Philadelphia Medicine

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Observational status — what are we doing about it?

The issue of observation status is top priority and PAMED is working with legislators, insurers, hospitals, and others to raise awareness of the urgent need to find solutions for Pennsylvania patients and physicians.

PAMED's Board of Trustees recently approved several actions to:

- Help increase patient awareness
- Further educate physicians on admission screening guidelines and documentation requirements
- Work on the issue with national organizations, such as the American Medical Association and the Centers for Medicare and Medicaid Services, including investigating creation of a specific place-of-service code for observation services.

How are physicians and patients affected by observation status?

When their hospital stay is classified as outpatient observation, patients are charged for various services they received in the acute care hospital, including their prescription medications.

Another twist: They are also charged for their entire subsequent skilled nursing facility stay, having never satisfied Medicare's three-day hospital stay requirement.

Physicians in this situation are then faced with two thorny problems: 1) Extensive research and paperwork to track, document, and defend the status under which they believe their patient should have been classified; and 2) Furious patients who may blame the physician for their higher than anticipated medical bills, which can have a negative effect on the physician-patient relationship

A recent survey conducted by PAMED asked how physicians and their patients are being affected by observational status. Members shared with PAMED why this is such a problem for the membership and patients alike:

- The worst outcome occurs when a patient needs to be transferred to a skilled nursing facility and hasn't met the three-day requirement. This has happened many times.
- Patients who are unaware or who don't fully understand what observation status means. They don't realize that although they are taking up a hospital bed and getting all of the usual hospital services, they are technically outpatients and all of their outpatient cost shares apply.
- Patients finding out later that their medications were not covered.
- Copayment having to be billed to the patient, which often means they get bills they weren't expecting.
- Higher costs from hospitalization as well as difficult choices about appropriate discharge plans.
- Some patients are unable to pay the higher-than-expected bills and get mad at their physician.
- Delays patient going from the emergency department to the inpatient unit until their status is determined.

An article in the *Wall Street Journal* notes:

ObamaCare is pushing physicians into becoming hospital employees. The results aren 't encouraging.

Big government likes big providers. That's why ObamaCare is gradually making the local doctor-owned medical practice a relic. In the not too distant future, most physicians will be hourly wage earners, likely employed by a hospital chain.

The irony is that in the name of lowering costs, ObamaCare will almost certainly make the practice of medicine more expensive.

http://online.wsj.com/article/SB10001424127887323628804578346614033833092.html?mod=googlenews_wsj

PCMS NEWS

PCMS seeks physician volunteers

President-Elect Curtis T. Miyamoto, MD, is seeking member volunteers with interest in possible appointments to PCMS Committees and Sections during his term of office through June, 2014. PCMS would like to develop a diverse list of interested talented expertise to help formulate society focus and activities.

The list of Committees and Sections appears below. If you are interested in serving on PCMS Committees or Sections, please call Mr. Mark C. Austerberry, Executive Director, at 215-563-5343, Ext. 101.

- Editorial Review Board: Oversees content of PCMS monthly newsletter, *Philadelphia Medicine.*
- Delegate Caucus to PAMED Annual Meeting: Develop and review resolutions pertaining to the practice of medicine and governance of The Pennsylvania Medical Society. Delegates attend PAMED House of Delegates in October held in Hershey, PA.
- Public Health: Works with the Philadelphia Department of Health in advocating for healthcare for the citizens of Philadelphia. Promotes good health practices through its block captains programs.
- Membership: Oversees member benefits programs and outreach to physicians.
- Young Physicians Section: For physicians 40 years and younger.
- International Medical Graduates Section: Forum for IMGs to discuss common concerns.
- Residents/Fellows Section: Forum for discussion of common concerns.

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

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Editorial

Is it time to legalize drugs?

by Harvey B. Lefton, MD

For the past 45 years, the United States has engaged in a "war on drugs." This was popularized in the mid-70s by President Nixon who even enlisted the help of Elvis Presley to speak out against drugs.

