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Ohio Podiatric Medical Association

Journal

OHIO PODIATRIC MEDICAL ASSOCIATION

INSIDE THIS ISSUE

President's Message

A Landscape of Successes

by Marc S. Greenberg, DPM

2013 OPMA PRESIDENT

The landscape of medicine continues to change and present new challenges. Technology enables better procedures for some problems, yet we have relatively fewer dollars available to manage them.

President John F. Kennedy said, "Change is the law of life. And those who look only to the past or present are certain to miss the future."

On December 1 at the 2012 OPMA House of Delegates, members met to discuss these challenges head on, taking proactive steps to ensure every podiatrist in Ohio has a prosperous future. To assist in our legislative efforts, the House of Delegates approved reserving, with the Ohio Secretary of State, the use, as needed, of the title *Ohio Foot and Ankle Medical Association* when addressing our legislators to assist with understanding our profession with issues such as fee parity, protection of our scope of practice and Title XIX.

Many new Congressmen and Congresswomen take office in January. The OPMA thanks those who contributed to our OPPAC fund. I urge all of you to contribute in 2013. Additionally, I urge you to visit the APMA advocacy page and email your state and federal representatives. It will take all of five minutes.

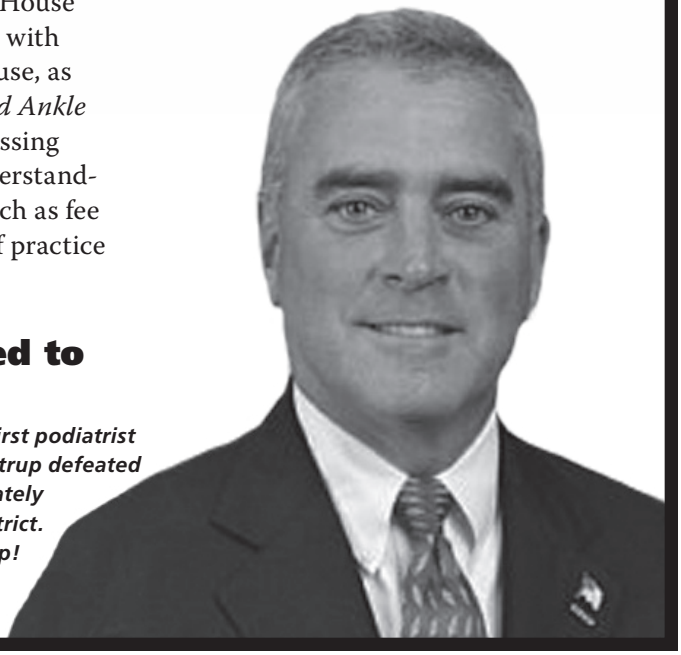
The OPMA will host the APMA Coding Seminar again in April that covers updates and changes with ICD-10, CGS policy, OSHA and HIPAA guidelines.

At the OPMA House of Delegates, APMA President Joseph Caporusso, DPM, and Vice-President Frank Spinosa, DPM, spoke about Vision 2015 and efforts to adapt closer to our MD allies, with three-year model residencies and testing equivalencies—making changes as needed helps ensure closer comparisons with issues such as fee parity.

As OPMA President, I will lead us through the issues facing podiatry; and I urge all members to relay the benefits of membership to non-members and inform them on the measures the OPMA is taking to make our future a brighter one.

OPMA Member Elected to U.S. Congress

Dr. Brad Wenstrup (R) has become the first podiatrist ever elected to the U.S. Congress. Wenstrup defeated his Democratic rival, winning approximately 60 percent of the vote in Ohio's 2nd District. Congratulations, Congressman Wenstrup!



2012 LEGAL REPORT

The Department of Insurance Appeal

by Nanci L. Danison, Esq.

[Editor's note: Due to the historical and institutional importance of our court case in 2012, we wanted to review the Appellate Court report of our attorney as presented at the OPMA HOD in December. OPMA sincerely thanks each member who contributed to our legal fund.]

I argued OPMA's case against the Ohio Department of Insurance to a three-judge panel of the Franklin County Court of Appeals on March 15th. We drew Judge Peggy Bryant, who went from private practice in a mid-sized firm to the bench and has 27 years' experience as a judge; Presiding Judge Susan Brown, who was a teacher and flight attendant before law school, spent a year as an Assistant AG, and has been on the bench since 1995; and Judge Julia Dorrian, who had international civil rights experience before law school, private practice, and the bench.

The Judges had read the briefs and appeared to have read the evidence we submitted. They asked the Assistant AG how the statute applies if insurance companies paid DPMs so little that none of them signed contracts to be participating providers. He said insurers and DPMs negotiate rates. The Judges asked if the rates were a set dollar amount or a percentage of physician charges. The Assistant AG said "fixed amounts."

The Court's written decision was issued on June 19, 2012, with Judge Bryant writing for the Court. It is a well-reasoned and written opinion. The Court found the facts to be that insurers were offering DPMs half what they were paying MDs for the same service, that DPMs had to agree or be dropped from insurers networks, and that "insurance companies refused to negotiate the lower fees" citing the ODI letter to the OOA. ORC 3923.23 states in part: "Whenever such policy . . . provides for reimbursement for any service which may be legally performed by a person licensed in this state for the practice of osteopathy, optometry, chiropractic, or podiatry, reimbursement under such policy or certificate shall not be denied when such service is rendered by a person so licensed."

