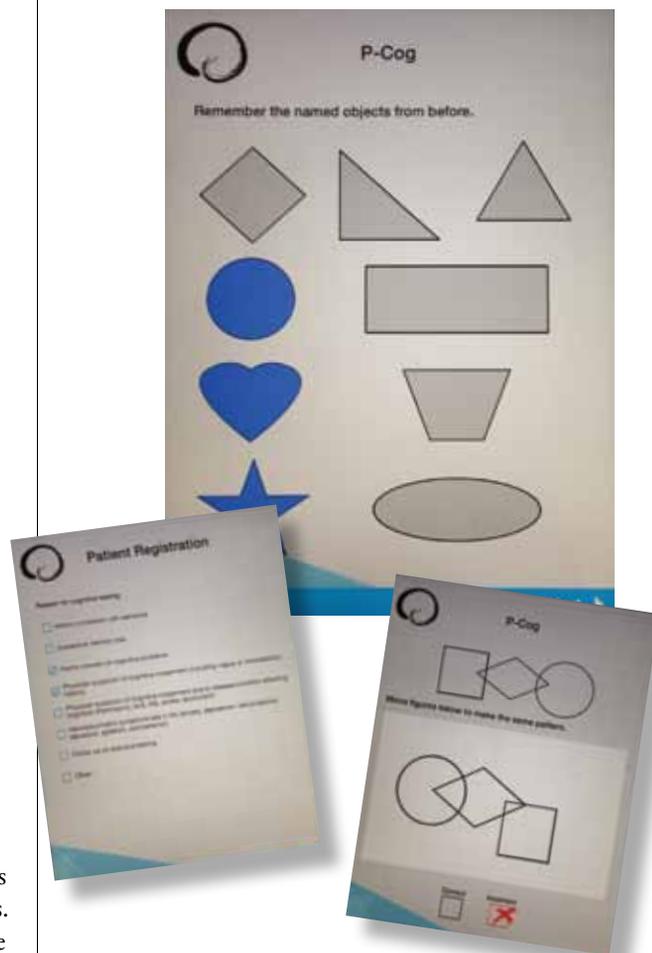
It all started when the three neurologists were discussing the pressures faced by primary care and non-procedural physicians. Doctors get paid disproportionately more to do procedures and read scans and less to listen and think, diagnose and deliver news. And although the Affordable Care Act attempts to reduce the disparity, the physicians agreed it does not. The new emphasis placed on digital records slows everything down as computers interfere with medicine at all levels. In a medical and business environment that rewards efficiency, how does one give patients time?

The physicians sought to find solutions. Dr. Khoury had heard of a procedural CPT code: 96120.

They knew, intuitively, that cognitive disorders are under-diagnosed and under-discussed. There are many barriers: misrecognition of cognitive changes among caregivers and patients, therapeutic nihilism, and the fact that identifying and discussing Alzheimer's disease is time consuming and thus penalizes doctors who have real discussions with their patients. They thought Medicare put the 96120 code in place to reduce such barriers. However, they needed a computerized cognitive test with a doctor's interpretation and report. Billed under a code of 96120, it garners \$50-60 under Medicare as long as it is billed with an associated ICD-9 code associated with cognitive problems. Many codes suffice.

Unfortunately, there was no good test on the market that they felt comfortable using.

So they set out to create their own iPad app. The assessment is a 30-question, multi-domain test that takes two to four minutes to complete. It is designed to be 'memory-heavy' to capture the most common form of mild cognitive impairment, amnesic. It also tests expressive and receptive language, logic, executive, math and visual spatial domains. The neurologists have found it to be user-friendly, intuitive,



and even fun for the patient.

The score, out of 30, correlates to a menu of possible action plans. For example, in a patient who scores 29, one might want to reassure the patient and recommend exercise. In a patient who scores 3, one may opt to discuss end of life care. The menu allows for a wide variety of action plans. The final report can be printed out and added to the patient's chart.

Because it is administered using an iPad, it can be billed under 96120. ■

Check it out in the iTunes App Store at <https://itunes.apple.com/us/app/id908942319> or email Dr. Weisman at dcweisman@gmail.com for additional details.

Help Your Patients To Quit Tobacco Smoking

Physicians Have More Influence Than They Realize

BY LEONARD OLU-WILLIAMS, MPH, PUBLIC HEALTH INFORMATION ANALYST,
MONTGOMERY COUNTY HEALTH DEPARTMENT

Every year, about 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the U.S. \$193 billion a year in direct medical expenses and lost productivity. (healthypeople.gov) Tobacco smoking causes a huge burden on public health.

