Philadelphia Medicine

Volume 110, No. 4 April 2014

Study examines public awareness of the use of online physician rating sites

In a survey of a nationally representative sample of the US population, 65% of respondents reported awareness of online physician ratings and about one-fourth reported use of these sites, according to a study in the February 19 issue of *JAMA*.

"Patients are increasingly turning to online physician ratings, just as they have sought ratings for other products and services," according to background information in the article. "Little is known about the public's awareness and use of online physician ratings, and whether these sites influence decisions about selecting a physician."

David A. Hanauer, MD, MS, of the University of Michigan Medical School, and colleagues surveyed the public in September 2012 about their knowledge and use of online ratings for selecting physicians. 60% (2,137/3,563) of the sample responded. 21% of respondents were 18 to 29 years of age; 17%, 30 to 39 years; 18%, 40 to 49 years; 19% 50 to 59 years; and 26%, 60 years or older.

Among the findings of the survey:

- Forty percent reported that physician rating sites were "very important" when choosing a physician, although rating sites were endorsed less frequently than other factors, including word of mouth from family and friends;
- Awareness of online physician ratings (65%) was lower than for consumer goods such as cars (87%) and non-healthcare service providers (71%).
- Among those who sought online physician ratings in the past year, 35% reported selecting a physician based on good ratings and 37% had avoided a physician with bad ratings.
- For those who had not sought online physician ratings, 43% reported a lack of trust in the information on the sites.

The authors conclude that "rating sites that treat reviews of physicians like reviews of movies or mechanics may be useful to the public but the implications should be considered because the stakes are higher."

Ensuring accurate information on *Physician Compare*

The data on *Physician Compare* comes primarily from the Provider Enrollment, Chain, and Ownership System (PECOS) and therefore depends upon physicians and other healthcare professionals keeping their information current in PECOS.

Accurate information helps ensure that a physician, other healthcare professional, or group practice is included in and listed correctly on *Physician Compare*. If key pieces of information, such as practice location or specialty, are not entered into PECOS, a professional will not be displayed on *Physician Compare*.

You can add, edit or correct your information via Internet-based PECOS. Enrolling in PECOS takes an average of 30-40 minutes, while a basic information update takes about 15-20 minutes. The data on *Physician*

Please see Ensuring accurate information *on page 3*

PCMS NEWS

Upcoming Programs

The Society of Ibero Latin American Medical Professionals of Philadelphia (SILAMP) and PCMS present
"XXI Multidisciplinary Conference: Doctor Carlos Finlay Program"
Date: Saturday, April 26, 2014
Time: 8:00 AM - 4:00 PM
Location: PCMS headquarters
Free parking in garage, entrance from 21st Street
Topics: New Guidelines for Cervical Cancer Screening; Stereotactic Ablative Radiotherapy—What is this? New Hope; An Endoscopic Journey into the GI Tract; Freedom from Addiction; Psychological Factors Affecting Mental Disorders; Obamacare; Cultural Competency; Dental Erosion: Its Etiology, Treatment and Other Oral Health Challenges; Neuropathic Diabetic Ulcer Wound Care, Hyperbartic Treatment
RSVP: 215-563-5343, Ext. 113

9th Annual "Tools for Success" Practice Management Conference

Date: May 8 and 9, 2014
Location: Springfield Country Club, Springfield, Pa.
Topics: Compliance Workshop for smaller practices; Risk Management – e-communications; Emerging Issues in PA Medicine; Population Management; Medicare Reporting program updates – the ACA's continuing impact; Bullying in the Workplace; Understanding hospice and palliative care; Working together with behavioral health providers; Paying staff properly. For more information and to RSVP: *www.delcomedsoc.org*.

We're on Facebook!

Want to read more about your fellow PCMS members and medical history in Philadelphia?

Check out our new Facebook page

www.facebook.com/PhilaMedSoc

Philadelphia Medicine

EDITORIAL BOARD
William S. Frankl, MD
Stephen L. Schwartz, MD
Paul D. Siegel, MD
David Woods, PhD

PHILADELPHIA COUNTY MEDICAL SOCIETY

President
Curtis T. Miyamoto, MD

President-Elect
Anthony M. Padula, MD

Secretary
J. Q. Michael Yu, MD, FRCPC

Treasurer
Stephen R. Permut, MD, JD

Immediate Past President
Harvey B. Lefton, MD

Executive Director
Mark C. Austerberry

Executive Offices
2100 Spring Garden Street
Philadelphia, PA 19130
Phone: (215) 563-5343
E-mail: stat@philamedsoc.org
Web site: www.philamedsoc.org
ISSN 0031-7306

Philadelphia Medicine is an editorial project management service of Healthcare Media International, Inc. (HMI). HMI provides writing, editing, and contract publishing and medical communication consulting services.

