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(more on the Chapter website: www.acponline.org/chapters/fl)

From the Governor

Kay M. Mitchell, MD, FACP

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"Sound Off"

The practice of Medicine never ceases to amaze me. Today I had to jump through 2 more hoops before I could get an MRI of a patient's foot because of health plan refusals. I am not sure that it will be approved this time, but they would approve a "therapeutic" massage. After dealing with this early this morning, I got a call from the ICU to speak to a patient's family. My patient was on the ventilator, but conscious and had written note that she wanted to see me and thank me before life support was discontinued.**.(she had the tube pulled.) I visited with her and her family at the bedside and talked with her about her decision, my respect for her and her choices. It was incredibly hard, but when I left the room she smiled at me and I smiled back. This is why I am a doctor.

I think all of us have similar stories and that's why we continue to practice. I'd like to think that hassles with managed care, Medicare, and liability issues would wear themselves out, but they're not. They are wearing us out. ACP is very aware of the challenges that we face day to day in our practices as well as the challenges faced by our Medical Students and Residents here in Florida. At the ACP Annual Meeting this April, the Board of Governors discussed "The Dysfunctional Payment System" otherwise know as CMS (Centers for Medicaid & Medicare Services) or Medicare. Internists from across America are sending messages to us and to Congress that changes must be made. In the past several years, organized medicine and politically active doctors have curbed significant cuts in Medicare, but I think there are some "hard" times coming.

It is clear that President Bush wants to improve Medicare and eliminate the liability issue, but the road there is now even longer and harder. CMS is pushing 'quality" which should be everyone's goal, but until technology reaches every practicing physician, we can't produce the quality and changes necessary to meet the "pay for performance" payment system that is the "buzz" word in CMS and all other payers. To meet this demand, effective continuing medical education, not seat time, will have to be embraced by physicians from the time they leave medical school until they see their last patient. It will have to be self-motivated and available at the bedside and in the office. To get there, we will have to have computers in the office and hospital that interface and are interactive with those across the medical community as a whole. This will take time and money and incredible costs on the doctor's office and patients until everyone is connected. The President has already started this ball rolling last year by creating the Department of Health Information Technology (HIT), headed by David Brailer, MD, an Internist

This monumental task is moving down the hill with lightning speed and will certainly take out some practices with its force. While HIT is running to improve medical quality, patient safety and financial efficiency, the CMS will begin CMS Recovery Audit in physician offices in 3 states in May, with Florida being one. CMS will hire vendors to identify and recover overpayments and underpayments related to Medicare claims submitted by doctors. Payment to the vendors will be incentive based.

Well, if all of this hasn't made you furious and frustrated, then this will. USA Today and national news announced that there would be a shortage of doctors in the next decade. What a surprise! Do you think Florida gave them the idea???? Now you've heard me, let me hear from you.

- Kay Mitchell

Mark Your Calendar ! Sept 16-18, 2005
Florida Chapter Regional Mtg Sarasota

Tallahassee May 5, 2005

Christopher L. Nuland, Esq. , Chapter Lobbyiest

If a theme were to apply to health care issues in the 2005 Legislature, it would be that legislators passed what they absolutely had to pass, defeated what they absolutely had to defeat, and left a series of other issues for 2006.

During their meetings with legislators, Chapter physicians emphasized the need to narrow the scope of the adverse constitutional amendments, maintain the ability of physicians to self-insure, and to stop any expansion of the scope of practice of allied health professionals. On each of these critical issues, the Chapter and its allies within Organized Medicine were successful.

Amendment Implementation: When Amendments 7 and 8 passed on Election Day, many physicians were concerned that virtually all hospital peer review records would become public information and that three malpractice settlements would cause a physician's license to be revoked. Through the efforts of the FMA, FHA, the Chapter, and other health care advocates, what passed was legislation drastically reducing the negative impact of Amendments 7 and 8. Under the passed legislation, events occurring prior to Election Day, 2004, will not be subject to either amendment. With regard to Amendment 7, only bona fide patients may receive adverse incident reports related to their actual procedures or their own care. Moreover, "strikes" will only occur when the Board of Medicine, by clear and convincing evidence, determines that malpractice has occurred. Special thanks to all who have worked so hard on this issue, including our allies at the FMA and FHA.