There are policy measures to control tobacco use in the United States. But not a whole lot of attention has been given to what healthcare professionals can do in their routine work with patients, to help them quit tobacco smoking. Tobacco use remains the leading preventable cause of disease, disability, and death in the United States, making tobacco prevention, cessation and policy issues a top priority in public health. Thirteen percent of Montgomery County adults currently smoke cigarettes according to survey data released from the 2012 Southeastern Pennsylvania Household Health Survey, an annual survey by Public Health Management Corporation (PHMC) Center for Data Innovation.

On average, smokers suffer for years with more health problems due to their smoking and ultimately die earlier by a decade or more compared to nonsmokers. In fact, smokers' overall health is worse and they are sick more often than nonsmokers. Smokers need to go to the doctor more often and they are admitted to the hospital more often than nonsmokers. Additionally, smoking is known to compromise the balance of the immune system. This increases the risk for several immune and autoimmune disorders. New evidence finds that smoking is a cause of rheumatoid arthritis and interferes with the effectiveness of certain treatments for condition. (2014 Surgeon General's Report: The Health Consequences of Smoking—50 Years of Progress)

According to *An Implementation Guide for Community Health Centers*, epidemiologic data suggest that almost 70 percent of smokers want to quit and about 52 percent try to quit every year. Many of those who attempt to quit do so without help, and they are often unsuccessful. Tobacco dependence is difficult to break, and people may need to make several attempts to quit before they are successful. The good news is that there is strong evidence showing that advice from a health care professional can more than double smoking cessation success rates. Research also shows that "patients are more satisfied with their healthcare if their primary care provider offers smoking cessation interventions—even if patients are not yet ready to quit." (aafp.org)

As a physician, you can play a key role in fighting tobacco use. You know the drastic effects that smoking can have on your patients' health and also know the toll secondhand smoke can take on the children and families of smokers. Studies have shown that smokers want to quit and getting started often takes support and motivation from trusted sources, like you.

A brief tobacco intervention tool can be used during patients' visits. (CDC, 2015)

THE BRIEF TOBACCO INTERVENTION The 2As & 3Rs

ASK about tobacco use:

"Do you currently smoke or use other forms of tobacco?"

ADVISE the patient to quit:

"Quitting tobacco is one of the best things you can do for your health. I strongly encourage you to quit. Are you interested in quitting?"

REFER the patient to resources:

IF READY TO QUIT: Provide direct referrals to resources that will assist the patient in quitting. Prescribe medications, if appropriate. "This is a resource I recommend. It will provide you with support, help you create a plan to quit, and talk to you about how to overcome urges you might have to smoke after you quit."

IF NOT READY TO QUIT: Strongly encourage patients to consider quitting by using personalized motivational messages. Let them know you are there to help them when they are ready.



Recommended resources include:

- Free telephone-based state tobacco quitlines: 1-800-QUIT-NOW
- The National Cancer Institute's website: www.Smokefree.gov
- The National Cancer Institute's text-messaging quit smoking program: SmokefreeTXT; Text QUIT to 47848
- The Department of Health and Human Services website: www.BeTobaccoFree.gov
- Appropriate community-based or local cessation resources (e.g., classes, support groups)

Visit the following websites for more information and resources to help your patients quit tobacco smoking.

1. Healthcare Professionals: Help Your Patients Quit Smoking (2015). <http://www.cdc.gov/tobacco/campaign/tips/partners/health/hcp/>
2. Help Your Patients Quit Tobacco Use: An Implementation Guide for Community Health Centers. http://www.prevent.org/data/files/actiontoquit/leg-community_health_report_inside_final_web_101013.pdf.
3. The Coalition for a Tobacco-Free Montgomery County. <http://www.tobaccofreemontco.com/> ■



Out with the Cold, In Comes Spring Allergies

BY GEORGE R. GREEN, MD

Many couldn't wait for the cold and snow-covered winter to loosen its grip, but for allergy sufferers, it's a welcomed relief from the spring pollens that now fill the air.

The first tree pollens usually start to appear in March. Since southeastern Pennsylvania has a variety of species, pollen tends to last through May. This period usually overlaps with the grass pollen season, which peaks around Memorial Day and often continues into June. There is usually a reprieve until August and then fall ragweed begins, eventually subsiding after the first frost.