The Court ruled that the word "reimbursement" in ORC 3923.23 must be construed as defined in ORC 3901.38(E), which says: "'reimburse' means indemnify, make payment, or otherwise accept responsibility for payment for health care services . . ." Inserting that definition into ORC 3923.23, the Court ruled that the statute unambiguously provides that "payment, indemnification, or responsibility for payment 'shall not be denied'" when a DPM provides the service. The Court ruled that the statute's purpose "is apparent", i.e., insurers may not refuse to reimburse an insured for a covered service that a DPM performs. But ORC 3923.23 does not mention either rates of reimbursement to be paid or equality of payment among MDs, DOs, and DPMs. The Court ruled that it would have to add language to ORC 3923.23 in order to interpret it as requiring payment parity, which a court is not allowed to do. The Court assumed that since the General Assembly could have expressly stated payment parity and didn't, the omission was intentional. The Court ruled that it could not interpret ORC 3923.23 in light of current payment practices where physicians contract to be members of an insurer's network and payments are made directly to physicians instead of patients, which is what the Assistant AG wanted. The Court noted that the conflicting ODI letters do not make ORC 3923.23 ambiguous, and, the legislative history stating the purpose of 3923.23 was to "guarantee full protection and recompense" does not apply to contracts between insurers and doctors—only insurance policies. The Court ruled that ODI's letters and legal memorandum merely interpreted ORC 3923.23 and did not expand duties or establish a new rule, regulation, or standard. So those documents did not constitute illegally-adopted administrative rules. Finally, the Court of Appeals ruled that Dr. Blank and others who filed complaints were not entitled to a hearing under the unfair insurance practices statute (ORC 3901.21(W)) because the Court had previously ruled that Aetna and Anthem had not violated ORC 3923.23. Final note: "To the extent an insurer were to compensate a podiatrist at a drastically reduced rate compared to

My recommendations for legislation:

Propose a small amendment to current ORC 3923.23 rather than a whole new statute, i.e., "reimbursement at the same rates as paid to allopathic physicians under such policy or certificate shall not be denied when such service is rendered by a person so licensed." This type amendment makes the best use of the Court of Appeals decision . . .

other physicians, the insurer may cross the line from issues of reimbursement amount to refusal to reimburse in violation of the statute. On the facts before us, we acknowledge that the disparity of payment may well deserve a remedy, but remedy does not lie with the court."

"'The court has nothing to do with the wisdom or unwisdom of the provisions of the statute, and if its plain terms, reasonably construed, do not give the relief desired, the remedy lies with the legislative branch of the state government.'" *My recommendations for legislation:* Propose a small amendment to current ORC 3923.23 rather than a whole new statute, i.e., "reimbursement at the same rates as paid to allopathic physicians under such policy or certificate shall not be denied when such service is rendered by a person so licensed." This type amendment makes the best use of the Court of Appeals decision and makes it work in your favor because the Court held that reimbursement cannot be withheld for services a DPM renders that are covered when an MD provides them. Proposing a new statute based on one used in another state will carry the baggage of court interpretations of that other statute in that other state, which decisions have not been favorable to DPMs. It's easier to sell 9 new words to an existing statute than a whole new one that will be debated and edited.

FROM CAPITOL SQUARE

Legislative Briefings

Following the election lawmakers returned for the customary lame duck session. There are always surprises during a lame duck session and bills loaded up with unrelated amendments looking to hitch a ride to the Governor's desk. A breakdown of key bills that passed and will be signed by Governor Kasich follows:

HB 417 Physician Termination — Sponsored by Rep. Cheryl Grossman (R-Grove City) — requires patient notification when the physician is terminated or leaves a hospital or practice. If the departing physician is part of a practice, the patient can be provided with contact information for another physician at the practice.

HB 284 Physicians Assistants — Sponsored by Reps. Gonzales (R-Westerville) and Letson (D-Warren) — makes several changes to the scope of practice for PAs.

SB 301 Controlled Substances — Senator Dave Burke (R-Marysville), a pharmacist — makes technical corrections and cleans up some provisions of last year's historic pill mill legislation.

HB 62 Nurse Assault — Sponsored by Rep. Anne Gonzales (R-Westerville) — Increases the penalties for assault of a doctor, nurse, or hospital employee. The Senate added language to apply these new penalties to assault of judges, magistrates, court officials, and judicial employees.

HB 303 Health Care Workers — Sponsored by Rep. Kirk Schuring (R-Canton) — A 'Christmas tree' bill, a bill that gets loaded up with amendments. It creates a license for pediatric respite care programs, sets restrictions on the location of methadone clinics in relation to schools, and makes changes to state funding for skilled nursing facilities in fiscal year 2013.

HB 334 Pseudoephedrine Tracking — Sponsored by Rep. Terry Johnson (R-McDermott) — requires pharmacies to track the sale of ephedrine and pseudoephedrine. Additionally, at the request of Ohio Attorney General DeWine, 'controlled substance analogues' was added to the bath salt ban.

The lame duck session also saw a flurry of activity surrounding the Affordable Care Act (ACA) and Medicaid Expansion. Despite a last minute deadline extension by HHS, Governor Kasich sent a letter to Secretary Sebelius indicating that Ohio will not establish a state-based exchange, opting to allow the federal government to set one up. Ohio will maintain some regulatory oversight of this new insurance marketplace. The Kasich administration releases a framework proposal on February 15, 2013.

The state has until December 26, 2012 to designate a benchmark plan for determining essential health benefits. HHS has also released draft rules for essential health benefits and related premium and coinsurance provisions that will provide states with more guidance once they are finalized early next year.

