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Ohio Podiatric Medical Association
Journal

OHIO PODIATRIC MEDICAL ASSOCIATION

INSIDE THIS ISSUE

President's Message

In The Eye of The Beholder

by Alan J. Block, DPM, MS

2011 OPMA President

As a practitioner of the lower extremity, I am acutely aware of the nuances that are germane to the region. Eighty-five percent of amputations are preceded by a foot ulcer. The algorithm for the treatment of these lower extremity ulcers is not a one-size-fits-all formula. A patient's treatment is unique.

Recently, I was in attendance at a vascular medicine conference. The conference was attended by vascular surgeons, interventional cardiologists and radiologists. I was amazed by the progress of endovascular limb salvage procedures in the past eight years. Treatment of blockage by plaques and calcium from the hip to the foot has grown exponentially.

In one breakout session, physicians were displaying their own cases in an open forum. One physician was demonstrating a case in which a non-ambulatory woman confined to a nursing home had developed a heel ulcer. A vascular surgeon had performed a limb-saving endovascular procedure by using two devices, one for above the knee and a second for opening up the vessels below the knee. The cost was $6,000.

As the case was opened for discussion, a vascular surgeon in the audience stated, "I would have performed a below-knee amputation and been done with this case. She is not ambulatory anyway."

Without forethought I spoke up and identified myself as a podiatrist. I started by explaining that treatment of a foot ulcer in 2008 was $48,000. I continued that diabetic ulcers are the most common cause of hospitalization, and that amputation causes a one-hundred percent increase in the metabolic rate of an already compromised biological system.

Amputation costs between $51,000 and $76,000 per procedure, and more than $100,000 per year to care for one patient in a skilled-nursing facility. This does *not* take into account the cost of prosthesis or the treatment of the depression and the stress on the patient. Less than fifty percent of patients who have a below-the-knee amputation and less than twenty-five percent of patients with an above-the-knee will ever walk again. Additionally, after three years the mortality rate for non-trauma induced amputation patients is greater than fifty percent.

The moderator of the breakout opened a line of questioning on this subject. It was quite lively, with doctors sharing ideas and asking questions.

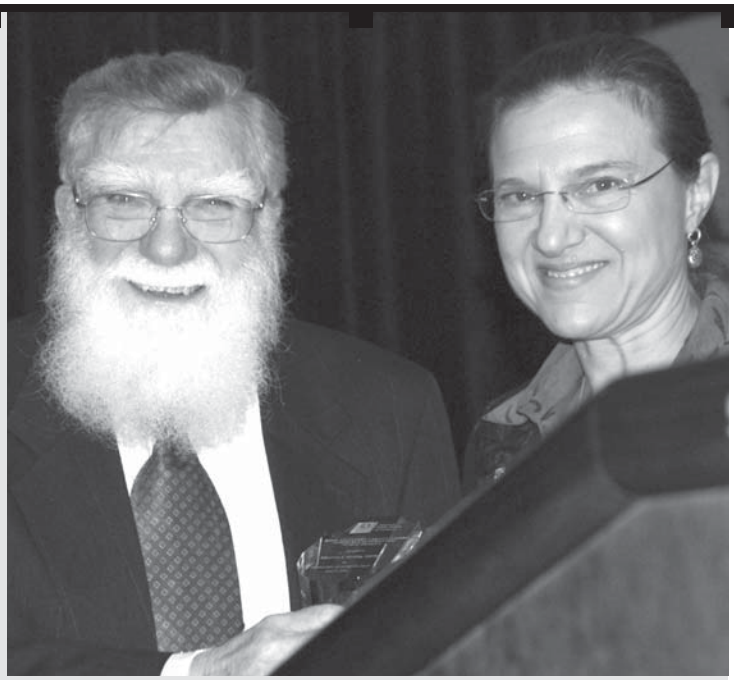
Towards the end of the conference, I presented on limb salvage. Following my presentation, the vascular physician who raised the idea of amputation approached me, asking for a copy of my slide deck—and, at the same time, explaining his thought processes on amputation. The disconnect was that I know what I know, and assumed he knew what I knew and *vice versa.* For every mistake made for not knowing, ten are made for not looking.

HOUSE OF DELEGATES

News from APMA

Resolution No. 2-11: Dues Increase. **The house voted to adopt a dues increase**. The dues increase will be the first since fiscal year 2001-2002 and is urgently needed to maintain and expand APMA's many services and initiatives, including Vision 2015, the *Today's Podiatrist* campaign, the Coding Resource Center, regional lecture series, educational webinars, the Center for Professional Advocacy, and other expanding programs. **The increase will be $50 for full, active members in fiscal year 2011-2012, and $25 in each of the subsequent two years.** As you are aware, OPMA's HOD voted to *not adopt* the proposed dues increase. APMA has stated that they will continue to take all appropriate measures to be a responsible steward of members' dues.

Resolution 5-11: Residency Genesis Facilitator—The house voted to adopt this resolution, which will provide for $70,000 of financial support from APMA to help fund the Residency Genesis Program established by the Goldfarb Foundation. This amounts to half of the annual budget for this program. The house was enthusiastic about the opportunity to contribute further to alleviating the residency shortage for students of podiatric medicine.



Dr. Marvin Rubin and Dr. Janet Simon

Resolution 8-11: AMA Scope of Practice Partnership—The house voted almost unanimously to adopt a resolution condemning AMA's failure to appropriately acknowledge the education, training, and experience of doctors of podiatric medicine. Virtually every delegation signed on to cosponsor the resolution.

Resolution 10-11: State Restriction on APMA Board of Trustees—The house adopted a resolution that would require a proposition before the 2012 House of Delegates limiting the number of members of any component serving on the APMA board to no more than two.

Podiatry Section of APHA John and Jan Carson Award—Marvin Rubin, DPM, accepted this award from Janet Simon, DPM, in honor of his long-standing commitment to podiatric medicine and public health. Dr. Rubin is a member of Ohio, and has been a member of the American Public Health Association podiatric section since its inception in 1973. Dr. Simon commented on Dr. Rubin's "sincere commitment to podiatric public health."

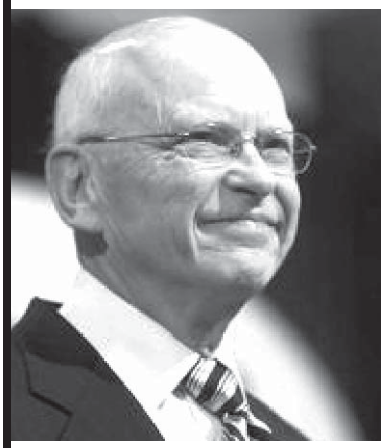
Dr. Simon also remarked, "Marvin Rubin has been a member of our profession for over sixty years and is one of our podiatric Health Section's original members from 1973. Marvin has served in many leadership positions in the New Jersey Public Health Association, Ohio Public Health Association and APHA. He currently serves as one of our Governing councilors for our section in a body similar to this HOD. Marvin was recently honored by OPHA as the recipient of the John D. Porterfield Distinguished Service Award."