The government's role in controlling narcotics was actually first strengthened in 1914 when the Harrison Act expanded the Pure Food and Drug Act of 1906 to restrict heroin and cocaine sales in medications. Prior to 1906, today's controlled substances were widely available in unmeasured amounts as shown by Coca Cola which initially did have cocaine instead of caffeine as a stimulant. Over the years, marijuana, "the Mexican drug," and crack cocaine were introduced into popular usage. Today methamphetamines have joined the panoply of popular usage.

Colorado and Washington State recently joined California in offering some form of legalized marijuana, in some cases for medical use. The debate rages as to the true medicinal value of cannabis. Opponents cite the drug as a stepping stone to heroin and cocaine, and even suggest a tetragenic effect. I have personally had patients ask me to prescribe Marinol, the schedule 3 form of tetrahydrocannabinol for nausea. They have been unhappy with my refusal to do so. In a recent debate on National Public Radio about drug legalization, 45% of the audience was in favor and 32% opposed legalizing drugs prior to the debate. At the end of the debate, which featured the former head of the Drug Enforcement Agency, the number in favor of legalization rose to 58% and those opposed went down to 30%.

While public policy should not be directed by popular polls, there is a growing acceptance in society to bring some change in current policy. I believe this is fueled by public recognition that our war on drugs has been about as successful as the wars in Vietnam, Iraq and Afghanistan. The difference with this war is that it is aimed at a social phenomenon and an inanimate object.

Our present policies towards drugs have had a number of deleterious effects. Organized crime controls the drug trade. It is a blight on our society. Illegal drugs are readily available in spite of law enforcement efforts to stop them. Their purity is unregulated with criminals adulterating the drugs to increase their profit. Addicts have no idea if they are getting 3% or 10% of an item.

If CVS or Walgreens were licensed to sell drugs, this random violence would subside. At present, the Mafia controls heroin, Jamaican gangs crack cocaine and the Medelline cartel cocaine.

As a physician I abhor drug use and addiction of all forms. But isn't it time we recognize the misery and the ineffectiveness of present programs?

By legalizing drugs, the huge profits that fuel organized criminals and the money extracted from narco states would decrease. This money is often used to fund international terrorism that is used against us. Allowing pharmaceutical companies to produce drugs and having them regulated by the government would allow standardization of available drugs. The billions of drug dollars now hidden or laundered would be subject to taxation, and they would become a source of public revenue. Also, the diseases spread by sharing needles among IV drug users could be eliminated. Another benefit is that the tens of billons of dollars spent to incarcerate drug users and sellers could be used for rehabilitation and drug education projects.

As a physician I abhor drug use and addiction of all forms. But isn't it time we recognize the misery and the ineffectiveness of present programs? Shouldn't we spend more money on educating people about the dangers of drugs and eliminate drugs as the only source of livelihood in poor neighborhoods? It may be too much to ask a government that hasn't passed the budget in four years to develop an enlightened social conscience.

But at some point we need to recognize that the disease of drugs is destroying our society. It needs to be treated in a more effective manner.

Dr. Lefton is the president of PCMS.

Is your EHR ready for the ADA?

Physicians risk lawsuits if they fail to make electronic resources accessible to disabled patients

After twisting her ankle, Anne Taylor visited a Maryland health care clinic, where she was given a computer tablet and asked to fill out her medical history electronically. But Taylor could not perform the task. She is blind, and the tablet had no way of recording medical information without typing.

"Obviously, I couldn't do it, so I had to get help from the clerk," said Taylor, director of Access Technology for the National Federation of the Blind in Maryland. "In a sense, I was giving my personal data to essentially a stranger. I didn't have any choice. I wanted to get my injury looked at."

