President’s Message

“United We Stand:” Help PSG make its voice heard!

By David A. Sass, MD, FACP, FACG, AGAF

The PSG Board continues to be empathetic to the plight of Pennsylvania gastroenterologists. In May, we learned of an announcement by Highmark Blue Shield in the April issue of the Policy Review and News (PRN) newsletter that Highmark would change coverage criteria established for monitored anesthesia care (MAC), effective June 30, 2014. In essence, Highmark planned to end reimbursement for anesthesia services in routine endoscopies and colonoscopies for our “healthier,” ASA 1, and ASA 2 patients, except under special circumstances. MAC anesthesia was deemed not medically necessary in these “individuals at average risk for anesthesia and sedation.”

From both a patient comfort and patient safety perspective, PSG views this announcement as a serious step back in the care of our patients. Over the past decade, there has been a paradigm shift resulting in the standard of care in most hospitals and ASC’s of deep sedation for the vast majority of patients using MAC anesthesia. This change allowed a more thorough examination by the gastroenterologist, allowing us to be more focused on the luminal examination of the patient than the need to concomitantly oversee a nurse administering sedation. From a safety standpoint, the CRNA or anesthesiologist is better trained and equipped to provide advanced airway management, if required. Finally, a more comfortable experience and more rapid recovery post-procedure clearly leads to better patient satisfaction scores and adds to their willingness to undergo repeat procedures, especially those of future surveillance colonoscopies.

One must not under-emphasize the patient satisfaction component. In recent years, there has been a big push by our national GI societies to endorse and strongly promote universal colorectal cancer screening. The 2014 National Colorectal Cancer (CRC) Roundtable initiative, co-founded by the American Cancer Society and Centers for Disease Control and Prevention, has committed to eliminating CRC as a major public health problem and is working toward the shared goal of 80% of adults older than 50 years of age being screened for CRC by 2018. This initiative has been endorsed by dozens of organizations, including the AGA. Highmark’s policy change would no doubt deter patients from undergoing colonoscopic screening. It is contrary to sound public health policy, and will significantly undermine the shared goal of “80% by 2018.”

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Legislative Update

By Richard E. Moses, DO, JD
Chair, PSG Legislative Committee

PSG, in cooperation with the Pennsylvania Medical Society (PAMED) and other state societies, continues to track health care legislation introduced into the Pennsylvania General Assembly. 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.)

2014 has been a relatively quiet year at the state level with regard to healthcare legislation. Until June, approximately 88 healthcare-related bills were introduced; however, the majority of these bills do not deal specifically with gastroenterologists. What the remainder of 2014 will bring remains to be seen. However, I would like to discuss Pennsylvania House Bill 2105, in addition to some federal legislative issues.

**HB 2105:** An Act providing for certification of central service technicians who perform sterilization procedures in healthcare facilities; imposing continuing education requirements; and providing for the duties of health care facilities and the Department of Health.

HB 2105 is also known as “The Central Service Technicians Certification Act.” Although on its face it would apply to large healthcare facilities such as hospitals, the bill can also be interpreted to apply to Ambulatory Surgical and/or Endoscopy Centers. HB 2105 would potentially result in an increase in overhead expenses to the facility. The alternative argument is that this bill is important from a patient safety and infection standpoint.

For the time being, PSG has maintained a neutral position to the first draft of the bill. If you are interested in the specifics of HB 2105, I refer you to the original draft of the bill at: http://www.legis.state.pa.us/cfdocs/legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2013&sessInd=0&billBody=H&billTyp=B&billNbr=2105&pn=3174.

“Access to Medicare Act of 2014”

On April 1, 2014, President Obama signed into law the “Access to Medicare Act of 2014.” The law provides for a 0.5% physician payment update through December 31, 2014. It also provides for a one-year delay of ICD-10 implementation (to October 2015,) a payment freeze from January to March 2015, a six-month delay of the hospital admissions “two midnight rule,” a one-year extension of the Medicare work geographic payment cost index floor of 1.0, a one-year delay of reductions in payments to disproportionate share hospitals, and redirects savings captured from misvalued codes to undervalued codes, to capture any excess as budget savings.

The Act represents another one-year patch of the flawed Medicare physician payment formula.