APMA Celebrates Foot Health Awareness Month

The epidemic of childhood obesity in America is well documented. One way to combat that epidemic is through activity done with pain-free feet. An APMA survey revealed that many health-conscious parents don't have high standards for foot health when it comes to their children's feet.

In fact, only 25 percent of parents polled have taken their children to a podiatrist for foot ailments. Therefore, the 2011 APMA Foot Health Awareness Month campaign will focus on educating parents and children about their feet. Emphasis will be on the important role today's podiatrist plays in pediatric foot health, amd simple ways parents and children can maintain health feet, stay active and combat obesity.

Make plans to move with APMA during Foot Health Awareness Month. Stay tuned to APMA News Brief and the APMA News magazine for details. Remember to follow APMA on Twitter (@APMAtweets) and "Like" APMA on Facebook.



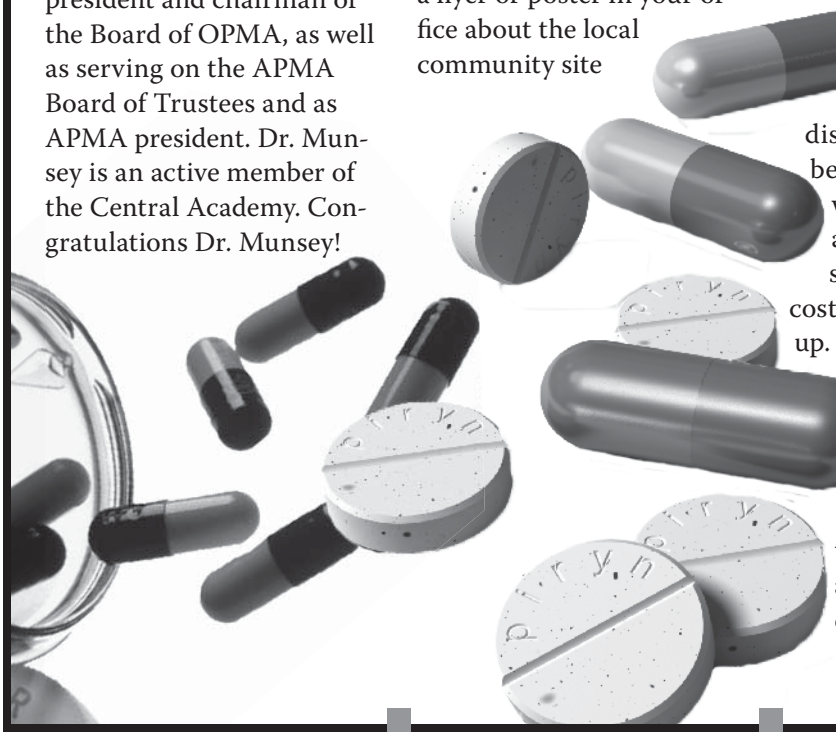
Dr. William Munsey

Munsey Named to OCPM Hall of Fame

William Munsey, DPM was recently named to the OCPM Hall of Fame. Dr. Munsey has been a leader of the podiatric medical community for more than 54 years. He received the Man of the Year Award in 1967 from the Ohio Podiatric Medical Association (OPMA), and he served as president and chairman of the Board of OPMA, as well as serving on the APMA Board of Trustees and as APMA president. Dr. Munsey is an active member of the Central Academy. Congratulations Dr. Munsey!

Second Nationwide Prescription Drug Take-Back Day in April 30 in Ohio

The 2009 National Survey on Drug Use and Health reports that more Americans currently abuse prescription drugs than the number of those using cocaine, hallucinogens, and heroin combined. *From 1999 to 2008, Ohio's death rate due to unintentional drug poisonings increased 350 percent, and the increase in deaths has been driven largely by prescription drug overdoses.* To help combat the issue of prescription drug abuse, the U.S. Drug Enforcement Administration (DEA) and its community partners are holding the second National Prescription Drug Take-Back Day in Ohio on April 30. You may want to make a flyer or poster in your office about the local community site along with April 30th information. The link below lists all the sites in Ohio that will be participating in the program. Find your community and inform your patients to remit expired or unused drugs on April 30. https://www.deadiversion.usdoj.gov/NTBI/ntbi-pub.pub?_flowExecutionKey=_cD3D6680A-DF88-BE14-1991-1ECD31DC4609_k57119DA2-109D-53A0-4EE9-BAF11A842B8B



North Central Academy

The NCAPM undertakes great efforts to subsidize advancement of our profession. Scholarship is one way we have invested and helped our podiatric schools. We have been giving students awards for twenty-five years.

Some years we were able to contribute more than others. In the past ten years, we've held steady at a $6,000 – $8,000 gift each year. This year $7,500 will be distributed to OCPM on behalf of six students who were chosen to receive an award. Tuition never seems to go down, and costs of living keep going up. It was amazing how involved and hard working our recipients are this year. We like to help students who will contribute to our profession and who will make our country a better place. This is a privilege and we are blessed. The members of our academy plan to continue this practice for many years.

OPMA First Vice President Running for City Council

OPMA First Vice President and Elyria podiatrist Dr. David Hintz is running in the at-large Council race. Hintz, who is on the Elyria Charter Review Commission, Lorain County Children Services Board, Lorain County Community Alliance and Lorain County Solid Waste Management District's Policy Committee, said he is a lifelong resident of Elyria and would like to help turn the city around. Hintz said he would like to focus on making Elyria a small-business friendly city, reduce crime, and making government work more efficiently.

Dr. David Hintz

From The Desk of the Executive Director

Wondering What We've Done for You, Lately?

by Jimelle Rumberg, PhD, CAE

This quarter has been absolutely one of the busiest since my tenure as OPMA's executive director. Some OPMA accomplishments and activities include:

- Tackled legislative concerns to include podiatric physicians as a provider class in HB 93—*The Pill Mill Bill.*
- Attended House and Senate hearings at the Capitol.
- Hosted a successful 2011 APMA Coding Seminar as well as GXMO course.
- Completed an OPPAC mailing and dues mailing.
- Held a quarterly board meeting and executive committee meeting.
- Visited OCPM for APMA Visitation Day.
- Attended Provider Coalition meetings.
- Attended the NYPMS meeting and the APMA State Advocacy Forum.
- Attended two academy meetings (Central and Mid West Academies) and the No Nonsense seminar;
- And, if that wasn't enough, attended ten legislative receptions with your OPMA President and consultant lobbyist in tow.