Naturopathic Physicians: The Senate Health Care Committee defeated the "Naturopathic Physician" bill by a 6-4 vote on April 26, ending this issue for the Session. Under the original bill, naturopathic "physicians" would have been allowed to "perform minor surgery" and to prescribe many types of medications. Thank you to everyone who contacted members of the committee, as several members commented on the volume e-mail they had received from physicians.

Financial Responsibility: As the bills were originally filed by Representative Farkas and Senator Jones, all physicians would have been required to double the amount of coverage, and those with hospital privileges would have to be covered for at least $500,000 per incident. Moreover, physicians would have been precluded from self-insuring. After a barrage of lobbying from medicine, including a meeting between Chapter physicians and Representative Farkas, the sponsors agreed to drop the increase in PLI coverage, but the bill continued to prevent physicians from self-insuring. Although the bill did pass the House Health Regulation Committee, the Senate Health Committee spent two weeks hearing the bill, and Senator Jones voluntarily asked that the Committee drop its consideration of the issue for the session. A final week effort by Senator Jones to add additional disclosure requirements on self-insured physicians was removed by the House.

Supervision of Physician Extenders: The Senate Health Committee opted not to hear either of the proposed "supervision" bills, effectively killing the issues for this session. As a result, the Ortiz decision, which prevents the Board of Medicine from regulating or disciplining physicians for the actions of nurses who work under their direct supervision, remains unchanged. Moreover, the use of physician extenders in satellite offices remains virtually unregulated, and both of these issues will likely re-emerge next year.

ARNP Prescribing: Likewise, the ARNP Prescribing bill was not heard, effectively killing that issue for the year.

Tort Reform: Other than dealing with the constitutional amendments, the Legislature showed virtually no inclination to tackle tort reform this year, and several good proposals by freshman Rep. Paige Kreegel, M.D. and others regarding subsequent treating physicians, expert witnesses, litigation reform, and other such issues were not considered.

Managed Care: Similarly, managed care reform took a back seat this session, as revisions to the Prompt Pay law offered by Rep. Ed Homan, M.D. failed to receive a meaningful hearing during the year.

Overall, Organized Medicine and the Chapter should be proud of its accomplishments during the 2005 Legislative Session. On the issues of greatest importance to the Chapter, members contacted legislators an outstanding 18,976 times, greatly enhancing the Legislative Program's effectiveness. Special thanks go to the 22 physicians who took time out of their busy schedules to travel to Tallahassee to meet personally with legislators and their staff. Nothing influences legislators more than having a constituent physically take the time to approach the lawmaker to lobby the issues of greatest importance.

Although much work remains for next year, our success on the Amendment Implementation, Naturopathic, and PLI issues was both notable and the result of a considerable amount of work not only by the Chapter, its physicians and staff, but also those of allies such as the FMA and FHA with whom the Chapter worked closely throughout the year.

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Council continued p 3)

From The President

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If You Don't Know the Diagnosis, Shut Up and Listen

She was a particularly odious patient, a house-officer's nightmare. She was unpleasant and mean-spirited, acting as though she knew more medicine than anyone else. She was recalcitrant to our suggestions, constantly demanding us to explore her own differential diagnosis. This was complicated by a new and different chief complaint every morning during work rounds.

She had been admitted several days earlier because of weakness and tiredness. A glimpse would offer a clue. Despite weighing 350 pounds, I doubt she had 50 pounds of lean muscle mass. She could have been a fold-out for Couch Potato Journal. She spent almost her entire life either in bed or just watching TV, often from bed, but, on particularly athletically-inclined days, maybe from a chair.