**Physician Medicare Data Transparency**

The Centers for Medicare and Medicaid Services (CMS) recently made reimbursement data available to the public for healthcare services provided by physicians and other healthcare entities. The information collectively reflects $77 billion in payments for 2012 on more than 880,000 health care professionals in all 50 states for services delivered to beneficiaries under the Medicare Part B Fee-for-Service program. This is part of the ongoing effort under PPACA to bring transparency to healthcare. Further information is available on the CMS website: http://www.cms.gov.
ATTENTION PSG MEMBERS: Pending bylaws change

Dear PSG Member,

There are two proposed bylaws amendments of which you should be aware. Both regard the addition of ACG governors seats on the PSG Board. A vote on these amendments will be conducted on Sunday, September 21, 2014 during the Annual Business Meeting during the Annual Scientific Meeting.

Below, the proposed changes are noted in **bold**:

**Article V-Governing Board**

5.02 The governing board will all have voting rights, and be composed of:

a) the four elected officers
b) five councilors
c) the immediate past president of the Society
d) chairs of the standing committees
e) the archivist
f) up to four fellows in training
g) the current ACG governors for Pennsylvania

**Article VII-Other Board Members**

7.01 The archivist:

a) The president shall appoint an archivist who will keep a record of the history of the organization and prepare such histories as requested. He/she shall be a voting member of the board.

7.02 Fellows In Training

a) There shall be up to 4 fellows in training serving on the board. Two will be fellows who have finished their first year of fellowship and two who have completed two years of fellowship. They will act as a liaison between the board and fellows training in the Commonwealth. They will assist the board in developing matters of interest to fellows in training. Each fellow member may serve one one-year term at each level, second year and third year.

7.?? ACG Governors

a) The two active governors of the American College of Gastroenterology (ACG) for Pennsylvania shall serve on the board. The ACG Governors shall act as a liaison between the ACG and the governing board, on matters of interest of the constituents. The ACG Governors shall report matters of interest as raised by the governing board directly to the leadership of the ACG as well as advise and consult the governing board on ACG matters that affect the constituency and the PSG.
Contractor Advisory Committee Update

By F. Wilson Jackson, MD

The Contractor Advisory Committee (CAC) for Jurisdiction L, which encompasses the territories of Pennsylvania, New Jersey, Delaware, Maryland and Metro DC, met at Tyson’s Corner, Virginia on June 18, 2014. For those of you who have followed recent communications from Medicare, you are aware of the local coverage determination, (LCD) DL32628, which would change how Monitored Anesthesia Care (MAC) anesthesia is reimbursed for many Medicare beneficiaries. Novitas administers Part A and Part B Medicare services for our jurisdiction. They also manage Jurisdiction H. Jurisdiction H covers much of the South-Midwest to include Texas.

In an effort to improve administrative efficiency, Novitas has methodically consolidated the LCDs between these two jurisdictions. They have approximately 200 policies that they plan to align between these two jurisdictions which are about 80% complete. The policy for MAC differs between jurisdiction L and H, and Novitas is moving to create one uniform policy between these two areas. The most notable change is the removal of V58.83 code, which is the billing code for MAC anesthesia used in endoscopic procedures.

As many gastroenterologists in the state know, over the past ten or more years, MAC anesthesia has become a standard of care for endoscopy, both in the ambulatory and hospital environments. Few would argue its superior patient satisfaction compared to conscious sedation. In the state of Pennsylvania, however, nurses cannot administer propofol, and the FDA limits its use to those trained in airway rescue. The proposed LCD is more restrictive and would eliminate MAC as a covered service for many patients. The LCD lists a number of ICD-9-CM codes that may support medical necessity for MAC, but many patients would not meet the criteria. Patients would be effectively divided into covered and non-covered categories.

As you all know, one cannot a priori anticipate which patients will have respiratory difficulty with sedation, particularly conscious sedation. The incidence of sleep
apnea has risen considerably, yet many of these patients
would not qualify for anesthesia services. PSG’s position
is that this new MAC policy would compromise patient
safety and increase liability exposure based on deviation
from a now established standard of care.

The Centers for Disease Control (CDC,) along with
numerous other societies, including the American Cancer
Society and the American College of Gastroenterology,
has set a goal to screen 80% of the eligible population by
2018. We have finally begun to see a decrease in the inci-
dence of colon cancer based on the most recent CDC data.
Much of this reversal is no doubt driven by increased
awareness of colo-rectal cancer, improved surveillance/
screening efforts and increased patient compliance driven
to some extent by the higher level of satisfaction that
propofol brings to the procedure. Reversal of this policy
could negatively impact this goal and could potentially
reduce screening and surveillance in the population.