Perhaps the most critical development came when Secretary Sebelius released a statement indicating that HHS will not provide full federal reimbursement for partial expansions of Medicaid. Ohio's Medicaid Director, John McCarthy, had been exploring a partial expansion of Medicaid eligibility to adults up to 100% of the federal poverty line. Under ACA, the feds would cover 100% of the cost of expanding Medicaid to all adults up to 138% of the poverty line; that share would decline to 90% in 2022. This announcement means that unless Ohio full expands Medicaid per ACA we will only receive the standard 60% federal share.

It is unclear what Ohio's next steps will be on insurance exchanges, essential health benefits, and Medicaid expansion. The Kasich administration still has a number of unanswered questions from the feds and is still crunching numbers for next year's budget proposal. The Governors FY14/15 operating budget, due out on February 6, 2013, will shed considerable light on how Ohio will proceed. The Ohio Podiatric Medical Association remains engaged on these important issues and is committed to ensuring full and fair treatment for podiatric physicians.

From The Desk of the Executive Director

Podiatry: A Foot and Ankle Above The Rest

by Jimelle Rumberg, PhD, CAE

What's in a name? You say tomato; I say toe-mot-to. That's how the song goes and has gone for decades. It's charming and catchy.

From Chiropody to Podiatry to Confusion

Is it *Chiropody?* With a *sh* sound or a *k* sound—I've heard both pronunciations. Furthermore, we have explained what chiropody is and it's now called podiatry. Our name is podiatric and not pediatric. *Argh!* Haven't we all spent time explaining the differences? Realistically, we need to educate, but when the general public has a reading level of the average fourth grader. We go from becoming a realist to becoming being a literalist . . . literally speaking.

Podiatrics, Pediatrics—What's the Difference?

In December, during the OPMA House of Delegates, a resolution (12-01) was considered regarding a business name change. The Reference Committee debated the pros and cons for over an hour. When the Committee considered all the public aspects of our name legislatively and randomly, the Committee decided to amend the original resolution and render its verdict. RESOLVED, that the Ohio Podiatric Medical Association include the DBA name as the Ohio Foot & Ankle Medical Association (OHFAMA).

OHFAMA Is Calling

Of course, OPMA has been a long-standing corporate name since 1985, when it was changed from Ohio Podiatry Association to the Ohio Podiatric Medical Association. My guess is to unmistakably align podiatry as a medical physician entity.

Now that we have endured 27 years as that entity, it's time to describe our specialty within the medical specialty realm by including our name as the Ohio Foot and Ankle Medical Association. The acronym is pronounced OH-Fame-Ah).

We are still incorporated as the Ohio Podiatric Medical Association and our charter with APMA will remain the same as a component organization. Our tax name will remain the same; however in some instances, we will include the Ohio Foot and Ankle Medical Association to explain what we do. It's logical and literal.

Drawing the Line, Literally

As you may realize, hospital departments are becoming more compartmentalized. It may no longer be called *Orthopedics—Lower Extremity* but *Foot and Ankle.* The new title is much more inclusive and tells patients that the department only does foot and ankle, not spines or shoulders. Likewise, it contains orthopods and podiatric physicians working together as specialty physicians.

Yes, There Is A Name For That

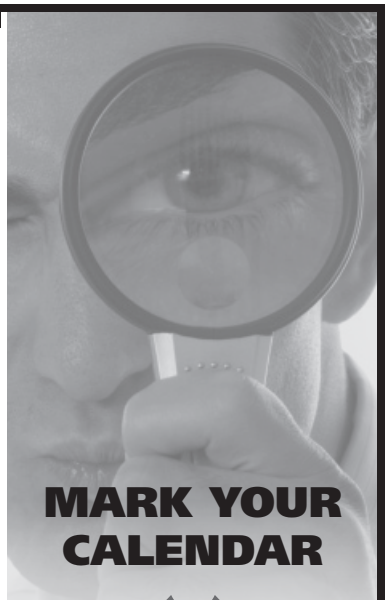
Yes, it may take 27 years longer to teach the public that podiatric is foot and ankle, but we can now begin using this name in legislative circles, and wherever we need a clearer understanding of what we do with state agencies or the public.

Time will tell whether this will become more than just a DBA-type name. Although it will be hard for everyone to make the eventual change-over through the decade, don't be surprised if you call our office and hear—

"Good Morning, the Ohio Foot and Ankle Medical Association.

"May we help you?"

[NOTE: The National Association of Chiropodists changed its name to American Podiatry Association in 1958.]



MARK YOUR CALENDAR

March 7-8, 2013
GXMO Didactic Course
OPMA Office I Columbus

March 9, 2013
GXMO Didactic Course
OPMA Office I Columbus

March 8-10, 2013
2013 No-Nonsense Seminar
Holiday Inn I Independence

April 5, 2013
2013 APMA Coding Seminar
Columbus I TBA

April 17, 2013
13th Annual Surloff Memorial Seminar
Akron General Health & Wellness Center - West
Akron

May 4, 2013
Sports Injury Clinic
Columbus I TBA

June 6-8, 2013
APMA Region IV Seminar
Hilton at Easton I Columbus

July 18-19, 2013
GXMO Didactic Course
OPMA Office I Columbus

July 20, 2013
GXMO Didactic Course
OPMA Office I Columbus

MEMBERS' MARKETING "RE"SOLUTIONS

OPMA Practice Marketing Store Online

Coming in January, OPMA members will be able to order exclusive apparel, selected promotional items and printed materials that help to educate patients on podiatric services, increase referrals and print practice logo/location information on the promotional items.

