President's Message

If Not Now, When?
Ralph D. McKibbin, MD, FACP, FACG, AGAF

In my inaugural column I noted that “serious threats are gathering on the horizon.” Presidential election drama is dominating the nightly news and it would be easy not to notice the issues before us. In the past, physicians were often detached from politics and financial stressors facing other sectors of the economy. Those days are gone. A survey of recent health care news and events affecting gastroenterologists shows:

• In western Pennsylvania, Highmark Health is cutting reimbursement to doctors by 4% effective April 1 for care provided to patients with health insurance bought through the government exchange.

• Nationally, Forbes reports that UnitedHealth Group may withdraw from the exchanges in 2017 due to more than $1 billion in losses in 2015.

• Pennsylvania insurance commissioner Teresa Miller unveiled a proposal to ease financial pain for patients adversely impacted by “surprise medical bills.” A proposed legislative fix would require providers to take the in-network rate and would prohibit and possibly criminalize directly billing the patient. Forcing in-network rates on providers misaligns or eliminates the concept of contract negotiations.

• Colonoscopy fees were reduced up to 17% in 2016 but CMS feels that lower GI endoscopy services are still misvalued due to changes in practice patterns and increasing use of anesthesia. It is proposed to further reduce endoscopy payments by the value of the anesthesia.

• Eligible providers who did not meet PQRS reporting requirements will receive a 2% reimbursement cut.

• Practices not meeting Value-Based Payment Modifier goals face an additional 2% cut in reimbursement.

• The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the creation of the Merit-Based Incentive Payment System (MIPS). Details are still to be determined.

Storm clouds on the horizon indeed. During big election years, more than any other, people clamor to be heard. So often in the past we have been quiet and left results to chance. Now, more than ever, we need to speak up. If we do not make our own case we will surely, once again, find ourselves the scapegoat for others spending priorities. The process is daunting and the goal seems distant, but to paraphrase Taoist philosopher Lao-Tzu, “every journey begins with a single step.”

To use a cheap metaphor, I suggest we think of ourselves and our practices as patients. We need to take our own advice and use the tools we have offered to others. Just as we urge support systems on our IBD and cancer patients, we need to utilize the same concepts. Teamwork is needed continued on page 14
TIN Cans?
By F. Wilson Jackson, MD

The Medicare Contractor Advisory Committee (CAC) met February 10, 2016. The CAC is the forum for our Medicare Jurisdiction (Jurisdiction L) to review amendments that are too old or to comment on new coverage determinations as they pertain to Medicare beneficiaries. There is representation from the full spectrum of medical specialties on the CAC and the PSG speaks on behalf of gastroenterologists, particularly those in Pennsylvania. There were six Medicare policies discussed but none had direct relevance to gastroenterology.

The other portion of the meeting was devoted to updating members on a variety of policies and initiatives within Medicare. As you all know, there are numerous reporting requirements in various phases of initiation and retirement as part of the ACA bill. Some time was devoted to the Value Modifier (VM) program but further questions were referred to the CMS webpage. I can share some perspectives of these programs to the extent I understand them.

The Value Modifier program builds on the PQRS initiative and participation in PQRS is essential to VM enrollment. It is useful to remember that the VM program is a Peter-Paul plan. Essentially those practices that score low in quality and high in cost subsidize the bonus payments to those that score better in these categories. It is a zero-sum game.

I recently had an opportunity to query the CMS website on behalf of our practice here in South Central Pennsylvania and see how we scored in the early phases of the Cost Composite Score program. CMS has a four-square grid to characterize cost and quality. See Graphic 1 on next page.