Website Upgrades You Should Know About

Some internal upgrades to our Web site's administrative capabilities include "cloud-based" data and financial storage capabilities. As time permits you will see a cosmetic change on our home page as we revamp many sections and feature videos. You will have dues paying capabilities through our Web site (also the ability to print an invoice and pay by check which we recommend) as well as have optional Web registration for Region IV and GXMO. When the smoke settles, our Region IV will be underway June 9-11 at the Columbus Hilton at Easton.

Register for Region IV and GXMO

Did you know our attendee brochure is posted on our Web site? Please reference www.opma.org under "*Doctors*" and see our exciting sessions! Our Scientific Chairs have planned an outstanding educational venue for you, so we hope that you'll register quickly for the "early bird" special pricing. It's simply going to be a terrific event and one you won't want to miss. We're offer 24.5 CPME hours. A new Regional event will be a late-afternoon Thursday *Welcome Reception* hosted by PICA, the preeminent malpractice liability carrier for podiatrists in Ohio. Given that the PICA lecture will be on Thursday, attend the lecture for your **15% renewal discount** and afterward relax with friends over wine and cheese before dinner on your own at Easton Towne Center.

Our Commitment Never Ends

OPMA was proud to assist legislatively so that Optional Services remained intact for podiatry, dentistry and optometry in Ohio's Biennium budget. We have left nothing to chance. In fact, our work doesn't stop here, as the OPMA President and I have met with the Medicaid Director and have attended JFS hearings at the Capitol. We are focused and committed to educate legislators on what podiatric physicians do and that podiatric physicians do it with cost-effectiveness—and we have the data to prove it! As I stated on our OPMA listserv, it's extremely gratifying to hear legislator's podiatry stories. Indeed, its rewarding to know that Ohio podiatrists are held in high regard in hometown communities.

APMA HOD News

The APMA House of Delegates was fast paced as usual. You can be proud of your Delegation from Ohio, chaired by Dr. Paul Lieberman. Other Delegates were Dr. Kevin Schroeder, Dr. Mark Gould, Dr. Angelo Petrolla, Dr. Thomas Kunkel, and Dr. Bruce Blank. Alternate Delegates were Dr. Bruce Saferin and Dr. Alan Block.

The dues increase passed, causing many to be re-billed for the additional dues owed APMA. As I oversee the OPMA budget for postage and staff time, we must produce and prepare yet another mailing at our expense for the additional dues of $50 for APMA. These unexpected expenditures strain OPMA's bottom line. Be aware that staff and the BOT are diligently trying to contain all costs to achieve financial balances by the end of the fiscal year.

New Medicare Service Carrier

CIGNA will be our new Medicare service carrier as we enter into a MAC with Kentucky. The effective date will be **June 18**. Please begin your transition now. We have posted many announcements regarding how to transition, so reference and implement changes now so that your services won't be interrupted with the change in June.

Know that we wish you a joyous Spring, and we look forward to greeting you at the Region IV meeting!

Be sure to visit our website at www.opma.org

AT THE ROTUNDA

Legislative Report

From left to right: Charlie Solley, OPMA lobbyist; Dr. Jimelle Rumberg, OPMA Executive Director; John McCarthy, Ohio's new Medicaid Director; and Dr. Alan Block, OPMA President.

On the campaign trail, Governor Kasich consistently expressed his desire to reform state government and to tackle the big issues, those that previous governors chose to avoid. With his first budget proposal, Governor Kasich demonstrates his commitment to follow through.

Governor Kasich certainly faces huge challenges in reforming state government, the most monumental is the structural deficit created by the loss of federal stimulus funding used to balance the last biennial budget. The disappearance of these federal funds and other one-time funding used in the last budget has created an $8 billion deficit. If left unaltered the state share of Medicaid spending would need to increase by $1.6 billion to maintain the Medicaid program as it exists today.

By recognizing that Medicaid reforms, including reimbursement reforms, would be addressed in this state budget, House Bill 153, OPMA and your statehouse lobbying team from the Capitol Consulting Group have spent the last three months meeting with influential members of the General Assembly and the Kasich administration to discuss the importance of podiatric care in Ohio.

These meetings have been productive in terms of educating elected officials about the type of care provided by Ohio's podiatric physicians and surgeons, and the critical role of foot care in the treatment of chronic diseases such as diabetes.

At the most recent meeting, OPMA President Dr. Alan Block, OPMA Executive Director Dr. Jimelle Rumberg and Capitol Consulting lobbyist Charlie Solley met with Medicaid Director John McCarthy and his staff. The conversation was very positive. Director McCarthy demonstrated a keen understanding of the podiatric care and the necessity that Ohioans have access to podiatric services.

As the state budget advances through the legislative process, culminating in the passage of the budget on June 30, OPMA leadership and Capitol Consulting will continue to work with the Kasich administration and elected officials to ensure that podiatry remains an optional service available to Ohio's Medicaid population.

On Tuesday, March 29, the House Finance Committee is scheduled to adopt a substitute version of HB 153, containing the detailed statute outlining the Governor's appropriations and reform proposals.

To date, the Governor's office has released the Executive Budget Summary, known as the "Blue Book." This document outlines several proposals that will be of interest to OPMA, including:

Optional Service

The budget blue book and subsequent testimony and comments by Medicaid Director John McCarthy reveal that the Governor has proposed maintaining Medicaid Optional Services.