Section 3006(f) of the Affordable Care Act directs the
Department of Health and Human Services to explore and
create a series of value based care (VBC) models. In their
report to Congress, colonoscopy was included as one such
program. The VBC for colonoscopy would bundle the
payment to include the physician professional fee, facility
fee, anesthesia, and pathology. Quality outcomes for the
episode of care would also be measured and reported
with eventual reimbursement linked to these metrics. The
current MAC policy would seem incongruous with the
proposed payment mode with anesthesia services poten-
tially carved out of the VBC reimbursement model.

In many ways, propofol is a natural evolution of seda-
tion for endoscopy. In the early days of endoscopy,
imtramuscular nembutal and demerol were administered.
Intravenous (IV) diazepam was developed and became
the new standard. This was later followed by IV fentanyl
and demerol. These narcotics were then coupled with a
benzodiazepine. IV droperidol was added for awhile for
the difficult to sedate patient. IV propofol became avail-
able and has proven to be an effective and safe agent with
high patient satisfaction and possibly improved polyp
detection based on increased patient comfort enabling the
endoscopist to focus on the procedure.

PSG participated in the CAC meeting and, working with
our anesthesia colleagues, have submitted comments to
Novitas to hopefully impact the policy, which would go
in effect in October 2014. Other items covered in the CAC
meeting include an improved provider enrollment status
query tool. See the Novitas website, www.Novitas-solu-
tions.com, for further information. ICD-9 was given a stay
of execution with the delay of implementation of ICD-10.
No conversion date is yet published, but the Secretary of
Health and Human Services deferred consideration until
at least October 1, 2015. Regardless, practices are advised
to begin migrating and mapping diagnosis codes towards
ICD-10 as it does seem inevitable.

Comprehensive Error Rate Testing (CERT) continues.
Common Part A errors and an ongoing emphasis for
auditors continue to be absent or undocumented physi-
cian order for diagnostic laboratory services and missing
or illegible physician signatures. Additional areas of audit
emphasis include documentation of medical necessity
for the billed level of service. Within Part B, CERT con-
tinues to target procedure services not supported within
the medical record and particularly 99215, established
patient follow-up office visits. Missing or illegible physi-
cian signature is also an area of emphasis for the CERT
program in Part B. While these seem arbitrary reasons
for denial, they will reject these claims. Hopefully, as we
move toward more electronic ordering, this problem will
be minimized. Another area that may pertain to gastroen-
terology includes Remicade infusion. CERT plans to more
closely evaluate medication infusion services that are not
supported by the medical record.

Novitas initiatives include further improvement to
their website home page, and you are encouraged to
review and provide feedback. A new helpdesk service,
NovitaSphere, is also available. The phone number is
1-855-880-8424. This helpdesk is designed to address or
obtain beneficiary eligibility status, check claim status,
and perform clerical error re-openings. Pass this informa-
tion to your billing department if they do not already have
the contact. One does need to register to access portions of
the site, and you are encouraged to
visit their website home page, and you are encouraged to
to review and provide feedback. A new helpdesk service,
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1-855-880-8424. This helpdesk is designed to address or
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the contact. One does need to register to access portions of
the site, and you are encouraged to
As always, please communicate any concerns or ques-
tions, suggestions or comments to our president, David
Sass, or myself at fwjjii@comcast.net

How to Get Involved with Rumblings

- Do you have an idea for future newsletter content? Contact
  Dr. Ravi Ghanta, Newsletter Editor, at rghanta@hotmail.com.
- Are you a resident or Fellow-in-Training in search of a job?
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  (http://www.pasg.org/ClassifiedAds/Ads.aspx) for information on job
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- Would you like to place a display ad in Rumblings? Visit
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  advertising contract.
- Are you a PSG member and have a professional accomplishment to
  share? We now welcome news items to publish in our “PSG Members
  in the News” feature. To submit a news item, contact Dr. Ravi Ghanta,
  Newsletter Editor, at rghanta@hotmail.com.
2014 Annual Scientific Meeting Schedule

**FRIDAY, SEPTEMBER 19**

6:00 – 7:30 p.m. Welcome Reception with Cocktails and Hors D’Oeuvres

**SATURDAY, SEPTEMBER 20**

7:00 – 7:45 a.m. Registration, Breakfast, Visit Exhibits and Poster Displays
7:45 – 7:50 a.m. Welcome and Introductions, David A. Sass, MD, PSG President

Pancreaticobiliary/Interventional Endoscopy
7:50 – 8:15 a.m. Management of Severe Acute Pancreatitis, John Lieb, MD
8:15 – 8:40 a.m. *EUS Updates: New Indications and Therapies, Ali Siddiqui, MD
8:40 – 9:10 a.m. Manometry for SOD: Is it Time to Abort?, Adam Slivka, MD, PhD
9:10 – 9:20 a.m. Q & A
9:20 – 9:40 a.m. Break/Visit Posters and Exhibits