Depending on which square you score within, your Medicare reimbursement is adjusted up, down, or remains neutral. Our practice did well enough but we decided to drill into what criteria were used to create our composite score. The process centers around the tax ID number (TIN). Claims made under your practice’s TIN are squared up against a particular beneficiary’s claims. A composite picture and score are then generated for your TIN. We then looked further to help us understand what contributed to our score. It turned out that we had a high cost score amongst a particular patient sub-population. Our practice sees patients in a Long-Term Acute Care (LTAC). We learned that these dozen or so patients negatively impacted our total cost score. When we examined these patient encounters, however, there was little that deviated from routine care; an initial consult, a fraction of patients who needed an endoscopic procedure, and a few follow-up visits. Why then, were we an outlier with regard to cost amongst these few patients as part of the much larger group of Medicare patients for whom we provided care? What if care is administered from several different practices, each submitting claims under their own TIN? How is the episode of care parsed and partialled?

The answer, it turned out, was hard to define. As far as I could determine, there is no adjustment when more than one TIN is applied to an episode of care. There are adjustments for complexity of care but after spending a long Sunday morning reading into how these scores are calculated, I had no further understanding. Our practice submitted a query to CMS through their web portal but the response we eventually received (the request was promoted to a second tier level support) did not answer the core question of how care provided to a Medicare beneficiary amongst several TINs are reconciled. One set of providers submitting a claim under one TIN have little impact on the care provided by providers submitting under another TIN. Maybe this is the intent; to drive further consolidation within any given medical community.

Regardless, below is the payment adjustment depending on where your practice, or more accurately, your TIN, scores and what the payment adjustment will be. The AF in the grid is an adjustment factor for high performing groups and is adjusted year to year. As far as I could determine, it is a “fudge factor.” See Graphic 2 on next page.

The program will deploy over several years depending on the size of your practice (as defined by your billing TIN) but three years from now, any practice with more than one provider will be subject to the Medicare payment adjustment.

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Your PSG organization will continue to advocate on your behalf here within Pennsylvania. We would welcome comments or feedback as these federal programs are deployed on how PSG can help you continue to deliver high quality care to your patients. Under the thoughtful leadership of Dr. Ralph Mckibbin, PSG will remain vigilant to changes within the Pennsylvania legislature in the context of the larger changes to health care delivery and reimbursement around our country. As always, please let us know of any questions or concerns.
Join PSG at the Kalahari Resorts & Conventions for the 2016 Annual Scientific Meeting

By Karen Krok, MD
2016 PSG Program Chair

This year’s PSG Annual Scientific Meeting will be held in the Poconos at the new Kalahari Resorts & Conventions from September 23-25, 2016. I am excited to be program chair for the meeting this year! Every year, this meeting attracts over 100 gastroenterology providers and nurses from all over Pennsylvania. It is a great time to connect with colleagues and meet up with friends and former trainees.

There have been some beautiful locations chosen recently for the Annual Scientific Meeting – Nemacolin Woodlands Resort, The Hotel Hershey, and Skytop Lodge to name just a few of them. This year’s venue will continue in that tradition and we hope that you will consider bringing your family, as the Kalahari Resorts has an indoor water park for all to enjoy! The resort also provides state of the art conference rooms for the educational component of the meeting.

The program will start on the night of Friday, Sept. 23, with cocktails and hors d’oeuvres. The sessions will run on Saturday from 7:45 am - 12:30 pm and on Sunday from 7:45 am - 12:00 pm. Breakfast is provided both mornings prior to the start of the sessions. Saturday will also have a revival of the GI Fellow Jeopardy from 12:30 pm – 1:30 pm, with lunch provided. Last year, the fellows were divided into three teams and even the providers in the audience were getting into the game. We hope that more people will stay and participate in Jeopardy this year. It is amazing what we forget when we are done with our training!

We have a fantastic line up of dynamic speakers representing all of the academic centers in Pennsylvania. We heard your requests for topics last year and this year’s program will focus on some of those desired themes.

2016 Program Topics

- Fecal Transplant for C. difficile
- New Colonoscopy Techniques to Improve Adenoma Detection Rate
- Management of IBD in the Childbearing Years
- Disparities in Liver Transplant
- Hepatitis C
- Metabolic Liver Diseases
- Endoscopic Management of Obesity
- Nutritional Information for the GI Practitioner
- POEM and Treatment of Achalasia
- The IBD Medical Home
- Telemedicine and Telehealth
- And More!