Physician Payment Code Reform

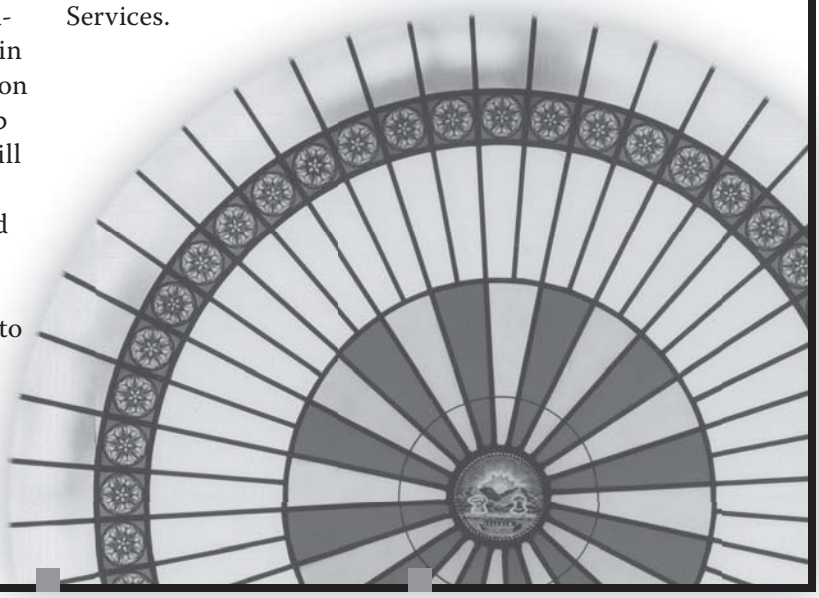
A number of Medicaid payment codes exceed the Medicare rate for the same service. Under the budget proposal Medicaid would no longer pay more than Medicare, establishing the Medicare rate as a price ceiling. This proposal would be effective July 1, 2011.

Crossover Claims

Governor Kasich has proposed Medicaid cost avoidance by limiting Medicaid payments for Medicare Part B crossover claims. The administration estimates that this policy will save the state $94.5 million over the biennium.

Promotion of Health Homes

Medicaid enrollees with at least one chronic condition drive costs within the Medicaid program, accounting for 70% of the costs, to approximately $7.2 billion annually. The administration is proposing to build on the medical home initiatives already in place throughout Ohio to better manage these chronic conditions.



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as of March 31, 2011

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Dr. Raymond Stolarski, DPM	Clarksville
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Dr. Thomas Vail	Findlay
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OHIO PODIATRIC MEDICAL ASSOCIATION

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READY, SET, RE-SET OPMA Website Member Log In

As of March 11, 2011 a new database was installed with the OPMA website; and, as a result, all previous Usernames and Passwords are reset.

All user names have been reset to each member's name: FirstNameLastName. Please note there is no word space between first and last names, and it is *not* case sensitive. All passwords have been reset to: OPMA (with all capital letters and this *is* case sensitive).

We apologize for the inconvenience to members who have recently updated their profiles; however, we hope that, as the new system is developed, members will be pleased with its easy navigation.

We hope that members utilize the online accounting function. Additionally, remember to update your membership profile with your current contact information.

Visit us online at opma.org

Looking for a new marketing tool? Sign up for Facebook at www.facebook.com for a free membership. Search APMA for APMA's Facebook group. Welcome to social networking!

SECRETS OF SUCCESS

Dismissing Employees Is Never Easy

by Lynn Homisak, SOS Healthcare Management Solutions, LLC
www.soshms.com

Whether it's because they fail to meet your expectations, the position has been eliminated, or because of an internal conflict, firing an employee is never pleasant. Plus, it can potentially turn your business upside down. To make matters worse, when all things are considered, it is extremely costly!

It's true that most states follow some form of the "at will" doctrine, but you need to be aware of the exceptions and variations that exist. If ever in doubt, checking with an employment attorney is *always* in your best interests.

Below are some helpful guidelines to keep in mind *before* dismissing an employee:

- Think things through. Is this a last resort? Is there a chance you could potentially improve this employee's performance before letting him/her go?
- Be sure you follow company policy regarding disciplinary process, written reviews, etc.
- Be sure you have adequate documentation concerning poor work performance, including specific verbal warnings.
- Is your decision a valid one? Be sure you have "non-discriminatory legal reason" to fire.
- Please email lynn@soshms.com for a list of questions you can and cannot ask during an interview.

If it is apparent that dismissing your employee is the best option, take note of these practical suggestions to help with the actual face-to-face encounter in an appropriate manner.

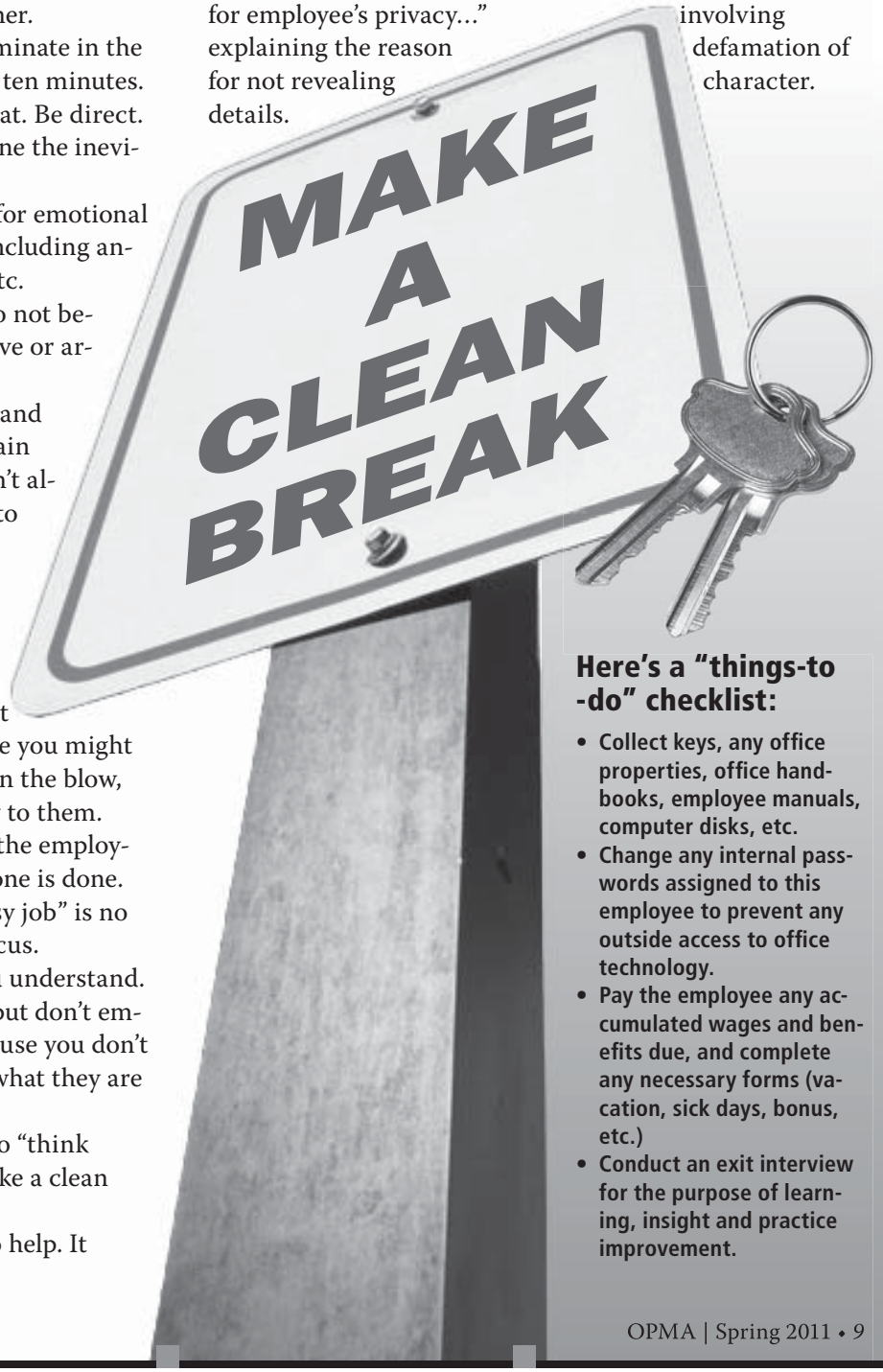
- Be brief. Terminate in the first seven to ten minutes.
- Don't chit-chat. Be direct. Don't postpone the inevitable.
- Be prepared for emotional outbreaks , including anger, crying, etc.
- Listen, but do not become defensive or argumentative.
- Stay focused and repeat the main message. Don't allow yourself to be distracted by their offer to change or make things better.
- Don't attempt humor. While you might want to soften the blow, it's not funny to them.
- Don't blame the employee. What's done is done. His/her "lousy job" is no longer the focus.
- Don't say you understand. Sympathize but don't empathize, because you don't *really* know what they are feeling.
- Don't agree to "think about it." Make a clean break.
- Don't offer to help. It contradicts your actions.
- Make no reference to age, sex or race, even casually.