Today's complaint was diarrhea and weakness. She occasionally had abdominal pain which could be in any massive quadrant at any time, and could be cramping, associated with nausea and vomiting, or any combination of gastrointestinal symptoms. She obviously used her symptoms *du jour* to further her own differential diagnosis *du jour*.

To say she was sullen would be an understatement. She questioned every order we had. For instance, she was found to have hypokalemic alkalosis. Although not knowing the exact etiology of the hypokalemia, we opined this might very well be part of her weakness. However, she refused to take potassium orally because it might "upset her stomach" as though it were not upset enough. She did actually permit repeated daily IV infusions of potassium. After 600 mEq/dL of potassium infused over a week, we were finally able to budge her potassium and the alkalosis slowly resolved, as did some dehydration-related azotemia. We were never able to find the source of the abdominal pain during this time. Tests were repeatedly done. Thoughts were given as to whether she had some type of potassium wasting GI lesion, yet she refused colonoscopy. As the attending, every time I examined her she had a different story and different physical findings.

Toward the very end of her admission, I had an instantaneous flashback to the first day she was there; one of her multiple chief complaints had been "diarrhea" to the point that she did not even know when she was going to have a stool and would soil the bed or sofa and her clothes. Initially I thought this was due to her weakness and poor conditioning such that she was unable or just too lazy to get to the toilet. Now, it fit together well, but I did not appreciate at the time that that would be the seminal clue.

During all this time, her zealous first-month/first-rotation medical student was trying to establish rapport with this recalcitrant crone. We all tried to get along with her, but she was one of those patients who could not get along with the attending staff, the housestaff, the nursing staff, the laboratory staff, or anyone!

Although we were unable to come up with any unifying diagnosis, once her potassium had increased, her alkalosis and azotemia improved, and we decided it was time for her to go home, but of course, she didn't want to go, since she was waited on hand and foot here. We noticed she didn't like to eat much. Re-enter the medical student. In an adventurous attempt to be an Androcles to this lioness, the medical student asked the patient what she might want to eat should her appetite improve. The patient, condemning institutional food, said that she wanted potato chips. The next day on rounds, the freshly-scrubbed-faced medical student pulled from her new white coat a large bag of potato chips. Determined not to be pleased, the patient looked at the bag of potato chips, grabbed and hurled it against the wall shouting, "These are not what I want — can't you see I'm overweight?!?! I want potato chips made with Olestra!" At that second, the diagnosis leaped to mind.

On further questioning, the patient was living off of four or five large bags of such potato chips a day. Just 8 grams of Olestra (equivalent to 16 potato chips) is able to statistically significantly increase diarrhea, and particularly "anal leakage" in patients. This patient was probably eating several hundred grams of Olestra each day causing her unwanted and uncontrolled bowel movements, often without knowledge or sense of urgency. Obviously, this continued leakage would be consistent with her hypokalemic alkalosis with a huge intracellular loss of potassium due to its chronicity.

(Continued on Page 4)

(Council continued)

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If You Don't Know (continued from page 3)

Her abdominal pain was probably cramping and occasionally even ileus from her hypokalemia, which at times had dropped to 2.1 mEq/dL.

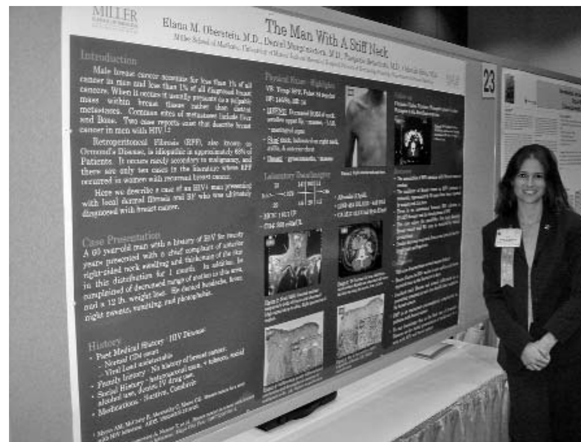
We pointed these out to the patient, but since this model did not fit with her notion of what was wrong, she dismissed it. The patient went home; I'm sure she will be back.