Saturday evening there will be a reception and dinner. This year we will be honoring one of our own – Dr. Harris Clearfield – who is an icon in the world of gastroenterology for the Philadelphia region. He has trained many of the GI physicians in Pennsylvania and we will acknowledge his dedication to the field of GI. If you have worked with or been trained by Dr. Clearfield, we would love to see you attend this meeting and reception in order to support him!

In addition to honoring Dr. Clearfield, we are excited to have comedian Joe Conklin as our special guest entertainer for the evening. Joe Conklin’s comedy show is geared towards a Pennsylvania audience, featuring topical sports humor and impressions of celebrities, sports figures and politicians, both past and present.

You will be receiving more information in the mail over the summer about this conference. Save the date now (before call schedules get finalized!) and we look forward to seeing you at this year’s Annual Scientific Meeting in September at Kalahari Resorts & Conventions in the Poconos!
Risk Management

Individuals Rights Under HIPAA to Access Their Health Information: New Guidance 45 CFR § 164.524

By Richard E. Moses, DO, JD

It is generally accepted that patients need to have access to their health information. In doing so, they will be in a better position to control decisions regarding their health and overall well-being. Patients are becoming “information empowered,” frequently searching the internet before and/or even during a medical encounter to become more informed of their medical problems, treatment options, and plans. In having the ability to view their medical records, patients are able to find and correct errors, track their health and medical management, and contribute to their health care.

The ACA, HITECH, and MACRA require health care providers to use EHRs and provide patients access to their data, in addition to communicating with them electronically. Given the advances in health care technology, the government and outside entities are pushing for patient medical records to be made available in an electronic format. A salient example of the latter is the GetMyHealthData Campaign. This campaign was started in July 2015. It is a collaborative effort of leading consumer organizations, health care experts, former policymakers, and technology organizations working to enhance consumer access to digital health information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy and security of individuals’ identifiable health information. It establishes patients’ rights with respect to their health information, with particular attention to their need to access and obtain a copy of their health information. The HIPAA Privacy Rule provides patients with a legal enforceable right to see and receive copies upon request of the information in their health records maintained by their health care providers and health plans, with limited exceptions. This creates confusion and a lot of potential risk for health care providers, who are in custody of their (at times voluminous) health care data, given the aggressive penalties for a HIPAA breach.

In January 2016, the Health and Human Services Department’s Office of Civil Rights (OCR) issued guidance, (Individuals Right under HIPAA to Access their Health Information - 45 CFR § 164.524), in an attempt to help providers understand how to respond to information requests and define what information should be released. Additionally, it discusses when patients can be charged for information.

A full review of this important OCR release is beyond the scope of this discussion. Some examples of the issues addressed in HHS’ new guidance include:

- How patients may request their records, making clear that providers cannot require patients’ physical presence or the use of regular mail.
- If a patient requests a particular electronic format (e.g., a machine-readable format such as a CCDA or PDF), electronic copies must be provided as long as the health care provider is able to readily produce a copy in that format. HHS is clear that the form and format of the records request is a question of provider capability (rather than willingness).
- Health providers are not expected to tolerate “unacceptable levels of risk to the security of the PHI” on their systems in responding to patient requests.
- The scope of the information patients can obtain, per the “designated record set,” includes medical records; billing and payment records; insurance information; clinical laboratory test results (including genomic information generated by a clinical laboratory); wellness and disease management program files; and clinical case notes.
- The time requirement for patients to receive their records is still 30 calendar days but HHS clarifies that with modern electronic health systems, turnaround time could be shorter, and encourages providers to treat the 30-day mark as an “outer limit.”