After the actual dismissal takes place, it's important to take care of a few additional details:

- Informing co-workers. Don't pretend it didn't happen. Instead say something like "despite repeated warnings…" to give them reassurance that they won't be next; followed by "out of respect for employee's privacy…" explaining the reason for not revealing details.

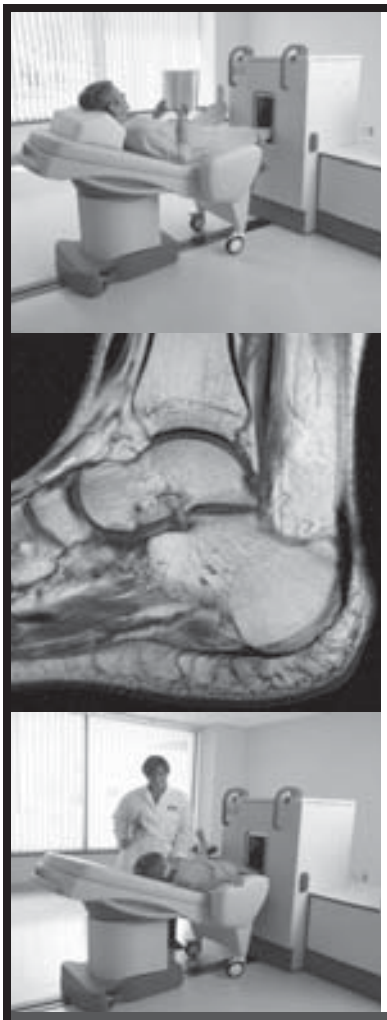
It is also strongly recommended to avoid disparaging words about the employee. It is unprofessional and a deterrent to employee morale.

- Dealing with reference calls from future potential employers. Keep the call short. "She did work here, she no longer works here." Stick to dates and salary confirmation. Beware of any potential for liability involving defamation of character.



Here's a "things-to-do" checklist:

- **Collect keys, any office properties, office handbooks, employee manuals, computer disks, etc.**
- **Change any internal passwords assigned to this employee to prevent any outside access to office technology.**
- **Pay the employee any accumulated wages and benefits due, and complete any necessary forms (vacation, sick days, bonus, etc.)**
- **Conduct an exit interview for the purpose of learning, insight and practice improvement.**



THE PATIENT'S CHOICE

Extremity Imaging Partners, Inc.

Extremity Imaging Partners, Inc. (EIP) has spent the past 10 years perfecting a unique alternative to the often intimidating MRI experience. Along with setting the industry standard in podiatric MRI, patient comfort and convenience continue to be a priority. Patients comment time and again, how much they enjoy and appreciate the focused one-on-one attention they receive at EIP. EIP does not double book appointments so each patient receives our undivided attention. In fact, our patients are pleasantly surprised when they arrive at our office and are greeted by the technologist who will perform their exam. Making this initial contact with the technologist puts our patients at ease and provides an opportunity to go over any questions and concerns they have about the MRI before they enter the exam room.

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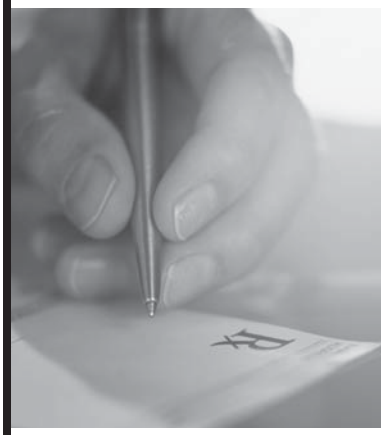
BOARD APPROVAL

Electronic Prescription Transmission Systems



Electronic prescription transmission systems allow prescriptions to be sent electronically from a prescriber to a pharmacy. For non-controlled substances, the prescriber can send the electronic prescription directly from his/her computer to a pharmacy computer or facsimile machine. Controlled substance prescriptions can only be sent and received electronically from a prescriber computer to a pharmacy computer and NOT from a prescriber computer to a pharmacy facsimile machine (See 1 and 2). Some of the systems are office-based, some are web-based, and some use a switch (e.g. SureScripts) to route the prescription to the pharmacy. The office-based systems allow the prescriber to send a prescription electronically directly from his/her office to the pharmacy. The web-based systems allow the prescriber to log onto a website, enter a prescription, and the website sends the prescription to the pharmacy. Systems utilizing a switch allow the prescriber to enter a prescription that is transmitted to a switch. The switch identifies the prescriber using specific data elements and then sends the prescription to the pharmacy.

Prior approval by the Board of Pharmacy is required for all electronic prescription transmission systems and pharmacy systems receiving electronic prescriptions used in Ohio. However, pursuant to rules 4729-5-21 and 4729-5-30 of the Ohio Administrative Code (OAC), a system meeting the Drug Enforcement Agency's (DEA) requirements noted in section 21 C.F.R. 1311 to send and receive electronic prescriptions for both controlled and non-controlled substances shall be considered approved by the Board.