Physician Breakout Sessions (9:40 a.m. – 12:20 p.m.)
9:40 – 10:00 a.m. Social Media: A Minefield of Legal & Compliance Issues for the Gastroenterologist, Richard E. Moses, DO, JD
10:00 – 10:20 a.m. Update on the Affordable Care Act, Barry Kisloff, MD
10:20 – 10:40 a.m. Colorectal Cancer Screening Guidelines: Update on Tests and Bowel Preps, Frank Friedenberg, MD
10:40 – 10:50 a.m. Q & A
10:50 – 11:10 a.m. Break/Visit Posters and Exhibits

Physician Hands on Track (11:10 a.m. – 12:20 p.m.)
Station 1: Single Balloon Enteroscopy, Ali Siddiqui, MD
Station 2: Confocal Endomicroscopy, Vinay Chandrasekhara, MD

Nurse Breakout Sessions 9:40 a.m. – 12:20 p.m.

Nurse Hands on Track (9:40 – 10:50)
Station 1: Single Balloon Enteroscopy, Ali Siddiqui, MD
Station 2: Confocal Endomicroscopy, Vinay Chandrasekhara, MD
Station 3: Over-the-Scope Clip, David Diehl, MD
Station 4: Fully Covered SEMS for Benign Indications, John Lieb, MD
10:50 – 11:10 a.m. Break/Visit Posters and Exhibits

Nurse Lecture Breakout Session
11:10 – 11:30 a.m. Liver Logic: Approach to Abnormal LFT’s, Dustin Latimer, MS, PAC
11:30 – 11:50 a.m. GI Emergencies That Wake You up at Night, Lia Kaufman, MD
11:50 a.m. – 12:10 p.m. ERCP: The Basics on Stones, Strictures, and Stents, K. Jane Malick, BSN, RN, CGRN
12:10 – 12:20 p.m. Q & A
12:20 p.m. Adjourn
12:20 – 1:00 p.m. FIT Breakout Session
FITs are invited to participate in an informal breakout session with members of the PSG board to discuss finding a job, interviewing, contract negotiations and general Q&A about going into practice.
6:30 – 9:30 p.m. Reception & Dinner at the Hotel with award ceremony for poster contest.
SUNDAY, SEPTEMBER 21

7:00 – 8:00 a.m.  Registration, Breakfast, Visit Exhibits and Poster Displays

8:00 – 8:10 a.m. Welcome and Introductions,
David A. Sass, MD, PSG President

Hepatology
8:10 – 8:35 a.m.  Hepatitis C Treatment: State-of-the-Art 2014, Jonathan Fenkel, MD
8:35 – 9:00 a.m.  *Drug Induced Liver Injury, Karen Krok, MD
9:00 – 9:20 a.m.  Managing the Patient with Acute Liver Failure, Shahid Malik, MD
9:20 – 9:30 a.m.  Q & A
9:30 – 9:40 a.m.  Annual Business Meeting
9:30 – 10:00 a.m. Break/Visit Posters and Exhibits

Luminal GI
10:00 – 10:30 a.m. New Treatments in IBD: When, Whom, and How, Kofi Clarke, MD
10:30 – 10:55 a.m. Updates in Pharmacology for Functional GI Disorders, David Levinthal, MD, PhD
10:55 – 11:20 a.m. Metabolic and Surgical Complications of Bariatric Surgery, Ramsey Dallal, MD
11:20 – 11:50 a.m. Esophageal Manometry: Nuts and Bolts for the Gastroenterologist, Asyia Ahmad, MD
11:50 a.m. – 12 noon  Q & A
12 noon  Adjourn

HOTEL ACCOMMODATIONS
To make your online hotel reservations, go to http://www.pasg.org/NewsEvents/Calendar.aspx and type the group code, PA0914. Or you can call the hotel directly by calling 1-800-422-2736 or 724-329-8555 and ask for reservations. Identify yourself as part of the PA Society of Gastroenterology to receive the discounted room rate of $260 for Lodge; $320 for Chateau and Townhouses. Resort fee is waived for PSG meeting guests.

Check in time – after 4:00 p.m.; Check out time – 11:00 a.m.
Reservations must be made on or before August 19, 2014. After this cut-off date, reservations will be accepted on a space-available basis.