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The Benefits of Your PSG Membership

Annual Meeting
• Free to members. The non-member meeting physician registration fee is $175 and $100 for physicians’ assistants and nurses. (Pending members who have a completed application on file are entitled to free registration.)
• The 2016 annual meeting will be held September 23-25 at the Kalahari Resorts & Conventions in Pocono Manor, PA.
• The annual meeting provides an excellent opportunity to earn CME credits.

Interaction with Other State and National Medical Societies
• PSG is a member of the DDNC and is represented at their meetings.
• PSG maintains a regular dialogue with the AGA, ACG, and ASGE on national issues that impact Pennsylvania gastroenterologists.
• PSG has a seat on the PA Medical Society (PAMED) Specialty Leadership Cabinet and a vote at their House of Delegates. Together, PSG and PAMED advocate for gastrointestinal issues on a state level.
• The two PA regional governors for ACG are now members of the PSG board and we will closely collaborate with them on matters of common interest.

Representation by GI Fellows In Training
• Four FITs sit on the PSG Board.
• PSG hosts a FIT poster competition at the annual meeting. Those who submit a poster and attend the meeting receive generous stipends.

Reimbursement and Health Care Issues
• PSG routinely corresponds with carriers to convey gastroenterology concerns and clarify questions.
• PSG sends a gastroenterology representative to the PA Medicare Carrier Advisory Committee.

PSG Website
The PSG website (www.pasg.org) has many features that benefit our physician members and their patients. Website features include:
• membership information – online join/renew opportunities;
• meeting information;
• legislative and payor relations updates;
• fellows in training details; and
• electronic copies of the PSG newsletter, Rumblings.

Rumblings Newsletter
• Contains reimbursement news and updates
• Alerts members of pending issues and problems relative to gastroenterology
• Informs members of state and federal legislative issues effecting Pennsylvania gastroenterologists
• Provides helpful information for GI fellows and new practitioners

If you received this issue of Rumblings as a non-member, PSG invites you to consider membership benefits such as free registration for the PSG Annual Scientific Meeting, representation in physician advocacy activities, and opportunities for dialogue with other GI professionals across Pennsylvania. To learn more about the Society, www.pasg.org.

Join us today! A membership application is enclosed in the following pages.
1. Instructions
   a. Please print or type all responses.
   b. Return completed form to: PSG, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105-8820
   c. Please attach current curriculum vitae.
   d. Please list the appropriate names as references in the space provided (Item #14, #15 or #16).
   e. Please enclose a check or credit card information to cover current year’s membership dues.

2. Application for (please check one):
   ❒ Active (Dues = $175)
   ❒ Associate (Dues = $0)
   ❒ Affiliate (Dues = $88)
   ❒ Non-Physician Clinician-NPC (Dues = $60)
   ❒ Check enclosed OR ❒ Charge my Mastercard, Visa, or Discover (circle one).

   Name__________________________________________ Exp. Date________________________
   Billing Address___________________________________________ 3 digit CCV __________
   Signature______________________________________________

   Active—must have authentic medical or osteopathic licensure; be in good standing in the community and of sound moral and ethical nature and free of any criminal record or indictment; must be board certification in gastroenterology or fulfilling the criteria for eligibility for board certification in gastroenterology; dues paying member.

   Associate—available to all residents or fellows during the period of subspecialty training in gastroenterology; will not pay and may not vote.

   Affiliate—any person of good character who evinces an interest in GI; may serve as a committee member but may not vote; dues are 50 percent of the active member rate.

   Non-Physician Clinician (NPC)—any person who is a certified registered nurse practitioner, physician assistant, nurse, or other NPC working in the field of Gastroenterology. Must include letter from their gastroenterologist employer with application; may serve as a committee member (but not as chair); may not vote.

3. Name __________________________________________

4. Office Address_________________________________ Home Address__________________________
   _______________________________________________ ________________________________
   _______________________________________________ ________________________________

5. Phone __________________________________________ Phone ____________________________________

6. Fax ____________________________________________ E-mail ____________________________________
   ❒ I give permission to the PSG to add my email address to their database for PSG use ONLY. PSG will not share your email information with outside parties.