The Board's electronic prescription transmission system approval process includes reviewing that each system has true "positive identification" of the prescriber sending the prescription as defined in OAC 4729-5-01 (N), that every system has security and accountability of all confidential information, that the pharmacist receiving the prescription can identify that the system has approvable status with the Board of Pharmacy, and that the pharmacist receiving the prescription can identify that the prescription is legitimate.

Please note that the Board's approval processes for electronic prescription transmission systems and pharmacy computer systems does not replace the need to meet the requirements of section 21 C.F.R. 1311 to send and receive controlled substance electronic prescriptions.

Information about electronic prescription transmission systems

1 No controlled substances may be sent to a pharmacy using an electronic prescription transmission system unless the system meets the DEA requirements noted in section 21 C.F.R. 1311.
2 No controlled substances may be received by a pharmacy using an electronic prescription transmission system unless the system meets the DEA requirements noted in section 21 C.F.R. 1311.
3 Dispense as Written" or "DAW" does not have to be handwritten on a prescription sent through an electronic prescription transmission system [see Section 4729.38 of the Ohio Revised Code (ORC)]. It does, however, require a positive action by the prescriber to physically select "Dispense as Written" or "DAW" when creating an electronic prescription. The electronic prescription transmission system cannot automatically default to "Dispense as Written" or "DAW".

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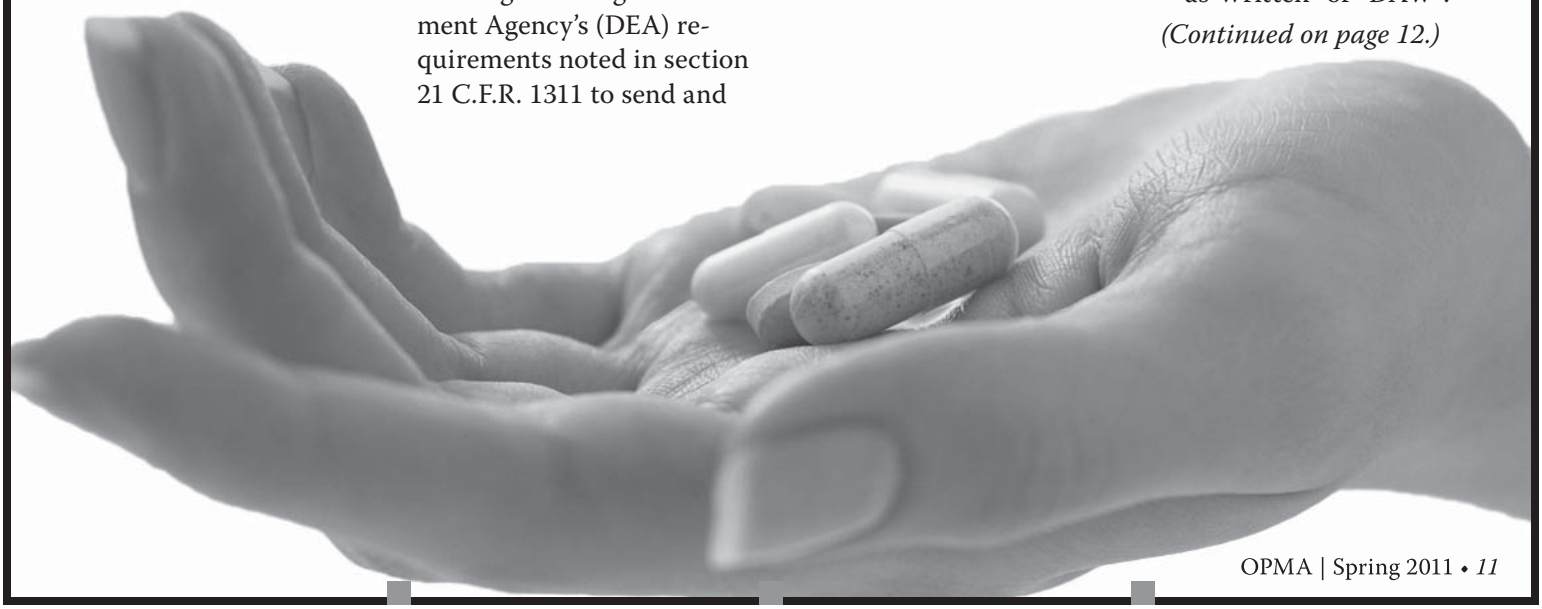

(Continued from page 11.)

4 You may, or may not, see a signature on a prescription sent to a pharmacy by a prescriber using an electronic prescription transmission system. Electronic signatures are not recognized as "positive identification" and are not required. If present the prescription must indicate that the signature was computer generated.

5 A prescriber may elect to print a prescription from the electronic prescription transmission system in his/her office and give it to the patient to personally present to a pharmacy. The prescription must be issued as any written prescription [see OAC Rules 4729-5-30 and 4729-5-13]. These prescriptions may contain a schedule II controlled substance, there can only be one controlled substance per prescription blank, "Dispense as Written" or "DAW" must be handwritten, and the actual handwritten signature of the prescriber must be on the prescription. Printed and manually signed prescriptions for both non-controlled and most controlled substances can still be legally sent from a prescriber facsimile machine to a pharmacy facsimile machine pursuant to OAC rule 4729-5-30.

The systems that currently have obtained an approvable status with the Board of Pharmacy are (Note 1: The approvable status applies ONLY to the electronic prescription transmission system and NOT to any other related electronic products, such as an electronic medical record; Note 2: the Board's approval process for electronic prescription transmission systems does NOT replace the need to meet the requirements of section 21 C.F.R. 1311 to send controlled substance electronic prescriptions):