Performing Better

Member savings average between 25-55% through efficiency, time, merchandise alternatives and buying power of the OPMA community. A custom OPMA web store will be available and regular communications will be sent on tailored promotional offerings intended to delight your patients and keep them coming back.

The Right Kind of Advertising

Members will find affordable, podiatric relevant merchandise useful to a patient and ordered securely online, by phone or personal consultation for an efficient, professional customer experience and satisfaction guarantee. All items can be customized with unique podiatric group practice information and colors. Many additional items available and more will be added. Member suggestions are very encouraged!

Performing as a Winner

This Podiatric practice marketing program will focus on four main areas:

- **Patient acquisition, retention and referrals.**
- **OPMA Academy seminar materials and promotion.**
- **Patient and community educational resources.**
- **Practice branding/ image.**

For More Information

To learn more about this program, please contact your OPMA Practice Marketing Store at (740) 971-8601.

Note: This exclusive member benefit is authorized by the OPMA, but is owned and operated independently from the OPMA and any of its members or affiliates.

MEMBER ARCHIVES

Nothing Stands Still

As part of OPMA 2015 Centennial Celebration, we will be recapping words of wisdom from the past. The more things change, the more they stay the same. Our first is from John H. Buchan, D.S.C., President of the Ohio Chiropodists Association in 1960.

"BITS FROM BUCHAN"
by John H. Buchan, D.S.C., President, The Ohio Chiropodists Association, Columbus, Ohio

There is great need to expand the work of the Association at the Committee level. This year there were 14 committees that had just over $1,000 to be divided among them to fill their needs.

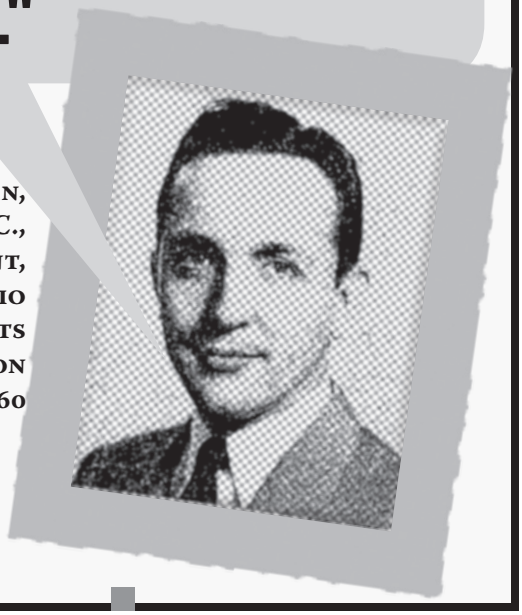
By May 1st we will have sent $30 per senior member to the national association (APA). This will approximate $9,000 which is taken from the dues payments you make to the State office and which cannot be and are not used for state program. Next year, 1960-61, in order to belong to the APA your dues will be $40. This means that you chiropodists in Ohio will be sending over $12,000 to the APA next year.

The National association does not provide any direct services that help our state program. The entire state program such as Vocational Guidance, Public Relations, Legislation, Speakers Bureau, Insurance, and all 14 committees are supported by what is left of your dues. We must keep abreast, in Ohio, financially, if our program is to continue to make progress.

To do this our House of Delegates will need to add to your dues—a total increase of $20 for a final total of $40 to APA. This is not an increase in state dues, it merely returns us to our original dues structure of 1954. It was upon this structure that the Ohio program was based. Our program must go onward. We cannot stand still. Nothing stands still, unless it's dead or dying.

[This article appeared in The O.C.A. News-Journal, January 1960 issue, published by The Ohio Chiropodists Association, Columbus, Ohio; J. Edwin Farmer, Editor; 50 West Broad Street, Columbus, Ohio.]

"We cannot stand still. Nothing stands still, unless it's dead or dying."



John H. Buchan, D.S.C., President, The Ohio Chiropodists Association 1959-1960

Extremity Imaging Partners—EIP: Podiatry's Win-Win

Extremity Imaging Partners (EIP) is one of the country's leaders in podiatric specific MRI services and is proud to be an Industry Affiliate of the Ohio Podiatric Medical Association. Since our start in 2001, EIP remains independent, strong and growing—delivering professional results to today's podiatric physicians with excellence. EIP attributes its success to three main things: commitment to its original podiatric based business model, superior clinical standards and a loyal referral base.

Along with setting the industry clinical standard in podiatric MRI, did you realize that EIP is also the lowest cost provider of MRI services? EIP has negotiated lower than average insurance contract rates which translates into lower out of pocket expense for patients. With more patients carrying the burden of high deductibles and coinsurance many are foregoing their diagnostic testing and putting themselves at risk for worsening injury, pain and suffering. Plus, when patients use EIP they only receive one bill for their MRI since EIP's billed charge includes both the MRI and the radiologist's interpretation. Patients scanned at EIP owe the minimal amount of out of pocket expense. For times when a patient is unable to pay their out of pocket expense in full, EIP customizes a payment plan tailored to their individual needs.

EIP is delighted to be in a position to continue offering the best MRI service available to foot and ankle patients. Superior clinical results and lower patient expense is a win-win situation for everyone in the podiatric MRI community.