7. Preferred Mailing Address ❒ Office ❒ Home

8. Date of Birth ___________________________ Place _________________________________________
9. Medical School ____________________________________________
   Degree ____________________________________________ Graduation Date ______

10. Residency ____________________________________________
    Subject ____________________________________________ Begin Date _______ End Date ______

11. GI Fellowship __________________________________________
    Begin Date _______ End Date ______
    Medical License Number ____________________________ State ___________ Date Issued ______
    In active practice of Gastroenterology since __________________________

12. Board Certification
    Internal Medicine  □ Yes  □ No (date ____________)
    Gastroenterology  □ Yes  □ No (date ____________)
    Affiliate members – Other ________________ (date ____________)
    (date ____________)

13. Member of  □ AMA  □ Pa Medical Society  □ CMS  □ AGA  □ ASGE  □ ACG  □ AASLD
    Fellow of ______________________________________

Reference Requirements

14. Active and Affiliate Applicants:
    Please list the names of two active members of the PSG or one active member and one of a medical colleague 
    familiar with your professional activities (e.g. chief of service or chief of medicine).
    The PSG office will send a reference form to the physicians you have indicated.

    1. ____________________________ (Please Print)
    2. ____________________________ (Please Print)

15. Associate Applicants Only:
    Please provide the signature of the director of your training program or chief of service.
    ____________________________ (Please Print)

16. NPC Applicants Only:
    Please provide a letter of recommendation from your Gastroenterologist Employer and return with application.

Application Process
    Administrative office must receive:
    • Completed application;
    • Copy of curriculum vitae;
    Application is reviewed and approved by Membership Committee.
    Application is reviewed and approved by Governing Board.
    Applicant receives letter of acceptance and membership certificate.
The DDNC 26th Annual Public Policy Forum was held on March 6th and 7th in Washington, DC. Professional societies, disease advocacy groups, and patients and their family members affected by digestive diseases met to perform congressional visits to improve public policy and raise congressional awareness related to digestive diseases. The first day of the forum was comprised of educational sessions.

A federal policy presentation was given to update attendees on upcoming priorities for the coming year. Stephen James, MD, Director, Division of Digestive Diseases and Nutrition at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) presented an overview of initiatives from their 2016 Recent Advances and Emerging Opportunities Report. Biomarker detection of pancreatic cancer, genetic markers for IBD, and the detection of microbial correlates with disease activity are areas of promise. Virus diversity in the gut is also noted to be altered in IBD patients with active disease. Colorectal cancer genetics and inflammation control are felt to be beneficial to those at risk for CRC. Obesity and fatty liver disease are on the rise. Nonalcoholic fatty liver disease (NAFLD) and nonalcoholic steatohepatitis (NASH) are being studied for both pharmacologic and lifestyle change therapy.

The second panel gave updates from academic institutions. Raymond Cross, MD, MS, AGAF, Director of the IBD Program, University of Maryland School of Medicine; Co-Director Digestive Health Center, University of Maryland Medical Center discussed upcoming therapies for IBD. Tofacitinib, a Janus kinase (JAK) inhibitor, and ustekinumab, an IL12/23 inhibitor, were reviewed. There are also encouraging results regarding the use of mongersen, an oral antisense SMAD7 oligonucleotide, for the treatment of Crohn’s disease. Renee Williams, MD, Clinical Assistant Professor, Department of Medicine, New York University Langone Medical Center presented data regarding the successful efforts of the city of New York and the State of Delaware to diversify colorectal cancer screening programs and achieve equal access for residents.

The third panel of constituent members Rohit Satoskar, MD, Chair Public and Clinical Policy Committee, American Association for the Study of Liver Diseases (AASLD) and Walter Park, MD, Chair, Public Health and Public Policy Committee, American Society for Gastrointestinal Endoscopy (ASGE) presented on the efforts of their organizations to advocate for patients and practitioners.