ACTIVITIES (pre-registration is required)
Friday, September 19, 2014
6:00 – 7:30 p.m. Welcome Reception
Attendees and guests are invited to join us for cocktails and hors d’oeuvres at the hotel.

Saturday, September 20, 2014
6:30 – 9:30 p.m. Reception & Dinner at the hotel with award ceremony for poster contest. Sidney Cohen, MD, Professor of Medicine, Thomas Jefferson University Hospital will be the 2014 recipient of the PSG Special Achievement Award.

Dinner Speaker – Michael Broome, Motivational Speaker and Stress Reduction Expert
Title of Presentation: A Humorous Look at Personal, Professional, and Family Success

Michael Broome has addressed over 3,000 audiences throughout the world. He has spoken to such varied audiences as a Congressional Dinner, CEO’S in Monte Carlo, and to a group in Spearfish, South Dakota at a Barbeque and “Goat-Dipping.”

Michael’s subjects include personal motivation, leadership, teamwork, and life balance. He is the founder of the Broyhill Leadership Conferences. Over 29,000 participants have attended the week-long conference to learn about the principles of achievement. He is the author of a book entitled Be a Liver of Life – Not a Gall Bladder.

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The Specialty Leadership Cabinet (SLC) of the Pennsylvania Medical Society (PAMED) convened on May 20, 2014. 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.

**Opioid Prescribing Guidelines**
Scot Chadwick, PAMED Legislative Counsel, State Legislative Affairs, spoke to the Cabinet about Pennsylvania’s pending opioid prescribing guidelines. Governor Corbett established a task force comprising dozens of stakeholders, including PAMED. The purpose of the task force is to research other laws and regulations regarding opioid prescription. A draft of the guidelines was referenced and approved by the SLC. On July 10th, PAMED hosted a press conference to formally release the guidelines. They can be accessed at [http://www.pamedsoc.org/opioidguidelines](http://www.pamedsoc.org/opioidguidelines).

**Maintenance of Certification**
Dr. Charles Cutler, Internal Medicine Cabinet member, gave a presentation regarding the challenges and pitfalls of ABIM’s Maintenance of Certification (MOC) program. ABIM certifies not only internists, but all practitioners within the medical subspecialties.

Challenges of the MOC program include cost, time commitment, and lack of connection between completion of the MOC requirements and actual improvements in a physician’s practice. The relevance of the survey component was questioned due to the difficulty of some physicians without a wide patient base to solicit enough surveys from patients. It was noted that the practice improvement modules are cumbersome, and an increasing number of physicians are now employed. In addition, the MOC pass rates for physicians ten years out of training are decreasing. In 2013, 22% of physicians in this group failed the MOC assessment.

The Cabinet decided to transfer the MOC issue to the PAMED Board of Trustees for discussion, specifically regarding PAMED’s approach, how to relay this concern to the American Medical Association, and other ways to address MOC.

**Opportunities for Collaboration**
- **Mcare Resolution Initiative (MRI)** – Dr. Angela Rowe, Orthopaedics Cabinet member, spoke about a proposed initiative of the Pennsylvania Orthopaedics Society (POS) to phase out the Mcare Program. The MRI will benefit all physicians by providing a mechanism to phase out the Mcare Program while holding physicians harmless in regard to the Mcare Fund’s unfunded liabilities. The proposed legislation will:
  - Modify the annual Mcare assessment methodology to ensure excessive surpluses are not created in the Mcare Fund;
  - Provide a state tax credit to the payer of Mcare assessments in the amount of the annual Mcare assessments paid; and
  - Provide that performing Independent Medical Examinations and Impairment Rating Evaluations in the workers’ compensation system shall not be considered the provision of healthcare services for the purposes of the Mcare Act.

As of yet, there has been no actuarial study on the Initiative. The POS seeks support of the other specialty societies.

- **Physician Dispensing (House Bill 1846)** – Sponsored by Representative Marguerite Quinn, HB 1846 will severely restrict physicians’ ability to dispense medications to workers’ compensation patients. In fact, as passed by the House of Representatives, HB 1846 will be a de facto ban on physician dispensing in the workers’ compensation system. HB 1846 targets not only physicians but insurance carriers as well.

PAMED President Dr. Bruce MacLeod spoke to the SLC about PAMED’s interaction with Rep. Turzai, the Speaker of the House. A new bill has been drafted in order to address the components of HB 1846 that PAMED opposes. PAMED has Rep. Turzai’s commitment.