Publisher
David Woods, PhD

Production Editor
Norman Kline

For more information about HMI's products and services call
215-351-5328
E-mail: HMI3000@comcast.net
or visit *www.davidwoods.info*

HMI HEALTHCARE MEDIA INTERNATIONAL

Why are the AMA, PMS and PCMS against legalizing medical marijuana?

By Curtis T. Miyamoto, MD

As you may know, the American Medical Association (AMA), the Pennsylvania Medical Society (PMS) and the Philadelphia County Medical Society (PCMS) are officially against legalizing medical or recreational marijuana. For some this is difficult to understand as nine states have legalized medical marijuana and decriminalized it; six states have decriminalized cannabis possession; eight states have legalized medical marijuana; and two states (Colorado and Washington) have legalized cannabis.

But cannabis remains a schedule 1 substance under federal law. Gonzales versus Raich in 2005 held that the Commerce Clause of the United States Constitution allowed the federal government to ban the use of cannabis including medical use, even if local laws allow it.

This in part has prevented serious medical studies of the indications, dosing, effectiveness, and long-term secondary effects. Unlike other medications, it has been allowed to bypass the usual FDA studies and regulations that almost all other medications are required to undergo before approval for medical use.

Carrying out studies of cannabis is extremely difficult and would be equivalent to studying the effects of medical heroin or cocaine. Although initially, it was felt to be of most benefit to patients suffering from cancer or AIDS, only a very small percentage of patients in states with medical use approval have these diagnoses. Most patients using medical marijuana have non-life-threatening conditions.

There are up to 400 components in marijuana. Many of them have not been studied. In New Jersey, an approved physician can prescribe up to two ounces of marijuana every 30 days. Patients are approved for 30, 60, or 90 day certifications and must register every two years. There are no legal limits for driving. This is not the case for alcohol. As with alcohol, marijuana can affect a person's judgment and potentially lead to an accident.

In Colorado, there is a legal THC (tetrahydrocannabinol) level of 5 ng/ml or less. How much marijuana it takes to achieve this level is more highly variable than for alcohol. It not only depends on the patient's size and amount of marijuana but on the strength of the marijuana, length of use and how deeply it is inhaled.

Tolerance, dependence and withdrawal effects occur with smoking marijuana and its use can lead to use of other psychoactive substances.

There is obviously a huge financial incentive for states to legalize marijuana. For example, in Colorado they expect a $60 million combined savings in additional revenue for the state budget this year.

There is obviously a huge financial incentive for states to legalize marijuana. For example, in Colorado they expect a $60 million combined savings in additional revenue for the state budget this year. They expect this amount to double in the next four years. Medical marijuana has also had the effect of developing multiple varieties of cannabis with significantly more potent psychoactive effects.

Marijuana can affect a person's judgment and therefore the heavy use of this for medical purposes, could lead to poor decision-making about their medical care and activities of daily living, including driving.

In summary, the AMA, PMS and PCMS are all against legalizing marijuana for medical and recreational use. If the FDA changes its classification to schedule II then studies can be done to establish the indications, dosing and the short and long term secondary effects of the drug. Federal funding should be used to carry out these studies. Until this has been done, we will continue to oppose legalization. What physicians prescribe should not be determined by anecdotal cases or by politicians for political or financial gain.

Dr. Miyamoto is President of PCMS.

Ensuring accurate information on *Physician Compare* from page 1

Compare are refreshed as the data files are made available. Please know that it may take three to six months for a change to take effect due to a lag data processing.

If your information in PECOS is up-to-date but you still see errors on *Physician Compare*, e-mail your name and NPI number (or the official name of your group practice and the NPI numbers for the individuals who are currently not accurately listed, if applicable), and the state in which affected individuals are licensed to practice to the *Physician Compare* team at *PhysicianCompare@Westat.com* and they will work to resolve the issue.

You must have an active National Provider Identifier (NPI) and have a web user account (User ID/password) established in the National Plan and Provider Enumeration System (NPPES). Email feedback and questions to the *Physician Compare* team at *PhysicianCompare@Westat.com.*

How to report PQRS to avoid penalties

Physician practices that do not report PQRS in 2013 could automatically lose 2.5% of their Medicare reimbursement due to a two-fold penalty set to go into effect in 2015.

When Congress extended the PQRS bonuses through 2014, lawmakers also enacted provisions for PQRS penalties to begin in 2015. An adjustment of 1.5% will be imposed in 2015. In addition, the value-based payment modifier (VBPM) will begin to be applied to payments of PQRS non-reporters in 2015 or 2017, depending on practice size.

The Affordable Care Act requires Medicare to implement a VBPM that will affect your reimbursement based on the quality and cost of care provided to Medicare beneficiaries enrolled in the traditional fee-for-service program. Under the VBPM, practices that fail to report PQRS will automatically be assessed an additional 1 percent penalty.