The fourth panel was composed of institutional and industry panel members. Raymond Panas, PhD, Senior Medical Science Liaison, Entera Health Inc. presented on efforts to get FDA guidance on medical food. Development efforts in the area of therapy and treatment are hampered due to inconsistencies in regulatory language regarding the need for an IND. Consensus efforts will be needed to continued on page 10
reopen this area of research. John Korney, MBA, Executive Director, GI and Respiratory Marketing, Medical Systems Group, Olympus America, Inc. presented on their efforts to advance care while maintaining safety and confidence.

The second day advocacy sessions were conducted at congressional offices. Attendees met with their home representatives and senators and staff to stress digestive disease issues and priorities. Key priorities for 2016 include:

- Fiscal year 2017 NIH funding at the level recommended by the National Commission on Digestive Disease Research
- Adopt the Precision Medicine Initiative looking at DNA regions associated with GI cancer
- Support the Cancer Moonshot
- Support the Department of Defense Peer Reviewed Cancer Research Program
- The Department of Veterans Affairs Medical Research Program which supports functional motility disorders, viral hepatitis, and liver diseases
- The 21st Century Cures (HR 6) to modernize and personalize health care
- Implement the National Pediatric Research Network Act (LAW 2013)
- Support the CMS letter to state Medicaid directors requesting less restrictions on access to HCV treatment
- The Supporting Colorectal Examination and Education Now (SCREEN) Act (HR 2035/S 1079)
- Removing Barriers to Colorectal Cancer Screening Act (HR 1220/S 624)
- The Ambulatory Surgical Center Quality and Access Act (HR 1453/S 2071)
- Medical Foods Equity Act
- Gluten in Medicine Disclosure Act (HR 3648)
- Viral Hepatitis Testing Act (HR 1101/S 1287)

A full listing of legislative and funding priorities is available from the DDNC. The DDNC Public Policy Forum has helped to initiate the discussion on digestive disease care and treatment for the upcoming year. PSG members are asked to keep abreast of changes and to reach out to your elected representatives on important issues.
The PSG, in cooperation with PAMED and other State Societies, continues to track Health Care Bill Legislation introduced into the Pennsylvania Congress. The PSG has made access to select bills available to members through a portal on the PSG website: www.pasg.org. This list of bills is periodically updated.

Although 2016 started out as an active year for the Pennsylvania Congress with the introduction of a number of health care related bills, there has essentially been minimal to no activity with regard to health care related legislation, especially involving gastroenterologists. I suspect this is due to the upcoming election in addition to the Pennsylvania government impasse in resolving the state budget.

On the federal level, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was signed into law on April 16, 2015. The legislation was bipartisan. After years of physician advocacy, the government repealed the sustainable growth rate (SGR) formula and allegedly stabilized Medicare payments for physician services with positive updates from July 1, 2015 through the end of 2019, and again in 2026 and beyond.

MACRA replaces Medicare’s multiple quality reporting programs with a new single Merit-Based Incentive Program (MIPS) that hopefully makes it easier for physicians to earn rewards for providing high quality, high value health care. This also supports and rewards physicians for participating in new payment and delivery models to improve the efficiency of care. This was discussed in our Fall 2015 issue of Ramblings by Dr. F. Wilson Jackson. I would refer you to his excellent summary of how MIPS consolidates the three current reporting systems: PQRS, MU, and Value-Based Payment Modifier (VPBM). The EHR incentive program will also be rolled into MIPS. The idea is that MIPS will provide physicians reimbursement for services if they participate in new payment and health care delivery models to improve efficiency of care. The fee for service model will be preserved as an option.

Although MACRA supports physicians who adopt new delivery and payment models (alternative payment models/APMs), it also retains Medicare’s fee for service model. Participation in the new models is voluntary. The American Medical Association has briefly contrasted the choices physicians have with MACRA. Please consult your health care attorneys or practice management consultants for further detail.