A4 Health Systems; Allmed; Allscripts; Allscripts – HealthMatics EHR; Allscripts eprescribe; Allscripts eRX NOW; Allscripts MyWay; Allscripts Professional; Alteer; Amazing Charts; Amicore; Aprima; Athenahealth; BlueFish; Centricity (EMR V9.2.3 & above; Practice Solution V.9.0.3 & above); CentriHealth; Cerner PowerWorks; ChartLogic; Compulink; Crowell Systems – Medformix; CyberAccess; DrFirst; e-Clinicalworks; EHS; Emdeon; e-MDs; E-Physician; Epic at Akron Children's; Epic at Catholic Health Partners; Epic at Cinc. Children's; Epic at Cleveland Clinic; Epic at Dayton Children's; Epic at Kettering Health Network; Epic at MetroHealth; Epic at Ohio State; Epic at Premier Health Center; Epic at Tri-Health; e-Referral; gCardio; GEMMS; gGastro; Greenway Medical; gUro; Health Probe; Healthfusion Medi-Touch; iMedica; InfoScribeRx; InteGreat; I-Scribe; KeyScribe; McKesson Horizon Ambulatory Care; Medent; Medflow; MedicWare; MedInformatix; MedPlus; meridianEMR; MicroMD; MI-LifeNet; MinuteClinic; Misys at Family Practice Assoc. of Dayton; Misys at Greater Cincinnati Cardiovascular Consultants; Misys at Northeast Center for Women's Health; Misys at The Family Medical Group; Mt Carmel/Medical Manager; My Practice Community; NetPracticeEHRweb at Premiere Medical Partners; NetScript; NewCrop; NextGen; OnCallData; Pinestar eDose Connect; Pinestar NMIS; Positive Business Solutions Inc./PBSI-EMR; Practice Partner; Relay Health; RxCure; RxNT; Sage Health; SequelMed EMR; SigmaPoint; SmartCareRx; Wellinx.

EMR and EHR: Deciphering the Lingo

The change of just one letter can cause a shift in the understanding and implications of certain terms. Case in point, consider the easily confused terms EMR (electronic medical records) and EHR (electronic health records). The primary difference can be summed up by noting that the term "health" is more comprehensive than the term "medical" and ends up covering a wider territory.

Electronic medical records (EMRs) are a digital version of the paper charts in the clinician's office. Their contents pertain to the medical and treatment history of the patients of that practice. EMRs help physicians track data over time, identify patients who are due for preventive screenings or checkups, and monitor and improve overall quality of care within the practice.

It is important that the information keyed into EMRs doesn't find an outlet from the area of practice. Occasionally, digital records need to be circulated to the others in the healthcare team in an accessible format either through printouts or emails. In these situations, the EMR system proves cumbersome.

Electronic health records (EHRs) take care of the above limitations by focusing on the total health of the patient. They are the collection point of all the information from the provider's office and at other care locations, thereby giving shape to an all-inclusive system. EHRs are designed to reach beyond the health organization that originally collects and compiles the information. They are built to share information with other health care providers, such as laboratories, support service providers and specialists. EHRs are a comprehensive storehouse of information from all the clinicians involved in the patient's care.

The National Alliance for Health Information Technology stated that EHR data can be created, managed and consulted by authorized clinicians and staff across more than one healthcare organization. The information forms a chain connecting the patient, the specialist, the hospital, the nursing home, an institution in the next state or even across the country. EHR seeks to provide a secure channel for the efficient transmission of information at a large scale, thereby facilitating effective communication for smooth decision-making. In simple words, an EHR system is a multi-level channel of communication of patient information between the different stakeholders including the patient him/herself.

EHR represents the ability to easily share medical information among stakeholders and to have a patient's information follow him or her through the various modalities of care engaged by that individual. Bottom line, the difference between an EMR and an EHR is that of access versus parties concerned.

Ohio Medical Record Reproduction Fee Schedule

Method to determine percentage change in Consumer Price Index (CPI) to Increase or Decrease Costs Associated with Providing Medical Records in Accordanc with Ohio Revised Code Section 3701.742

CPI for current period (2010)	218.056
Less CPI for previous period (2009)	214.537
Equals Index point change	3.52
Divided by previous period CPI (2009)	214.537
Equals	0.016
Result multiplied by 100	1.64
Equals percent change	1.64%

Costs for Calendar Year 2011 Based on a 1.64% change in the CPI

If the request is made by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

With respect to data recorded on paper or electronically, the following amounts:

For the first ten pages:	$2.88	per page
For pages eleven through fifty:	$0.60	per page
For pages fifty-one and higher:	$0.24	per page
With respect to data resulting from an X-ray, MRI, or CAT scan, recorded on paper or film:	$1.97	per page
The actual cost of any related postage incurred by the health care provider or medical records company.	Actual Cost	

If the request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

An initial fee which shall compensate for the records search:	$17.70	

With respect to data recorded on paper or electronically, the following amounts:

For the first ten pages:	$1.17	per page
For pages eleven through fifty:	$0.60	per page
For pages fifty-one and higher:	$0.24	per page
With respect to data resulting from an X-ray, MRI, or CAT scan, recorded on paper or film:	$1.97	per page
The actual cost of any related postage incurred by the health care provider or medical records company.	Actual Cost	

OHIO PODIATRIC MEDICAL ASSOCIATION

Calendar of Events

Mark your calendar!

April 8-10
GXMO | OPMA Headquarters

April 14
OPMA BOT | OPMA Headquarters

May 25
OPMA EC | Conference Call

June 9-11
Region IV | Columbus Hilton at Easton

June 9-10
GXMO – Re-cert Only | Columbus Hilton at Easton

June 11
Assistants CE | Columbus Hilton at Easton

August 4
OPMA BOT | OPMA Headquarters

August 26–28
GXMO | TBA

September 8
OPMA EC | Conference Call

September 23–24
MidWest Quickie | Belterra, IN

October 7–9
GXMO | TBA

October 13
OPMA BOT | OPMA Headquarters

October 20–23
NEOAPM Super Saver | Cleveland Airport Marriott

November 10
OPMA EC | Conference Call

December 2–3
OPMA HOD | TBA

THE TAX MAN COMETH

"Use Tax" is on the Way

In an effort to inform Ohio businesses of their responsibility to remit use tax on untaxed purchases, the Ohio Department of Taxation has established the Use Tax Education Program (UTEP). The goal of UTEP is to help businesses understand what *use tax* is and when businesses must remit it directly to Ohio. Additionally, UTEP will help businesses clear up any past unpaid use-tax liabilities.

What is "Use Tax"?

Use tax is a tax on the storage, use or other consumption of tangible personal property and certain taxable services in Ohio. The tax is a complement to the Ohio sales tax. Please refer to the Use Tax brochure for more information on what is subject to use tax or go to the website at tax.ohio.gov.

In general, if you have paid Ohio sales tax on an item, then you do not owe Ohio use tax. If you have not paid Ohio sales tax, then you have a responsibility to remit Ohio use tax directly to the State. For example, an Ohio company located in Cleveland purchases a set of file cabinets. The Ohio company has two choices; an in-state vendor or an out-of-state vendor:

Description	ABC Co. Buffalo, NY	XYZ Co. Columbus, OH
File Cabinets	$2,600	$2,600
Freight	$250	$200
OH Sales Tax	$0	$189
Total	$2,850	$2,989

The Ohio company would owe Ohio use tax on the $2,850.00 transaction if it purchases the cabinets from ABC Co. in Buffalo, NY and would need to remit the use tax directly to Ohio.