Such an experience is becoming more common for impaired patients as more medical practices move to electronic health records and electronic resources. Too often, health professionals do not consider whether disabled patients or employees are able to use electronic equipment such as EHRs, public websites and e-tools until a problem arises, legal experts say.

that you have to offer and to interact with your office efficiently. Making sure accessible technology is used is in everybody's best interest."

Excerpted from an article by Alicia Gallegos of the **amednews** *staff. Posted April 1, 2013*

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10 steps to making technology available to disabled patients

Poorly designed electronic resources can create unnecessary barriers for patients with disabilities. The Dept. of Justice provides guidance to ensure that health information technology is available for everyone.

- Establish, implement and post online a policy that your Web pages will be accessible and create a process for implementation.
- Ensure that all new and modified websites and content are accessible. For example, check the HTML of all new pages and make sure that accessible coding is used.
- If images are used, including photos and graphics, make sure to include a text equivalent by adding "alt" tags or long descriptions for each.
- If you use online forms and tables, make those elements accessible by labeling each control, including buttons, check boxes, drop-down menus and text fields, with a descriptive HTML tag.
- When posting documents on a website, always provide them in HTML or a text-based format.
- Develop a plan for making your existing Web content accessible. Let visitors to your site know about the standards or guidelines that you are using to make your website accessible. When setting time frames for accessibility modifications, make more popular Web pages a priority.
- When updating Web pages, remember to ensure that updates are accessible. For example, when images change, the text equivalents in "alt" tags and long descriptions need to be changed so they match the new images.
- Ensure that staff and contractors responsible for website control and content are trained properly.
- Provide a way for visitors to request accessible information or services by posting a telephone number or email address on your home page. Establish procedures that ensure a quick response to users with disabilities who are trying to obtain information or services in this way.
- Periodically enlist disability groups to test your pages for ease of use and use their feedback to increase the accessibility of your website.

ADA Best Practices Tool Kit for State and Local Governments, Dept. of Justice, May 7, 2007

Life after Sequestration – 9 Years?

On April fool's day, all Medicare services provided by physicians were reduced by a 2% payment cut under the budget sequestration. As it stands now, the sequestration will be in effect for nine years, unless Congress and the White House are able to reach a significant deficit reduction agreement that replaces it.

Medicare FFS claims with dates-of-service on or after April 1, 2013, will incur a 2% reduction in Medicare payments. The 2013 Medicare fee schedule will remain unchanged; the reduction will be applied to the payment amount, not the limiting charge. For assigned claims, the patient's coinsurance and deductible will remain unchanged.

The patient's coinsurance amount should continue to be based on the full-par or non-par physician fee schedule amount, also known as the Medicare allowed/approved charge.

The 2% cut will affect only the percentage of the allowable charge that a participating provider receives from Medicare. Patients cannot be billed for the payment reduction. For unassigned claims rendered by non-participating providers, the 2% cut will be applied to the Medicare payment made to the beneficiary.

These Medicare cuts are not cumulative. This means that the 2% reduction in 2013 will not be followed by another 2% reduction in 2014 or subsequent years. This year's reduction will simply remain in place every year through 2022 (unless Congress takes action against it).

The Centers for Medicare and Medicaid Services (CMS) encourages physicians who bill unassigned claims to discuss the impact that sequestration will have on patient's reimbursement.

Physicians are encouraged to share any stories about how your practices or health programs are being harmed as a result of the sequester. (Email *mausterberry@philamedsoc.org)* so that our advocacy efforts can incorporate the real faces and places that are persuasive to members of Congress as we continue working on this issue.

pcms people

US Congresswoman Allyson B. Schwartz appeared before the PCMS Board of Directors Meeting

Enrique Hernandez, MD, First District Trustee; Congresswoman Schwartz; Harvey B. Lefton, MD, President, PCMS

SAVE THE DATE
Saturday, June 8, 2013
President's Installation
and Awards Night
Celebrating the Inauguration of
Curtis T. Miyamoto, MD
PCMS 152nd President
The Rittenhouse Hotel
Philadelphia, PA

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