- **Clinical Laboratory Act** – Elizabeth Metz, PAMED General Counsel, spoke to the SLC about an amendment to Act 122, the Clinical Laboratory Act, which has changed the relationship physicians can have with clinical laboratories. In its current form, the legislation contains many ambiguities. The Pennsylvania Department of Health (DOH) is responsible for enforcing the legislation and has received several complaints regarding the new regula-
So what has PSG done to address this issue?

- PSG discussed the proposed revision to coverage criteria with Highmark’s medical director. As a result, Highmark issued a follow-up statement that it has delayed implementation of the new policy while they study all implications of this change.

- PSG leadership worked closely with the Pennsylvania Medical Society (PAMED), the Pennsylvania Society of Anesthesiologists (PSA), the Pennsylvania Association of Nurse Anesthetists (PANA), and the Pennsylvania Ambulatory Surgery Association (PASA) to aggressively oppose Highmark’s proposed action. A detailed joint letter was sent to Highmark’s Vice President of Medical Management and Policy.

- Through our Pennsylvania ACG Governor, who is also a PSG Board member, PSG is currently coordinating efforts on this matter with state and national ACG leadership.

It is also important for PSG members to be aware that Novitas Solutions, the Medicare carrier for Pennsylvania, has drafted a similar MAC policy to that of Highmark. PSG’s CAC representative and Past President, Dr. F. Wilson Jackson III, updates us on this very important matter in his CAC report, featured in this newsletter.

PAMED encouraged physicians to voice their feedback, and PSG sent a blast email to its members to voice their concerns about the implications of this policy change during the comment period, which ended July 10. We will continue to keep you updated by e-mail as events unfold.

On a lighter note, I wish to take this opportunity to wish all PSG members and their families a very pleasant and relaxing summer. We hope to see as many of you as possible at this year’s Annual Scientific Meeting in September at the beautiful Nemacolin Woodlands Resort, near Pittsburgh. This promises to be a very exciting and informative educational event!

PAMED Specialty Leadership Cabinet Report

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One of the issues dermatologists have raised with Act 122 regards client billing; it was suggested that this may be an area for which the SLC may want to form a work group, in which PSG expressed interest in participating. The specialties will be contacted regarding the proposed workgroup. The PAMED Executive Committee is familiar with the issue and requests input from the specialties before comments are submitted to the DOH.

Legislative and Regulatory Update

Larry Light, PAMED Senior Vice President Physician Advocacy & Political Affairs, thanked all of the specialty societies that signed the PAMED letter regarding medical student loan forgiveness and residency programs.

The state legislature has recessed for the summer and will return in the fall for several days. Legislation of medical interest that is still being considered this term addresses the proposed controlled substance database, property tax reform, truth in advertising, medical marijuana, and independent practice for Certified Registered Nurse Practitioners. Dr. Joseph Answine, Anesthesiology Cabinet member, spoke about the Pennsylvania Society of Anesthesiologists (PSA) legislation, House Bill 1603, which is still in committee, and mentioned the importance of the support of the other specialty societies. PSG has taken a neutral stance on the bill. Dr. Answine mentioned that at the 2014 PAMED House of Delegates, it was decided that all specialties would be supported in regards to supervision legislation.

Angela Boateng, PAMED Legislative Counsel, State Legislative Affairs, reviewed current child abuse reporting requirements. Between the end of 2013 and April 2014, three noteworthy laws were passed by Governor Corbett. The first law addresses the exposure of infants to illegal substances. Physicians are required to report instances of exposure to county agencies when dealing with children up to three years of age. This law is currently in effect. Two laws that will go into effect by the end of 2014 address updated requirements mandating immediate reporting of cases of suspected child abuse, and a required training mandate that mandated reporters be trained in the identification, recognition, and reporting of child abuse.

Scot Chadwick, PAMED Legislative Counsel, State Legislative Affairs, spoke about House Bill 2203 which addresses Zohydro and resistance to the availability of this drug. HB 2203 would mandate Zohydro prescribing guidelines in Pennsylvania; such a rule is in opposition to the PAMED policy that physician practice not be mandated. The PAMED opioid workgroup suggested opposition to HB 2203. The SLC moved to notify the Board of Trustees of its opposition.
Dennis Olmstead, PAMED Chief Strategy Officer & Medical Economist, spoke to the SLC about Governor Corbett’s Healthy PA program. On May 8, 2014, the Pennsylvania Department of Public Welfare (DPW) issued a Request for Application (RFA) for the Healthy Pennsylvania Program (Healthy PA). This aspect of Gov. Corbett’s Healthy PA program awaits approval by the Centers for Medicare and Medicaid Services as an alternative Medicaid expansion program. The RFA seeks applications from Pennsylvania-licensed health insurers interested in becoming Private Coverage Organizations (PCOs) for more than 500,000 estimated eligible enrollees, who must be under 133 percent of the federal poverty level, across nine ratings regions statewide, beginning January 1, 2015. The coverage population is newly eligible adults between the ages of 21-64 who are not medically frail. All applicants must provide both physical and mental health services.