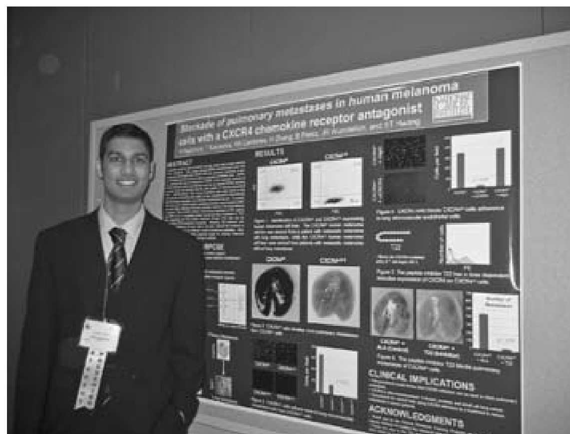
The lesson here is when we don't know what's wrong with a patient, we should just shut up and observe. The patient will often reveal, sometimes in parentheses, what is going on. This bit of history, had it been obtained earlier, could have saved an 18-day hospitalization, but at least we now understood what caused the majority of her heretofore unexplainable complaints.

Dr. Joe Lezama (l) Tazia Stagg (middle) Dr. Jennifer Johnson (back to the camera) and Dr. Ahmed Morales seem to be having a good time at the Associates Meeting !

Drs. Kitchens, Echeverria-Beltran and Mitchell (l to r) lead the panel discussion on Advocacy for Associates at the April meeting in Tampa.

The poster competition at the Associates Meeting was lively, albeit intense. Dr. Gloria Weinberg, (left) program director at Mt. Sinai Medical Center readies Dr. Tariq Al-Musawi for his close-up.





Congratulations!

Dr. **Elana Oberstein** (top left) of the University of Miami program took one of five top places at the Associates Clinical Vignette Poster Session at Annual Session in San Francisco for "The Man with a Stiff Neck: An Unusual Presentation of Breast cancer in an HIV+ Man."

Hari Nadiminti, (bottom left) also of UM, took one of five top places in the Medical Student Research Competition in San Francisco with his poster "Blockade of Pulmonary Metastases in Human Melonoma Cells with a CXCR4 Chemokind Receptor Antagonist" took one of five top places

The **Awards Committee** will select recipients of various awards for our upcoming regional meeting at the Sarasota. Please consider your colleagues who excel, review the awards and criteria outlined below and send your letter of nomination to our Clewiston office by June 30.

Laureate: Senior Florida Chapter physician who has demonstrated, by example and conduct, a commitment to excellence in medical care, education, or research and in service to the community and ACP.

Internist of the Year: for outstanding leadership and dedication to the practice of internal medicine.

Outstanding Teacher of the Year: for outstanding leadership and dedication to medical education.

Community Based Teacher for contributions to the education of medical students, residents and fellows as an office based internist.

CALL FOR NOMINATIONS

Elections for regional representatives to the Governors' Advisory Council will be held this summer. The duties of the Council are those ordinarily performed by a Board of Directors of a corporation There are seats available in all three regions for a three year term. Those who have been Associate members in good standing for at least two years as well as full Members and Fellows qualify.

If you would like to serve on the Council or know of someone whose area of expertise would add another dimension to our board, please contact the Chapter office (800-542-8461 Ext 1) in the very near future to request a biosketch form. The **Nominations Committee** will conclude their selection process in late June.

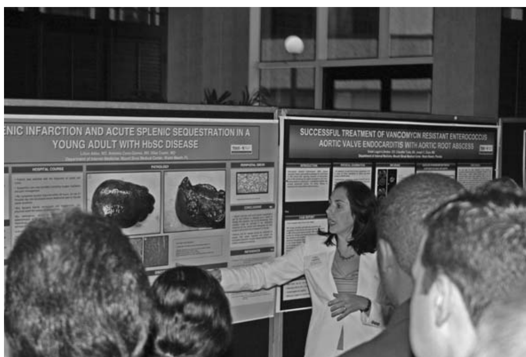
George A. Bishopric, MD, FACP died of pneumonia March 4, 2005 at Heartland Rehabilitation Center in Sarasota. He received his MD from Duke University, served internship at Emory and took residency training at Vanderbilt. He moved to Sarasota in 1954. Dr. Bishopric was honored as a Laureate of the Florida Chapter ACP in 1999 for advocating excellence in community-based medical education for more than 45 years.