Tree Pollen Can Travel Great Distances

Individual tree species tend to pollinate almost on the same day. Often cars that are parked near a particular species of tree end up coated with a fine yellow dust. Tree and grass pollens are very light, so the wind can spread them over great distances. Pine and other evergreen pollens are not only much heavier, but also have a coating. As such, they tend to grow in more narrow areas and are not as great a factor in human allergies. Some believe that allergy seasons and patient suffering have increased due to "global warming," but the evidence is lacking to substantiate

that claim.

After many years of managing allergy problems, it is evident that patients with sensitivity to multiple pollens have substantial and prolonged symptoms. This is due in part to what is called a "priming effect" on a patient's mucous membranes by one species, leading to even more discomfort when the next wave of pollen arrives.

Allergy Sufferers May Be Sleep Deprived

The classic symptoms of allergic sensitivity to pollens are sneezing and itching of the nose, eyes, ears or the roof of the mouth. A common symptom that people often do not attribute to allergies is fatigue. Allergies interfere with restful REM sleep, so even if an allergy patient gets eight hours a night, they may not feel rested. Allergies can really wear people down and the term "allergic fatigue" has some validity. After acknowledging the scope of the problem, the FAA conducted detailed long-term studies in flight simulators, using multiple medications to control allergy symptoms. Based on these studies, the FAA allows pilots to use two specific forms of antihistamines — Fexofenadine and Loratadine — when flying airline type aircraft.

Common Cold vs. Allergies

There may be difficulty in determining if symptoms are from a common cold or allergies. If you have fever, you likely have a cold or flu and not allergies. If the symptoms last longer than 10 days, it is allergies rather than a cold. If symptoms are worse outside, it is more likely due to allergies.

Tips to Managing Allergies

Approximately 40 million Americans have indoor/outdoor allergies. Although there is no cure, symptoms can be managed with proper prevention and treatment.

- Avoidance of exposure is the first rule in managing allergy symptoms. This may involve staying indoors with the windows closed and air conditioner on as much as possible, especially in the mid or late afternoon when pollen counts are highest (this also applies to traveling in a car). Going out to mow the lawn during grass pollen season can make one feel extremely uncomfortable.
- The use of medications (antihistamines) is key to controlling allergy symptoms. Starting the medication at the beginning of the season helps to control inflammation—a delay may prolong the misery. Antihistamines have long

been the mainstay of allergic symptom management. The “non-sedating antihistamines” Fexofenadine and Loratadine are now available without a prescription and are widely used. Older drugs like Benadryl are also effective but can cause sedation (its active ingredient, diphenhydramine, is often included in over the counter sleep aids). Cetirizine is also available over the counter, and can be effective, but the FAA found it to be too sedating to give to flying pilots, so plan accordingly.

- When avoidance and oral antihistamines are not enough to control symptoms, doctors may prescribe nasal steroids and or nasal antihistamines to help with symptom control. On the other hand, the use of over the counter decongestants to provide relief is generally not recommended.

- Immunotherapy, also known as allergy shots, can help people with more severe or refractory symptoms. This treatment takes dedication and requires weekly visits for several months, followed by monthly injections for as long as three to five years to reach maximum effectiveness. The FDA has recently approved sublingual materials for certain pollen allergic patients but this also requires several months of treatment ahead of the pollen season, which makes it similar to allergy immunotherapy. Take home point: people do not need to suffer through seasonal allergies as there are multiple treatment modalities available.

George R. Green MD is board certified in allergy and immunology, as well as internal medicine. He serves on the MCMS Board of Directors, is chairman of the Membership Services and Benefits Committee and serves as a member of the Finance Committee. Dr. Green has combined his passion for medicine with flying by volunteering with Angel Flight East. He is also a senior aviation medical examiner. His passion for flying was featured in the Summer 2014 issue of MCMS Physician.

Each year, the Asthma and Allergy Foundation of America (AAFA) declares May to be “National Asthma and Allergy Awareness Month.”