OPMA Workers' Compensation Update

2013 Quotes

Now is the time to review your workers' compensation program and costs. This is the ideal time to submit your authorization to allow CareWorks Consultants to review your program and offer you a quote through **OPMA's workers' compensation program**. OPMA's program includes various sizes of members from our industry. **Members in the OPMA's program are saving over $29,000 on their BWC premiums for 2012 alone**. For a no-cost, no-obligation program analysis, call OPMA's Program Manager, Jason Bainum toll-free at 1-800-837-3200, ext. 7114 or email him at jason.bainum@ccitpa.com. You may also submit an online application at www.careworksconsultants.com/groupratingapplication/podiatricmedical.

Upcoming Deadlines

For those of you who take advantage of BWC's 50/50 Payment Plan, the balance of your 1/1/12-6/30/12 premium payment is due **no later than December 1, 2012.**

Ohio BWC Updates

The Ohio BWC announced in October that they have determined the Credibility Table for the 2013 policy year (7/1/13-6/30/14). They will be keeping the same Credibility Table from the 2012 policy year, so once again the maximum credibility factor is **53%**. This means that the maximum achievable discount in a traditional group rating program will be 53%, just as it is for 2012.

If you have any questions or would like to receive a quote through OPMA, please contact Jason Bainum, CareWorks Consultants Program Manager, at 1-800-837-3200, ext. 7114 or via email at jason.bainum@ccitpa.com.

OHIO PODIATRIC MEDICAL ASSOCIATION

November 30–December 1, 2012

The OPMA House of Delegates

At the recent House of Delegates meeting on November 30–December 1, 2012, Marc Greenberg, DPM, of Dayton became President of The Ohio Podiatric Medical Association.

"Welcome," Marc, Board Members and Delegates!

Dr. David Hintz administers the Oath of Office to the new president, Dr. Marc Greenberg of Dayton.

The 2013 OPMA Executive Committee

Dr. Corey Russell of Toledo was elected OPMA Second Vice President.

The OPMA 2013 Board of Trustees (Not pictured: Dr. Bohach, Dr. Gould, Dr. Jackson and Ms. Kamery)

The 2013 OPMA Delegation to APMA HOD

MEMBERS MATTER

To The PAC

As one of the founding members of the Ohio Health Care Provider Coalition, OPMA is poised to draw upon our health care counterparts to lobby in support or defeat of legislation. Such was the case last summer when OPMA and Charlie Solley took the lead position to tackle the Small Waste Generator problem to remain exempt against the wishes of the Ohio EPA Director. Thankfully between dentistry and podiatry, we scored a major win to avoid more expense to you as a small medical waste generator.

As a coalition, we share newsletters and have bi-monthly meetings. We meet at the Ohio Dental Association. Naturally, when I read in the ODA newsletter that ODPAC received more than $250,000 in PAC contributions, and that nearly 40% of ODA members contribute to their ODPAC, I wondered why collectively podiatry is so lax in advocacy donations.

As I've always said, if you're not at the table, you're on the menu. What truly defines podiatry and you as a podiatric physician? Do most members think it's someone else's obligation to contribute and they don't really need to donate to the PAC? If that's the case, let me tell you like it really is.

It Matters to People with Feet

The devil is in the details. With over 2,000 pages in the ACA, the law will demand the very best representation from state and national professional associations to educate the membership. By ourselves, individuals will stand little chance of influencing the decision makers in Congress and Executive branch of government. Podiatry must be present in all discussions. Podiatry must be considered part of the solution to a better health care delivery system; one that has better access to the provider of choice with improved outcomes and appropriately managed costs. One certainty facing Ohio's podiatric community is the need for strong representation at all levels. This underscores the need for support both in membership and time through advocacy of *every* podiatric physician. The OPMA leadership and staff are committed to our very best efforts; therefore, the difference in success and failure may fall to the engaged grassroots membership.

Engaging the Gears

If you're not engaged, why not? When we ask for your support, we ask because it's a critical time of making sure that podiatry is at the table. The game is changing; tactical nimbleness and substantively is required in our legislative agendas. Simply put, we need your contribution. Dr. Karen Kellogg is the 2013 OPPAC chair, so please don't disappoint her or OPPAC.

You Make the Difference

Beginning in 2013, OPPAC will have contributor levels. We will maintain our January – December donation cycle. Our levels will be: Platinum Club (1,000-$5,000); Founders Club ($500-$999); President's Club ($250-$499); Cornerstone Members ($150-$249). Personal checks or credit cards only please. Monthly, quarterly and semi-annual contribution planning are gladly accepted.

Buck up, Buckeyes. We look forward to hearing from you soon.

OPPAC Contributors for 2012

Brian Ash
Renee Ash
Robert Bair
James Benedict
Animesh Bhatia
Bruce Blank
Michael Bodman
Chris Bohach
Michael Brondon
Tim Brown
Philip Cain
Vincent Cibella
Ruth Ann Cooper
Mike Coppers
Edward Cosentino
Mitch Dalvin
Linda DiDomenico
Sam Feinberg
Ron Freireich
Mark Gould
Marc Greenberg
Larry Greiner
Allen Guehl
Darryl Haycock
Rich Hofacker
Larry Hufford
Kevin Kane
David Kaplansky
Karen Kellogg
Michael Kessinger
Richard Kunig
Thomas Kunkel
David Kutlick
Paul Lieberman
Thomas McCabe
Rudolph McComb
James McLean
Arnold Milner
William Munsey
Lisa Nicely
Les Niehaus
Mark Nosin
Angelo Petrolla
Thomas Pokabla
Gene Pusateri
Luci Ridolfo
Dominic Rizzo
James Robinettee
Jimelle Rumberg
Corey Russell
Bridget Samek
Richard Schilling
Kevin Schroeder
John Stevenson
Kristin Titko
David Trimble
Gary Unsdorfer
Thomas Vail
Howard Waxman
Brian Weiss
Brad Wenstrup
Kelly Whaley
Susan Yu
Brian Zimmerman
David Zink
Thomas Zoldowski

THANK YOU for your dedication to our OPPAC advocacy efforts on your behalf in 2012.