Here's how to avoid penalties:

- To avoid the 1.5% PQRS penalty for 2015 make sure you report at least one PQRS measures group on one claim for at least one patient in 2013.
- Report successfully for the entire year starting in 2014 in order to avoid future PQRS penalties.
- Report successfully by 2013 or 2015, depending on the size of your group, to avoid both the PQRS penalty and the additional 1% VBPM adjustment.

In 2015, the VBPM will be implemented for group practices with 100 or more physicians. By Jan. 1, 2017, all practices will be phased in, regardless of the number of physicians.

Decision trees can help physicians earn Medicare incentives, avoid penalties

Do you find yourself wishing there was an easier way to make sense of the incentives and penalties for participation or nonparticipation in various Medicare programs? Now, there's a resource that can help you with meaningful use of EHRs, ePrescribing, and PQRS quality reporting.

The Centers for Medicare and Medicaid Services (CMS) developed decisions trees to help physicians and other eligible providers identify whether they are eligible for incentives or will face penalties.

See the decision trees on slides 18 through 37 of this presentation that was developed by CMS.

See more at *www.pamedsoc.org/MainMenuCategories/Practice-Management/MedicareMedicaid/News/Incentives-Penalties/Decision-trees.html#sthash.HQzDpBjZ.dpuf.*

All events are posted on the PCMS website. These include CME programs and seminars from outside sources. If you would like to post your event on the website, call 215-563-5343, Ext. 102

RAND study casts doubt on medical home model's effect

A study published online in the Journal of the American Medical Association casts doubt on the ability of patient-centered medical homes to reduce health care spending and improve quality, the *New York Times* reports

The study—conducted by the RAND Corporation and funded by Aetna and the Commonwealth Fund—evaluated 32 physician practices and four insurance plans between 2008 and 2011 while they participated in the Southeastern Pennsylvania Chronic Care Initiative, one of the first PCMH pilot programs in the country (Carrns, *New York Times*, 2/25).

In order to participate in the program, the practices were required to receive accreditation from the National Committee for Quality Assurance. Each participant was eligible for a $20,000 bonus support payment during the first year and between $28,000 and $95,000 in annual bonus payments (Steenhuysen, Reuters, 2/25).

The researchers compared data on 64,000 patients who received care from the 32 participating providers with data on about 56,000 patients who received care from 29 comparison medical practices (Pittman, "The Gupta Guide," *MedPage Today,* 2/26).

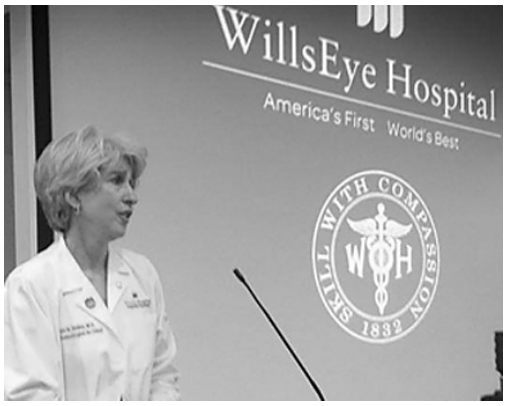
Additional study findings

Overall, the 32 participating practices delivered improvements in just one of 11 quality measures outlined for the PCMH model. The researchers found that the practices showed modest improvements in monitoring patients with diabetes for kidney disease and certain other aspects of diabetic care.

However, there were no reductions in emergency department visits, hospitalizations or overall costs of care over the three-year time period (*New York Times*, 2/25).

In addition, healthcare costs actually increased, from $389 per 1,000 patients per month prior to the study, to $430 per 1,000 patients per month in the study's third year ("The Gupta Guide," *MedPage Today*, 2/26).

pcms people



Julia Haller, *MD, Ophthalmologist-in-Chief, gives the audience a state of Wills Eye report at the recent Wills Conference.*

The following members of the Einstein Healthcare Network were selected as America's Top Doctors in the *Castle Connolly Guide*:
Mark J. Kotapka, MD
James S. Raphael, MD
Lawrence J. Solin, MD
Seth Zwillenberg, MD

Pennsylvania physician leaders recently traveled to Washington to urge Congress to pass legislation that would strengthen Medicare by updating the program's troubled payment system. From left: US Congressman Fred Upton (Chair, House Energy & Commerce Committee); Marilyn Heine, MD, PAMED past president; and Theodore Christopher, MD, PCMS past president.

Host your event at PCMS
Host your next party or conference/ seminar at PCMS headquarters. Ample free parking. Contact Louise Eder on 215-563-5343, Ext. 107 to schedule an appointment.

Save the Date
Saturday, June 14, 2014
President's Installation and Awards Night
Celebrating the Inauguration of
Anthony M. Padula, MD
PCMS 153rd President
The Union League
Philadelphia, PA

Official Publication of the Philadelphia County Medical Society • www.philamedsoc.org

Philadelphia Medicine
2100 Spring Garden Street
Philadelphia, PA 19130

PRSRT STD
U.S. POSTAGE
PAID
SOUTHAMPTON, PA
PERMIT NO. 225