It’s a peak season for asthma and allergy sufferers, and a perfect time to educate your patients, family, friends, co-workers and others about these diseases. Allergy is the fifth leading chronic disease in the U.S. among all ages, and the third most common chronic disease among children under 18 years old. It is characterized by an overreaction of the human immune system to a foreign protein substance (“allergen”) that is eaten, breathed into the lungs, injected or touched. This immune overreaction can result in symptoms such as coughing, sneezing, itchy eyes, runny nose and scratchy throat. In severe cases it can also result in rashes, hives, lower blood pressure, difficulty breathing, asthma attacks, and even death. A number of resources are available at www.aafa.org

Top 20 Allergy Capitals 2014

There is no place safe from allergies in America, and some cities are more problematic than others. The Allergy Capitals is an annual research project of AAFA to identify “the 100 most challenging places to live with allergies” during the spring and fall seasons. The data measured and compared each season includes:

- Pollen scores (airborne grass/tree/weed pollen and mold spores)*
- Number of allergy medications used per patient
- Number of allergy specialists per patient

Louisville, KY	Birmingham, AL
Wichita, KS	Knoxville, TN
Oklahoma City, OK	Buffalo, NY
Dayton, OH	San Antonio, TX
McAllen, TX	Dallas, TX
Memphis, TN	Providence, RI
Baton Rouge, LA	Columbus, OH
Jackson, MS	El Paso, TX
Chattanooga, TN	Des Moines, IA
Tulsa, OK	Syracuse, NY

As for Pennsylvania, Philadelphia came in at 40; Pittsburgh at 45; Scranton 53; Allentown at 66 and Harrisburg at 69. ■

Source: Asthma and Allergy Foundation of America, www.AllergyCapitals.com

To Vaccinate or Not to Vaccinate?

Dr. Steven A. Shapiro, a practicing pediatrician for more than 30 years, explains why vaccinations are safe, effective and necessary.



Affectionately known as Dr. Steve, Steven A. Shapiro, DO, has been nurturing children for more than

30 years. In 1980, he opened his practice, Pediatric Medical Associates, and services two locations in East Norriton and Rydal. Since January 2002, Dr. Shapiro has served as chairman of the Department of Pediatrics at Abington Memorial Hospital (AMH). He is a graduate of the Kansas City University of Medicine and Bioscience, and completed his residency in pediatrics at both the Naval Regional Medical Center-Philadelphia and the Children's Hospital of Philadelphia (CHOP). Following his residency, he completed a fellowship in pediatric hematology/oncology at CHOP. An outspoken advocate for children, Dr. Shapiro is board certified in pediatrics and is a Fellow of the American Academy of Pediatrics (FAAP) and the American College Osteopathic Pediatricians (FACOP). He currently serves on the Pennsylvania Medical Society Board of Trustees and has been a longtime member of the Montgomery County Medical Society.

MCMS Physician: How do vaccines prevent disease?

Dr. Shapiro: Vaccines prevent disease by challenging the immune system of children and adults to produce specific antibodies to a particular organism or virus. It will remain in the body to be available for activation should the child or adult be exposed to the particular offending agent.

MCMS Physician: Who should receive vaccinations? Children only?

Dr. Shapiro: Children obviously receive most of these vaccines to build their own immunity. But a major contributing factor to the resurgence of certain diseases that were thought to be well controlled (e.g., pertussis) is due to waning immunity in adolescents and adults that allows the organism to re-enter and spread into the community. Some of the vaccines that are in use today, while milder in terms of systemic reactions after administration, are not as immunogenic as were similar vaccines used in the past. Thus, the "perfect storm" of immunologic insufficiency has been created and the diseases have begun to reappear.

MCMS Physician: How old and how long should you receive vaccinations?

Dr. Shapiro: Routine primary immunization of children begins normally at 2 months of age. These primary immunizations are generally completed by 15-18 months and then the child begins to receive "Booster" doses at prescribed intervals. There are other vaccines administered during adolescence that provide protection for diseases that will typically occur during the second decade of life and thereafter.

MCMS Physician: Are vaccines safe?

Dr. Shapiro: Yes!

MCMS Physician: What are the possible side effects?

Dr. Shapiro: Side effects to any vaccine are predictable. If you expose the immune system to challenges on a regular basis, there will be reactions. They are to be expected, and fortunately are reasonably mild and require occasional use of antipyretics following the vaccination. Should a more profound event occur in association with any vaccination, there would be cause to consider exemption from further exposure, but these should always be considered on a case-by-case basis. It goes without saying that any child or adult with any type of immunologic insufficiency by virtue of disease or an inherited disorder must be considered carefully on a case-by-case basis before any vaccine is administered.

MCMS Physician: Do you believe all children should be vaccinated? If not, who are the exceptions?

Dr. Shapiro: Should there be exceptions? There is incontrovertible evidence

to suggest that vaccines are both safe and effective in their current schedules to be given to any child. Only in the event of a particular contraindication based on disease or immunologic status should an exception be made.

MCMS Physician: What are the community benefits to vaccinations?