Please remember to make your 2013 contributions early.

PRESCRIBING GUIDELINES

Emergency and Acute Care Facility Opioid and Other Controlled Substances

Under the leadership of the Governor's Cabinet Opiate Action Team (GCOAT), the Professional Education Workgroup (PEW), and the Emergency Department Opiate Prescribing Guidelines Committee, the *Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines* (ED Guidelines) were developed.

The guidelines provide appropriate clinical guidance for the prescribing of opioids and other controlled substances (OOCS) in the unique acute care environment where the treatment of pain is frequently indicated without the benefit of an established patient-doctor relationship. They are not intended to take the place of clinical judgment, which should always be utilized in order to provide the most appropriate care to meet the unique needs of each patient.

The Guidelines are printed here for your information. A detailed background document providing an explanation and references for the recommendations is available on the Ohio Department of Health at: www.healthyohioprogram.org/ed/guidelines.aspx.

Guideline Recommendations

OOCS for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction.

- Doses of OOCS for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
- Prescriptions for chronic pain will typically NOT be provided if the patient has either previously presented with the same problem or received an OOCS prescription from another provider within the last month.
- IV Demerol (Meperidine) for acute or chronic pain is discouraged.

Emergency medical clinicians will not routinely provide:

- Replacement prescriptions for OOCS that were lost, destroyed or stolen.
- Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.
- Long-acting or controlled-release opioids (such as OxyContin, fentanyl patches, and methadone).

Prior to making a final determination regarding whether a patient will be provided a prescription for OOCS, the emergency clinician or facility:

- Should search the Ohio Automated Rx Reporting System (OARRS) database (https://www.ohiopmp.gov/) or other prescription monitoring programs, per state rules.
- Reserves the right to request a photo ID to confirm the identity of the patient. If no photo ID is available, the emergency or other acute care facility should photograph the patient for inclusion in the facility medical record.
- Reserves the right to perform a urine drug screen or other drug screening.

Emergency/acute care facilities should maintain an updated list of clinics that provide primary care and/or pain management services for patients, as needed.

Prior to making a final determination regarding whether a patient will be provided a prescription for an OOCS, the emergency clinician should consider the following options:

- Contact the patient's routine provider who usually prescribes their OOCS.
- Request a consultation from their hospital's palliative or pain service (if available), or an appropriate sub-specialty service.
- Perform case review or case management for patients who frequently visit the emergency/acute care facilities with pain-related complaints.
- Request medical and prescription records from other hospitals, provider's offices, etc.
- Request that the patient sign a pain agreement that outlines the expectations of the emergency clinician with regard to appropriate use of prescriptions for OOCS.

Emergency/acute care facilities should use available electronic medical resources to coordinate the care of patients who frequently visit the facility, allowing information exchange between emergency/acute care facilities and other community-care providers.

Except in rare circumstances, prescriptions for OOCS should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care physician or appropriate specialist for reevaluation.

Each patient leaving the emergency/acute care facility with a prescription for OOCS should be provided with detailed information about the addictive nature of these medications, the potential dangers of misuse and the appropriate storage and disposal of these medications at home. This information may be included in the Discharge Instructions or another handout.

Emergency/acute care facilities should provide a patient handout and/or display signage that reflects the above guidelines and clearly states the facility position regarding the prescribing of opioids and other controlled substances.

| *Copied with permission from the Ohio Pharmacist, Volume 61, Number 10, page 14-15, October 2012.* |

JUST THE FACTS

The Truth About Prescribing For Family Members

What should you do if a family member asks you to examine, treat or prescribe to him or her? What are the ethical standards, rules and law, and guiding principles you should consider? Nearly every physician has or will be confronted with these questions at some point.

The following are some bright lines with respect to the issue of prescribing to family members:

Physicians may treat and prescribe **controlled substances** to family members ***only*** in emergency situations. See AMA Code of Medical Ethics Opinion 8.19, the February 2012 Practice Guidance Statement, *Prescribing to Self and Family*, State Medical Board of Ohio, and Rule 4731-11-08, Ohio Administrative Code.

"Family members" include a spouse, parent, child, sibling or other individual where the physician's personal or emotional involvement may render the physician unable to exercise detached professional judgment, such as a boyfriend or girlfriend. See Rule 4731-11-08, Ohio Administrative Code.

Physicians should not generally serve as a primary or regular care provider for immediate family members. See AMA Code of Medical Ethics Opinion 8.19.

A physician should always consider whether he or she can ensure that his or her personal feelings will not unduly influence his or her professional judgment and that the personal feelings will not interfere with the care being delivered. Please note that Medical Board regulations prohibit a physician from self-treatment with controlled substances due to the fact that a physician cannot exercise detached professional judgment when treating him or herself. See Rule 4731-11-08, Ohio Administrative Code.