Under the RFA, applicants must propose to serve all counties within a region and may propose to serve any number of regions. DPW expects to begin readiness reviews in August 2014, with contracts effective and coverage beginning January 1, 2015. The RFA indicates an initial contract term of three years, with two optional extension years beyond the initial term. The contracts with PCOs will be full-risk capitated agreements; therefore, applicants must have a Certificate of Authority to operate as an HMO in Pennsylvania. At least two PCOs will be selected per rating region. Notably, the Healthy PA regions and the Medicaid managed care regions do not align. The level of payment to providers from the PCOs is not discussed in the RFA.

PAMED Daily Dose

Mike Fraser, PAMED Executive Vice President, formally introduced Daily Dose to the SLC. Daily Dose is a short one-screen email to PAMED members that outlines current events in Harrisburg affecting Pennsylvania physicians. Mr. Fraser requested input and news items from the specialty groups for possible future inclusion in the Daily Dose emails.

PAMED Foundation Lifeguard Program

Heather Wilson, Executive Director, Foundation of the Pennsylvania Medical Society, presented details about the Foundation’s Lifeguard program, a clinical competency skills assessment program that provides recommendations for remediation when deficiencies are discovered. Lifeguard was developed to assist physicians who have a known or suspected clinical deficiency, medical deficiency, cognitive deficiency, about whom quality concerns have arisen, who would benefit from refresher/remediation experiences, who are seeking reentry into the workforce, or who have disciplinary actions on their license and are seeking reinstatement. Each competency assessment process is customized to specifically address the individual needs of each participant. For more information about the Lifeguard program, visit www.LifeGuardProgram.com or call 717-909-2590.

The next meeting of the PAMED Specialty Leadership Cabinet is scheduled for Tuesday, September 9, 2014.

The PSG would like to thank the following corporate sponsor for their support:

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The Benefits of Being a PSG Member

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 2014 Annual Meeting will be held September 19-21, 2014 at the Nemacolin Woodlands Resort near Pittsburgh.
• The Annual Meeting provides an excellent opportunity to earn CME /CEU 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’s) Specialty Leadership Cabinet and a vote at their House of Delegates. Together, PSG and PAMED on a state level advocate for gastrointestinal issues.
• The two PA regional governors for ACG are now members of PSG board and we will closely collaborate with them on matters of common interest.

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.

pasg.org
• The PSG website (www.pasg.org) has many features that benefit our physician members and their patients. Website features include meeting information, practice management tips, reimbursement updates, electronic copies of the PSG newsletter, Rumblings, “Find a Gastroenterologist,” a list of all current GI Fellows-In-Training programs, and access to a physician job posting service.

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 affecting Pennsylvania gastroenterologists.
• Provides helpful information for GI fellows and new practitioners.
• Join PSG today! Non-members, this is the last complimentary newsletter you will receive!

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

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 communication with other GI professionals across Pennsylvania. To learn more about the Society, visit our website at www.pasg.org. Join us today! A membership application is enclosed on 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).

   **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** ________________________________  
   - [ ] 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 ____________)

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. ____________________________________________

2. ____________________________________________

15. **Associate Applicants Only:**

Please provide the signature of the director of your training program or chief of service.

______________________________________________

16. **NPC Applicants Only:**

Please provide a letter of recommendation from your **Gastroenterologist Employer** and return with application.

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**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.
Risk Management

Telemedicine: The upcoming area of controversy and risk management

By Richard E. Moses, DO, JD

This article is intended to make PSG members aware of an evolving area in patient care—telemedicine. Despite the alleged potential benefits, telemedicine presents another area of risk for physicians who may plan to utilize this modality should it become a reality in Pennsylvania.

The demand for medical, and in particular, gastroenterology and hepatology, services continues to increase. As our population ages, people become more educated about health maintenance and diseases, the results of PPACA, and the physician shortage. The shortage of gastroenterologists is not expected to significantly improve in the near future. Telemedicine is a modality to increase patient access to the healthcare system on multiple levels.

Formally defined by the American Telemedicine Association (yes...there is such an organization), telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology.