Dr. Shapiro: Immunizing large populations allows for protection of all of the individuals in that community, and assures that the particular disease being addressed will not easily be communicated into that population. Recognize however, that regardless of how effective any vaccine or vaccination program is in any part of the world, vaccines should never be considered 100 percent effective, thus making the case for every member of that community to be involved in the effort.

MCMS Physician: Should parents wait to vaccinate their children until they are older?

Dr. Shapiro: Alternative schedules for immunization have been touted by others from the fringe of the pediatric community on many internet websites, by those individuals who are acting in contradistinction to best practices developed by the CDC and the ACIP (Advisory Committee on Immunization Practices) and by those who prey on the belief that there are still mysteries to the time proven techniques currently in place.

MCMS Physician: What would happen if you stop vaccinating?

Dr. Shapiro: We have already seen the jeopardy we place populations into when vaccines are withheld. The recent measles outbreak at Disneyland is proof positive that if vaccination programs are interrupted, diseases will re-emerge.

MCMS Physician: If a parent chooses not to vaccinate, how do you treat the child's medical needs?

Dr. Shapiro: Since the most recent measles outbreak in Disneyland, there has been an awakening to the issues created by non vaccination. Many of those parents who have chosen not to vaccinate have faced the reality that the few practices that left their doors open to them are rapidly disappearing as the risk of contamination to their office spaces and personnel for an extended period of time. Many of us have become deeply disturbed by having to face the reality of not being able to offer these children a proper medical home in their respective community.

How Vaccines Prevent Diseases

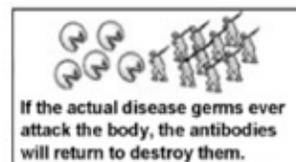
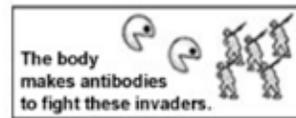
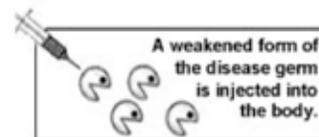
The diseases that vaccines prevent can be dangerous, or even deadly. Vaccines reduce the risk of infection by working with the body's natural defenses to help it safely develop immunity to disease.

When germs, such as bacteria or viruses, invade the body, they attack and multiply. This invasion is called an infection, and the infection is what causes illness. The immune system then has to fight the infection. Once it fights off the infection, the body is left with a supply of cells that help recognize and fight that disease in the future.

Vaccines help develop immunity by imitating an infection, but this "imitation" infection does not cause illness. It does, however, cause the immune system to develop the same response as it does to a real infection so the body can recognize and fight the vaccine-preventable disease in the future. Sometimes, after getting a vaccine, the imitation infection can cause minor symptoms, such as fever. Such minor symptoms are normal and should be expected as the body builds immunity.

Diseases that used to be common in this country and around the world, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, rotavirus and Haemophilus influenzae type b (Hib) can now be prevented by vaccination. Thanks to a vaccine, one of the most terrible diseases in history – smallpox – no longer exists outside the laboratory. Over the years, vaccines have prevented countless cases of disease and saved millions of lives. ■

Reprinted with permission from the Centers for Disease Control and Prevention, www.cdc.gov.



DISEASES THAT CHILDHOOD VACCINES PREVENT

- Diphtheria
- Haemophilus influenzae type b (Hib disease - a major cause of bacterial meningitis)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV - a major cause of cervical and other cancers)
- Influenza
- Measles
- Meningococcal
- Mumps
- Pertussis (Whooping Cough)
- Pneumococcal (causes bacterial meningitis and blood infections)
- Polio
- Rotavirus
- Rubella (German Measles)
- Tetanus (Lockjaw)
- Varicella (Chickenpox)

Welcome New Members...

To publish photos of new MCMS member physicians, please submit digital copies to montmedsoc@verizon.net

MCMS is pleased to welcome the following individuals who joined the Society in 2014:

November 2014

John Daniel Arena, Medical Student
Jack E. Gitterman, MD
Philip Emanuel Silkoff, MD

December 2014

Abigail Kramer Classen, DO
Kathleen Fullbright, Practice Administrator
Richard A. Harrigan, MD
Heather Lori Osher, DO

January 2015

Richard Edward Grant, MD
Aaron Jordon Jaworek, MD
Thomas M. Klein, MD
Jason Christopher Saillant, MD

February 2015

Juan J. Gan, MD

March 2015

Elyse Carrullo, Practice Administrator
Lingyi Chen, MD

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Questions?
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Necrology Report

MCMS regrets the loss of these society members since June 2014.

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