A physician is always responsible to provide care that conforms to the minimal standard of care, regardless of the identity of the patient. See Section 4731.22(B)(6),Ohio Revised Code. A physician is responsible for completing and maintaining accurate medical records reflecting the physician's examination, evaluation and treatment of all the physician's patients. See Rule 4731-11-02, Ohio Administrative Code.

While there are not specific rules or statutes prohibiting a physician from treating family with prescription drugs that are not controlled substances, physicians are also required to meet the applicable ethical standards of their profession. See Section 4731.22(B)(18), Ohio Revised Code. The AMA Code of Ethics Opinion 8.19 recommends a physician only treat family members in emergency or isolated settings when another physician is unavailable. Why is this so important? In cases involving the treatment of family members, physicians often times do not complete a full physical examination or history, do not inquire about sensitive information that may be pertinent to the diagnosis or treatment plan, and do not maintain patient records.

If the physician or patient feels uncomfortable, or if the physician does not feel that he or she could be objective, then the physician should not treat the family member. Consider the emotional and psychological impact that could occur if the treatment was inadequate, if the wrong diagnosis was made or if complications arose from the treatment.

Note: The rules, statutes, and minimal standards of care referenced apply to all physicians and physician assistants practicing in Ohio. The AMA Code of Ethics applies to medical doctors. The AMA Code of Ethics does not apply to osteopathic physicians, podiatric physicians, or physician assistants. Osteopathic physicians and podiatric physicians must meet the ethical requirements of the American Osteopathic Association or the American Podiatric Medical Association respectively.

RESOURCES:

1. *The AMA Code of Medical Ethics Opinion on Physicians Treating Family Members*, http://virtualmentor.ama-assn.org/2012/05/coet1-1205.html May 2012
2. Medical Board Practice Guidance Statement, *Prescribing for Self and Family Members,* February 2012 http://med.ohio.gov/pdf/Prescribing%20for%20Self%20and%20Family%20Members.pdf
3. *The Overlapping Roles of the Rural Doctor*, http://virtualmentor.ama-assn.org/2011/05/ccas1-1105.html May 2011
4. *Requests for Care from Family Members,* http://virtualmentor.ama-assn.org/2012/05/ecas1-1205.html May 2012
5. Rule 4731-11-08, Ohio Administrative Code, http://codes.ohio.gov/oac/4731-11-08
6. Rule 4731-11-02, Ohio Administrative Code, http://codes.ohio.gov/oac/4731-11-02
7. Sections 4731.22(B)(6) and 4731.22(B)(18), Ohio Revised Code, http://codes.ohio.gov/orc/4731.22 Approved October 11, 2012; Corrected

Injection Safety Checklist

The following Injection Safety checklist items are a subset of items that can be found in the **CDC Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care.** The checklist should be used to systematically assess adherence of healthcare personnel to safe injection practices. If an answer is unchecked, document a plan for remediation.

- ☐ **Injections** are prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids or contaminated equipment.
- ☐ **Needles and syringes** are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).
- ☐ **The rubber septum** on a medication vial is disinfected with alcohol prior to piercing.
- ☐ **Medication vials** are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient.
- ☐ **Single dose** (single-use) medication vials, ampules, and bags or bottles of intravenous solution are used for only one patient.
- ☐ **Medication administration tubing** and connectors are used for only one patient.
- ☐ **Multi-dose vials are dated** by HCP when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Note: This is different from the expiration date printed on the vial.
- ☐ **Multi-dose vials are dedicated** to individual patients whenever possible.
- ☐ **Multi-dose vials to be used for more than** one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., operating room, patient room/cubicle). Note: If multi-dose vials enter the immediate patient treatment area they should be dedicated for single-patient use and discarded immediately after use.

RESOURCES

Checklist: http://www.cdc.gov/HAI/pdfs/guidelines/ambulatory-care-checklist-07-2011.pdf

Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care: http://www.cdc.gov/HAI/pdfs/guidelines/standatds-of-ambulatory-care-7-2011.pdf

www.oneandonlycampaign.org

OHIO PODIATRIC MEDICAL ASSOCIATION

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SECRETS OF SUCCESS

Insurance Coverage: Yes or No?

by Lynn Homisak

Are you one of those doctors who think that it's a waste of your staff's time to have them verify patient insurance benefits? Those who have a high A/R but refuse to adopt this critical process are contributing to their own compromised collection attempts. Yes, it takes valuable time; and yes, if you have high patient volume, it may require hiring additional personnel, but the investment is one that doctors who live by this protocol maintain results in a positive return.

Doing Your Homework

Doing the necessary legwork to obtain each patient's eligibility, deductible and co-pay in advance of their visit effectively streamlines the billing office workflow with less steps and snags when it comes to collecting patient and third party balances. Being able to communicate this information to patients beforehand (along with having a detailed financial policy) gives patients the heads up about their financial responsibility, building better patient relations. And, the better their understanding and expectations, the less surprised and more compliant they are when payment is due.

Serving the Best Interests of . . . Everyone

Committing to checking patients' insurance benefits is in everyone's best interest. This benefits your cash flow. Having a patient sit idly in the treatment chair while your staff spends time on the phone does not make good economic sense.

While having knowledge of your patients' coverage in advance has its advantages, it should not be the determining or influential factor in deciding which direction to take with your treatment. Basing your treatment regimen solely on what type of coverage is unethical. Your guiding principle should always be to make your best recommendation to the patient based on what's medically necessary and then let them decide on whether or not it's in their budget. They need you to be their doctor not their financial advisor. *"Mrs. Jones, based on my diagnosis and clinical findings, it is my professional opinion that you would benefit from a pair of custom made prescription orthotics. (Explain why.) They are $X. I see here that your insurance will (will partially or will not) cover them, so your responsibility will be $X."* Depending on their response (and financial priorities), an alternate recommendation can and should then be made.