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<thead>
<tr>
<th>Fee for Service</th>
<th>APMs</th>
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<tr>
<td>0.5%, July 2015-2019; 0% 2020-2025; Thereafter, those in APM get 0.75%; others get 0.25%</td>
<td>5% bonuses for 6 years aid transition to new models with more than nominal risk</td>
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<tr>
<td>Previous reporting programs consolidated into MIPS</td>
<td>Physicians’ role in new models specified</td>
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<tr>
<td>Penalty risks reduced; potential bonuses added</td>
<td>Qualified medical homes count as APMs without requiring financial risk</td>
</tr>
<tr>
<td>Benchmarks set prospectively; more timely feedback on performance</td>
<td>Demonstrated savings will produce higher payments</td>
</tr>
<tr>
<td>Permanent coverage of chronic care management services with no annual wellness or preventive examination</td>
<td>Participants exempt from MIPS</td>
</tr>
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The Specialty Leadership Cabinet (SLC) of the Pennsylvania Medical Society (PAMED) convened on February 9, 2016. The SLC serves as a forum through which the specialty organizations can share information with their specialty colleagues and introduce possible collaborative efforts to the PAMED Board of Trustees.

Introductions

Dr. John P. Gallagher, SLC chair, convened the meeting and reviewed the background and mission of the SLC.

Mega Issue: Addressing the Opioid Abuse

Dr. Gallagher opened his remarks with a review of headlines from around the US which confirm that opioid abuse continues to increase. Of note, opioid-related deaths continue to rise in Pennsylvania and now exceed automobile-related deaths annually. Several bills are now proposed in the state legislature to address this problem. The progress of these bills will need to be followed. The PAMED’s position is focused on prescribing guidelines. These vary between patient populations. Online CME related to opioid abuse and the use of naloxone is available to the entire health care team through PAMED’s opioid resource center on their website www.pamedsoc.org. The Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) is expected to be underway this summer. A Prescription Drug Monitoring Program (PDMP) is a statewide program that collects information about controlled substance prescriptions that are dispensed to patients within the state. Prescribers will use real-time access to query the system for each patient the first time the patient is prescribed a controlled substance or if, using sound clinical judgement, a patient is believed to be abusing or diverting drugs.

National guidance is also expected as the opioid crisis is felt on a national basis. (Note: Since this meeting, the Centers for Disease Control have issued in the Morbidity and Mortality Weekly Report [MMWR] the CDC guideline for prescribing opioids for chronic pain – United States, 2016, http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.) In addition, Senator Toomey has introduced a bill that would restrict Medicaid participants to the use of one pharmacy and one provider when obtaining opioid medication. It is suggested that each specialty should have guidelines for opioid prescribing.

Wrong Site Nerve Blocks

Dr. Donald Martin reported that wrong site nerve procedures had an uptick at the end of 2015. Anesthesia groups are working with the Patient Safety Authority on guidelines and policy.

Workers Compensation

Dr. Angela Rowe reviewed ongoing discussions. Issues with the current system include:

- Most require paper billing
- Penalties should be given to insurers who delay payment of claims beyond 30 days
- There is no recourse for physicians experiencing delays in payment
- Silent discounting should be eliminated
- The claims database cannot be viewed to prevent denials for problems outside the original claim

There is expected to be a public hearing in the spring.

CRNP Scope of Practice

This issue remains open. There is proposed legislation but the dynamics of the legislature are changing. This will be monitored.

Balance Billing

Mr. Dennis Olmstead presented a PA Insurance Department proposal related to a 10/1/2015 hearing regarding out-of-network billing. New York and Illinois also have proposals. Carriers and patients feel that bills can be both a “surprise” and excessive. There is a feeling that providers should be required to take the in-network rate and would ban any attempt to collect additional money. Ms. Emily Carroll of the AMA Advocacy Resource Center added that this is a national concern. Access to care is involved which makes this problematic. From the provider standpoint, transparency is important and quantitative...
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President’s Message

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to achieve the best outcomes. The PSG and others will advocate, but we need to add our individual voices to best engage the decision makers that affect us. I urge you to talk to those who influence our professional lives. Nothing is more influential than real world examples from our own neighborhoods.