2005 Associates Meeting

Tampa hosted the April 2nd and 3rd Florida Chapter ACP Associates' Meeting. Oral presentations began on Saturday afternoon. Each of the training programs selected two cases in local competitions for the oral presentations They were judged for presentation and content. The three presentations judged most outstanding will be re-presented at the Regional Meeting. They include: **Stephen Clum, MD** of the University of South Florida - "An Interesting Case of An Elusive Rash & Progressive Ulceration of the Fingers"; **Claudia Maidana-Paz MD** of Mount Sinai Medical Center - "What a Pick Up" and **Arial Moufflet, MD** of Mount Sinai Medical Center - "The Almost Unfinished Symphony."

Twenty-one abstracts were accepted for display for the poster competition. **Violet Ligari-Libhaber, D.O.** of Mount Sinai Medical Center and **Einar Lurix MD** of the Cleveland Clinic Florida shared top honors in the poster competition presenting "Successful Treatment of Vancomycin Resistant Enterococcus Aortic Valve Endocarditis with Aortic Root Abscess " and "Eosinophilia Invasion, respectively

On Sunday **Drs. Philip Altus and Kay M. Mitchell** treated the attendees to a display of diagnostic acumen in an entertaining session of "Meet the Professor." A primer on acquiring advocacy skills featured **Daniel D'Amato, MD, Mary T. Busoswski, MD, Craig S. Kitchens MD, FACP and Kay M. Mitchell, MD, FACP**. This was followed by hotly contested rounds of "Doctors Dilemma" and ultimately the teams from **Cleveland Clinic Florida, the University of Florida and the University of South Florida** won the honor of going on to the Regional Meeting to compete for the traveling trophy. ❖



Lillian Abbo, MD (center) presenting her poster at the Associates Meeting.

For more photos from the meeting go to the chapter web site www.acponline.org/chapters/fl

Council of Associates

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Scientific Meeting
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Sarasota Hyatt, Sarasota
Associates Meeting
Spring 2006, Miami

THE FLORIDA INTERNIST

Legal Update

Medicare Audits Are Coming. Are You Ready?

Christopher L. Nuland, Esq., General Counsel

The Centers for Medicare and Medicaid Services (CMS) has announced the creation of its "Recovery Audit Contract" initiative, set to begin by May. Under the program, contractors will be secured to review up to 5% of the Medicare charts of physicians to determine if overpayments have been made. Florida, California, and New York have been targeted for the first phase of the program, which is set to begin in May and last up to three years.

Historically, such audits yield a recovery rate of between 6-10%, which must be repaid by the physician with 30 days of receiving a determination letter. Physicians and practices will be targeted based upon a review of their claims history, with statistical outliers more likely to be audited early in the program. Because the contractors will be compensated based upon a percentage of overpayments recovered, physicians should be prepared for a thorough and aggressive review of their Medicare claims, although appeals are allowed to same extent as carrier audits and requests for repayment.

Any physician who has not already done so should consider the establishment of a Corporate Compliance Program, complete with an independent but privileged review of their coding and billing practices. While the CMS audits will only examine claims that are at least one year old (to ensure that the payment cycle has been completed on all such claims), the establishment of a compliance program immediately may help prevent charges of criminal intent should a pattern of overbilling be discovered.

For more information on the Recovery Audit Contract initiative, visit http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0469.pdf. For legal information on how you can prepare and respond to such an audit, members may contact General Counsel Christopher L. Nuland free of charge at nulandlaw@aol.com.