Beginning more than forty years ago with demonstrations of hospitals extending care to patients in remote areas, the use of telemedicine has spread rapidly and is now becoming integrated into the operations of hospitals, specialty departments, home health agencies, private physician offices, and consumer homes and workplaces. (For more information, see: http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.U4s_FmBOXIU.)

In late April 2014, the Federation of State Medical Boards (FSMB) issued new guidelines for the practice of telemedicine. They changed the definition of telemedicine to “care that typically involves the application of secure video-conferencing...to provide or support healthcare delivery by replicating the interaction of a traditional encounter in person between a provider and a patient.” The FSMB stated that telemedicine is not “an audio only, telephone conversation, e-mail/instant messaging conversation, or fax.” The policy statement also recommended that physicians be licensed in the state where the patient is located, disclose their credentials, obtain a consent form for the care they are delivering, verify the identity and location of the patient they are treating, and not write prescriptions for patients based solely on an online questionnaire.

The practice of medicine comes under the purview of individual states. The FSMB statement is intended to help state medical boards develop the necessary policies and standards for their physicians. The goal of the FSMB was to ensure that a patient’s care does not proceed for extended periods of time relying on “audio only” conversations. However, the statement has come under a lot of criticism by some professional organizations and advocacy groups that feel it is restrictive and will limit patient access to health care. In particular, they want telephone conversations and instant messaging conversations to be included in the FSMB statement, as their theory asserts that these modalities, among others, will increase access to physicians in rural areas. Also, there has been discussion that not everyone has access to a computer and the internet.

Governor Tom Corbett announced that Pennsylvania will increase access to specialist care for the 2.1 million Pennsylvanians covered by the Medical Assistance program by expanding coverage for Telemedicine on May 23, 2014. The use of telemedicine had previously been limited to specific specialist consultations. Now, it has been expanded to include additional specialty physicians.

To expand the use of telemedicine, the following changes have been made to the Department of Public Welfare’s Medical Assistance program:

- The use of real-time interactive technology, such as audio and video equipment as a method of delivering consultation services was established
- Consultations can now occur between all physician specialists like cardiologists, obstetricians, or neurologists, and
- The requirement that Telemedicine consultations can only be performed with participation from the referring physician has been removed.

Telemedicine leads to better results for patients because of increased choice and access to quality care. It is one of the fastest-growing trends in health care as many employers, insurance carriers and now, Pennsylvania’s Medical Assistance program, are more fully embracing the technology.
Register Today!

http://www.pasg.org

The 2014 Annual Scientific Meeting of the Pennsylvania Society of Gastroenterology

September 19-21, 2014

Nemacolin Woodlands Resort, Farmington, PA
Not only does July bring a new batch of first-year fellows to bear the brunt of call and service duty, but it also means that our senior fellows graduate and move on to “bigger and better things.” Some will start advanced fellowships while others finally enter independent practice. With all the excitement that comes with starting a new chapter in life, this time also allows for reflection on the final years of medical training. At a recent dinner held to celebrate the completion of yet another year, some PSG graduating fellows were asked to address a series of questions: What will you miss least about fellowship, what will you miss the most, and what are you looking forward to for next year? Here is what they had to say:

What will you miss least about fellowship?
The overwhelming responsibility associated with aspects of fellow call, such as the physically-demanding task of hauling endoscopy carts to ICUs for middle-of-the-night scopes on bleeders, or taking after-hours calls from the answering service, which can include such “gems” as reviewing the directions of a colon prep in mind-numbing detail for the 100th time (“No, you cannot have lasagna for dinner the night before your colonoscopy.”)

What will you miss most about fellowship?
GI fellowship can be tough, demanding one’s blood, sweat, and tears along the way. This intensity however, combined with long hours at the hospital, can create strong bonds between coworkers. The camaraderie and friendship amongst fellows is the most common aspect of fellowship that will be missed the most by those moving on.

What are you looking forward to next year?
After 10 years of medical training within a strict medical hierarchy, autonomy is the most anticipated aspect post-fellowship. After all the sacrifice and hard work poured into the acquisition of knowledge and specialized skills, it is finally time to show the world what you can do—and finally be reasonably compensated (an increase in salary was the second most common response.)

Congratulations to all the graduating fellows, and good luck in your first year as practicing gastroenterologists!
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The PSG would like to thank the following corporate sponsor for their support:

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Mark Your Calendar!  
PSG Reception at the ACG 2014 Annual Scientific Meeting

Monday, October 20, 2014
Philadelphia

Watch your inbox and www.pasg.org for location and registration information. This event is open to all Pennsylvania gastroenterologists—spread the word!