Do you have an engagement program? Patients are supposed to have a portal to their doctor’s office. Do you have access to your elected representatives? Insurance carrier liaison? The insurance commissioner? The Physician General? How many of us even know the name, let alone the address or phone number? How about the name of the receptionist? An email address? Online resources and internet communications literally place information at our fingertips. This information is readily available but somehow we are too busy to claim it. I encourage you to take the time to make the connections.

We are also blessed with far more organization than we have ever had in the past. The PSG as well as our other state and national professional societies have committees and staff dedicated to sorting through the issues and developing reasoned responses. Educate yourself on the issues at hand. We are the experts with the information that the decision makers need regarding the issues facing us. Why are we reluctant to share it? I urge you to utilize these resources and reach out and engage. As Hillel the Elder once said, “If I am not for myself, who will be for me? If not now, when?”

Specialty Leadership Cabinet

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data is needed to come up with the best solution. Hospital, emergency, and non-emergency scenarios could be lumped together. This is not likely to “go away.”

Physician General Update

Dr. Rachel Levine provided additional updates on the opioid crisis and Zika virus. Opioid abuse is currently the biggest health crisis in PA. According to the 2014 Pennsylvania Coroners Association’s report, seven people die each day form a drug overdose. This number is expected to be even higher on the 2015 report. Guidelines and monitoring are geared to reduce unnecessary opioid prescribing. In addition, naloxone will be made available in schools through a private foundation grant.

Zika virus has been confirmed in Pennsylvania. These cases were in patients who traveled to affected areas. Both cases involved male to female sexual transmission. Mosquito transmitted cases could possibly occur in the state and will be watched for. It is recommended to call the Department of Health with concerns.

Legislative Update

Ms. Angela Boateng, Regulatory Counsel for the PAMED, gave two brief updates. Regulations for registered dieticians have been amended by CMS. The PA Department of Health has agreed to be included in the attachment. Also, the Child Protective Services Law (CPSL) has been an issue since last year. Interpretation of the law has been at issue. The State Board of Medicine and the Osteopathic Board of Medicine plan to issue regulations to update the board’s existing rules regarding the mandatory reporting of suspected child abuse pursuant to the recent amendments to the CPSL.

The next meeting of the PAMED State Leadership Cabinet is to be scheduled.

Risk Management

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The guidance addresses other important issues, such as when providers may deny access, the process for transmitting a patient’s record to a different person (such as a family caregiver), and the interaction between the HIPAA right of access and patient online access requirements per the Electronic Health Record “Meaningful Use” Incentive Program. I encourage you to either personally review 45 CFR § 164.524, or have it reviewed by your practice administrator and/or health care attorney, to ensure your Compliance Plan regarding patient records remains in compliance.
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Contact Hours: This activity has been submitted to PA State Nurses Association for approval to award contact hours. PA State Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

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Luminal GI
- Achalasia and Endoscopic Treatment with POEM
- Management of C. difficile with Fecal Transplant
- New Colonoscopy Techniques to Improve Adenoma Detection Rates
- Autoimmune Pancreatitis and Cholangiopathy
- Managing IBD in the Child-Bearing Years

Hepatology
- Disparities in Liver Transplant Allocation and Update on the MELD Allocation System
- Metabolic Liver Disorders
- Hepatitis C: Newest Treatment Options and What to Do When We Cure It!
- Liver Tumors

Nutrition and GI
- Endoscopic Management of Obesity
- Nutritional Deficiencies for the GI Practitioner
- IBD and Nutrition
- IBS-D: What Are The Best Diets And Medical Treatment?

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