It's true that spending the time to find out the details of a patient's insurance coverage is not the physician's office responsibility. This should be made clear to the patient at the onset of any insurance discussion (and in your written financial policy). Don't make getting paid for your services a gamble. Be proactive and file claims based on fact; not on information inaccurately translated to you from a patient (who may or may not understand their policy limitations.)

You don't need a high-salary employee to undertake the insurance verification task. Arm them with the proper tool (a form with standardized questions to ask), making sure they get the insurance agent's name, phone number date and time of call. **(Email lynn@soshms.com for a sample copy.)** Each call should take anywhere between 5-10 minutes.

Some Tips That Can Really Pay Off

- **It is wise to sort calls according to insurance companies; for example, when calling Blue Shield, information on multiple patients can be obtained with one call.**
- **Avoid delay of claims by asking the insurance representative to confirm the mailing address for claims. The address listed on the card is not necessarily the most accurate one.**
- **This is the time to be detail-oriented in order to avoid unnecessary claim denials. Verify subscriber and patient demographics (including name spelling), policy and group numbers, effective dates, deductibles, co-pays, timely filing limitations, when medical necessity documents are needed, DME benefits, policy exclusions, in- and out-of-network benefits and prior authorization requirements.**
- **Some companies have very thorough physician websites where most information can be acquired and printed; however, most times a personal phone call needs to be made for DME benefits.**
- **Make it a point to check every patient's insurance card at each visit to determine if benefit changes have been made. It is a common practice to update insurance information annually on existing patients and upon scheduling an appointment for each new and inactive patient.**

STEPPING UP

Baby Steps

Send BWC your National Provider Identification (NPI) number

BWC is preparing to move to the new 5010 electronic data interchange (EDI) billing protocols. In preparation for the transition, BWC must receive NPIs from all eligible providers and organizations currently having an NPI.

Thus, they're requesting that you send your individual NPI number and your organizational NPI number to BWC. If you do not have your original notice, please include the National Plan and Provider Enumeration System (NPPES) verification sheet.

To ensure their records are accurate and they pay your bills correctly, please fax this information along with your BWC provider number to their provider enrollment unit at (614) 621-1333.

HITECH Act Amendments in HIPAA Security Manuals

The Health Insurance Portability and Accountability Act (HIPAA) marks its ninth year since being enacted in 2003. OPMA reminds members that APMA's 2010 HIPAA Security Manuals have the revised HITECH Amendments information. Go to http://www.apma.org/files/secure/index.cfm?FileID=5225 to view the manual. The Manual states that "Practitioners are strongly encouraged to conduct refresher' training on the HIPAA Privacy Rules and include discussion of the new HITECH Act amendments." PMA hopes that you will join us in April for the 2013 APMA Coding Seminar, which will have pertinent HIPAA information for your practice. See you on April 5. More details to follow.

ICD-10 Countdown

CMS now provides a list of questions providers should ask clearinghouses and billing services about preparing for the Oct. 1, 2014 compliance date for ICD-10. The questions include asking if the organization is prepared to meet the ICD-10 deadline and if so, how their transition process is progressing.

It's not a bad idea to ask to see their time table for process implementation. Providers should ask clearinghouses to verify that their electronic transaction systems are updated to Version 5010. Providers should ask to set up regular check-in meetings and establish a primary contact for issues regarding the ICD-10 transition. Clarify how clients will be involved in testing ICD-10 claims codes and whether the provider can be involved in such tests. Finally, providers should inquire about any training or guidance that the clearinghouse will provide for changing clinical documentation to comply with ICD-10 and, of course, whether all of this will result in any price changes.

OPMA Membership Hits An All-Time High!

The OPMA House of Delegates received great news on membership. An all-time high membership has been achieved, with several more admitted to membership since the graph was developed. This is due to the efforts of Luci Ridolfo, Director of Membership and her persistence to refine our database, contact residents to join and show the value of OPMA membership to podiatric physicians. Our educational venues, communications and meetings are cost-effective and timely. We go the extra mile for our members. Another positive has been the electronic dues reminders and the payment plans for both dues and OPPAC. Know we're here for you and will continue the momentum to expand our services for your expectations.

Study Shows Volunteering at Five-Year High

The national rate of volunteering has reached its highest level in five years, according to a report released in late December by the Corporation for National and Community Service. In 2011, roughly one in four adults (64.3 million Americans) volunteered in a formal organization, an increase of 1.5 million from 2010. Altogether, Americans volunteered approximately 7.9 billion hours last year with an estimated value of $171 billion to the economy. Volunteering and non-profit work is *big* business. The financial rewards of contributing and serving are not the only lure. One's sense of altruism gives great self-satisfaction. What are you doing in your community and within OPMA to volunteer? Call or email us and ask about opportunities at Region IV.

Make a Little History: Take Part in OPMA's Centennial Celebration

Want to help us celebrate the Centennial of OPMA? Show others how much you care about OPMA and your profession. We could use your help! Offer your congratulations by supplying your business card and $25 for ad space in our Centennial Gala promotion. Special recognition will be given and it helps OPMA celebrate 2015 with a Century of Service to Podiatric Medicine.

All you do is remit your check to OPMA Centennial Fund and two (2) business cards. We will do the rest.

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