How will UTEP be rolled out?

In the first half of 2011, the Department will provide educational opportunities to Ohio businesses through presentations, including business association meetings and workshops.

In the second half of 2011, the Department will analyze its current systems and other information to identify businesses that are registered for a tax other than use tax, but are not registered for use tax and identify businesses that are not registered for another tax, but should be registered for use tax.

The Department will contact these businesses informing them of their responsibility to be remitting use tax. The businesses will be able (through UTEP) to register and begin remitting use tax on future purchases. The businesses will also be able to enter into a UTEP agreement to clear up the past unpaid use tax liability. In general, the terms of the agreement will include:

- Business agrees to register and remit use tax prospectively;
- Business agrees to pay use tax (plus applicable interest) on untaxed purchases for the last four (4) years (or less depending on when the business started);

Note: *By law, the business could owe use tax for up to 10 years. The Department's general practice is to audit for the last seven years.*

- The Department agrees, in the absence of fraud, to waive the use tax liability for all years beyond the look back period; and
- The Department agrees not to apply the 15% penalty applicable for the unpaid use tax.

If a business does not take advantage of the voluntary disclosure opportunity, the Department may audit and/or assess the business based on Department practice.

If a business is unregistered, can a business enter a voluntary disclosure agreement prior to being contacted by the Department through UTEP? Yes. The Department will accept a request for voluntary disclosure prior to the contact through UTEP. Once the Department has contacted a business through UTEP, the business will be required to conduct an agreement under the terms allowed by UTEP.

What are the use tax rates? The use tax rates are generally the same as the sales tax rates.

How do I remit use tax directly to Ohio? A business would need to register for a Consumer's Use Tax account to begin remitting use tax directly to Ohio. Businesses who meet certain requirements may also register for a Direct Payment Authority [see Information Release 2003-01, as revised 12/4/2004].

If I have unremitted use tax for past years, how can I resolve that liability? The statute of limitations for unregistered businesses is 10 years. If your business is contacted by the Department to perform an audit, the audit period will generally include the last seven years. However, if you voluntarily approach the Department through our Voluntary Disclosure program, you can generally limit the look-back to the last three years. Please see the Department's website for details of our Voluntary Disclosure program.

In 2011, the Department will be contacting businesses who are not registered to remit use tax as part of the Use Tax Education Program (UTEP). UTEP will allow these businesses to enter a UTEP agreement with a four year look-back. If businesses do not take advantage of UTEP, they may be audited and/or assessed use tax for the past seven years.

Please see the Department's website for more details on UTEP. For more information on Use Tax visit the website at **tax.ohio.gov.** To register to pay the Use Tax, phone (888) 405-4089. For general questions regarding Use Tax, phone (888)-405-4039.

ON A ROLL

Baby Steps

OSHA On-line for Infection Control

OPMA is offering Bloodborne Pathogen Infection Control in the Workplace as well as other OSHA programs at the discounted price of $15.95. OPMA members and their employees are eligible to take the course for the discounted price of **only $15.95** per registrant (payable with a credit card).

Simply visit www.OSHAEZ.com and click on the ONLINE course tab. Select the course entitled Bloodborne Pathogen Infection Control in the Workplace. To receive the special OPMA discounted member price, during checkout, identify yourself as the Ohio Podiatric Medical Association member by entering this coupon code: EVFIBW

CPT 93924 change

The CPT Editorial Board has made changes to the description and requirements for CPT Code 93924, which is the code used to describe non-invasive vascular testing with pre-and post-exercise measurements.

New CPT code language for 93924 is as follows: 93924: Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (i.e., bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study.

It is important to note that the CPT Editorial Board changes intend that a motorized treadmill be used for the performance of these tests. A commonly cited protocol for performing the treadmill portion of the test is to use a motorized treadmill at a constant speed and grade, e.g.; 2 mph speed with a grade or incline of 12 percent. The patient is to walk on the treadmill for five minutes or until symptoms occur and the patient is forced to terminate the exercise protocol.[1]

When undertaking treadmill stress testing, it is important to be familiar with the contraindications for treadmill stress testing and under what circumstances treadmill testing should be stopped immediately. These contraindications can be found in the commonly cited protocol for treadmill stress testing.[2]

The language in CPT 93924 also requires that pressures must be taken and recorded at timed intervals following performance of the exercise protocol. A common protocol used to perform these timed interval pressures is to take ankle pressure measurements and calculate ABIs bilaterally immediately post-treadmill beginning with the symptomatic limb, or the limb with the lowest pre-exercise ABI, and then at one–two minute intervals for up to 10 minutes, or until ankle pressure measurements return to the pre-exercise levels.[3]

1 "Vascular Technology Professional Performance Guidelines: Lower Extremity Arterial Segmental Physiological Evaluation" Copyright by the Society for Vascular Ultrasound, 2009.

2 *Ibid*.

3 *Ibid*.

CPT 97597–CPT 97598 CCI Edit Glitch

APMA has learned of an issue when billing selective debridement codes CPT 97597 and 97598 in combination. Currently, the National Correct Coding Initiative (NCCI or CCI) edits bundle CPT 97597 (the first 20 sq cm of selective wound debridement) and CPT 97598 (the add-on code representing each additional 20 sq cm) together.

The edit bundle designation has an indicator of "0" (a zero indicator means that no modifier will ever unbundle these codes when they are billed together). In addition, the NCCI lists CPT 97598—the lesser-valued service—as the Column 1 code in the edit bundle with CPT 97597—the higher-valued service—the Column 2 code. All this means only one of the two therapy codes will be recognized and reimbursed (i.e., CPT 97598—the add-on code).

APMA has corresponded with the NCCI director regarding this bundling edit error. The NCCI is currently working on a solution and recommends that APMA members delay submission of claims reporting combination of CPT 97597 and CPT 97598 until the NCCI replacement file is in place and implemented by CMS. The April 1, 2011, version of NCCI does not contain this edit error. APMA is still exploring a more immediate solution. NCCI assures APMA they will be working to provide one, if possible. At this time, there has been no indication that claims submitted but processed in error will be automatically reprocessed. APMA is checking with CMS for a clarification.

Note: In general, for submission of claims for active wound care management selective debridement (CPT 97597, 97598), DPMs may likely submit far fewer claims for selective debridement over 20 sq cm than claims for selective debridement 20 sq cm or less.

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CHANGE SERVICE REQUESTED