

New Hampshire Chapter GOVERNOR'S NEWSLETTER

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

Fall 2006

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GOVERNOR'S MESSAGE



ANNUAL STATE MEETING

On October 13 we held our annual state ACP meeting at the Grappone Center in Concord. About 60 members, fellows, masters, residents, and medical students attended. We heard clinical presentations on Avian Flu, Angiogenesis, Radiation Safety, and Fever. There was a repeat of the challenging M&M that kept all the clinicians in the audience on their toes. We heard from Dr. **David Dale**, President-elect of the ACP talk about what was happening on the national level. Throughout the day we had the opportunity to view 9 poster abstracts displayed by residents from DHMC. The day was topped off with outstanding associate presentations. **Sharlene D'Souza** presented a case of myxedema crisis. **Lindsey Madden** presented a case of a young man with overwhelming acute pneumonia. **David Crites** presented a case of hospital acquired staph enteritis. Finally the winning presentation by **Felicitas Thol** was an unusual case of acute renal failure after Caesarian Section.

The entire program was very well received. I want to again personally thank **Lin Brown** who was the program chair and spent many hours putting the day together. As soon as the day was over we began our planning for next year. We are considering again combining our meeting with the Vermont Chapter and holding it in the Lebanon area. This venue gives us a chance to interact with our colleagues in Vermont and enhances the pool of speakers available for the meeting. If you have any thoughts on this please contact me at drmerrithew@adelphia.net.

BOARD OF GOVERNOR'S MEETING

On October 5 - 7 I attended the BOG meeting in Tahoe Nevada. This was another great meeting of the leadership of the ACP. The main message I want to bring home to you is that the college really does understand the plight of the practicing Internist. Although many topics were discussed and debated, including residency training, pay for performance, health information technology, etc, the majority of the meeting was focused on ways to save General Internal Medicine. We discussed payment reform, reduction of administrative burden, life style issues, and the ever-dwindling supply of new Internists finishing training. The College's public message is that there is a crisis in primary care and Internal Medicine in particular. The crisis is here and must be addressed now.

My sense is that the message is getting out. I have seen much more publicity about the issue in the press. I have seen legislators openly acknowledge the problem. I have seen our non primary care colleagues admit that the crisis must be addressed ahead of their own issues. CMS has accepted the premise of payment reform to increase payment for cognitive services as a necessary component to fix the problem. On all these issues the ACP is the most visible and respected voice in the discussion. The ACP wants your voice to add to that discussion.

Through all the discussion about what is wrong with our health care system and frustrating about IM practice it is important that we continually step back and remind ourselves what we love about Internal Medicine. This is particularly true when we are working with young medical students and residents. It is no wonder that so few are choosing IM when they hear the frustrations of our daily work. We need to take time to remember what a privilege it is to be the "doc". The challenge of diagnostic evaluations, the long-term relationships with our patients, the privilege to share our patients most intimate feelings - these are the true rewards of being an Internist. Reflecting on these things will not only encourage others to follow in our path but it will make walking that path better for our patients and us as well.

INTERNAL MEDICINE INTEREST GROUP

One of the ongoing activities of our chapter is the sponsorship of an IMIG at DHMC. This is a way to foster support for medical students considering a career in Internal Medicine and its subspecialties. The annual kickoff for this activity is a dinner at Jesse's Restaurant in Lebanon to which we invite the first and second year students and members of the IM faculty as well as the governor's council. The event was held again this year on October 24 and was well attended. Throughout the year the students will have the opportunity to meet with Internists from a variety of practice styles in a more intimate environment over pizza and beer. If you are interested in coming to one of these meetings and sharing your love of Medicine with the students please contact **Elaine Silverman** at DHMC. Elaine has again agreed to coordinate this activity for the chapter along with 3 student leaders.

LEADERSHIP DAY IN WASHINGTON

It is again time to start planning Leadership Day. This year Leadership Day will take place on May 16 and 17 in Washington DC. This is an important activity for the ACP and the local chapter. We will send 4 delegates from the chapter to Washington for the event. They will spend the first day being informed on pending legislation by the ACP national staff. The second day will be spent on Capital Hill meeting with our New Hampshire legislators and lobbying them on ACP positions. This is the most effective way for you to influence the legislative process in our country. If you are interested in participating in this event please contact me. Each year we try to send a balance of "seasoned" advocates with new advocates. If you cannot participate in this event I would encourage all of you to be active advocates throughout the year. You can do this very easily by signing up to be an advocate or "*key contact*" at acponline.org. I would also encourage you to consider joining ACP services, the College's PAC. Remember if you are not part of the solution you are part of the problem. Politicians listen to their constituents. The more constituents who voice a common message the more likely it will be that they will act upon the concerns.

ACP BOARD OF GOVERNORS ACTION ON FALL 2006 RESOLUTIONS

At its October 7, 2006 Business Meeting, the ACP Board of Governors voted to adopt 9 resolutions as amended, to accept 2 resolutions as reaffirmation of College policy, and to not adopt 2 resolutions. The Board of Regents will ultimately decide on the final disposition of these resolutions at its meeting later in the fall.

If you have any questions about these resolutions, please feel free to contact me for more details.

Adopted as Amended:

- 1-F06. Engaging with CMS to Ensure Medicare Coverage for Abdominal Aortic Aneurysm Screening
- 2-F06. Proposing Modifications to Medicare Part D to Reduce Administrative Burdens on Physician Practices
- 4-F06. Supporting Modified Versions of the Advanced Medical Home for Small Medical Groups
- 5-F06. Considering the Impact of ACP Policy Changes on Small and Rural Medical Practices
- 6-F06. Ascertaining the Economic Impact of ACP Supported Public Policies to Practicing Physicians
- 9-F06. Developing Alliances that Facilitate a Linkage between Medical Education and Care for the Medically Underserved
- 11-F06. Developing an ACP Health Literacy Toolkit
- 12-F06. Affiliating a College Award with the Name of a Woman Who is or was a Prominent ACP Leader
- 13-F06. Encouraging Chapters to Include Associate Subspecialty Fellows on Councils, Committees, and in Other Activities

Accepted as Reaffirmation:

- 3-F06. Prohibiting the Release of Physician Prescribing Information to Pharmaceutical Companies, Pharmaceutical Manufacturers or Pharmaceutical Distributors for Sales and/or Marketing Purposes
- 8-F06. Maintaining CMS Reimbursement for Resident Training through Didactic Learning

Not Adopted:

- 7-F06. Requesting Residency Review Committee Reevaluation of Resident Work Requirements
- 10-F06. Evaluating Concierge Care and Providing Guidelines Regarding Participation in Concierge Practices

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HOW TO BILL FOR THE 'WELCOME TO MEDICARE' VISIT

Since its introduction in 2005, the Welcome to Medicare visit has continued to confuse physicians with its requirements and limitations. Medicare will cover one initial preventive exam within the first six months of the effective date of a beneficiary's Part B coverage. The Welcome to Medicare visit is likely different from any other service that a physician would typically perform, so it is important to review the requirements for the service, which are:

- **Comprehensive medical and social history review.** This review should pay particular attention to modifiable disease risk factors. At a minimum, the medical history must include:
 - o Past medical and surgical history, including illnesses, hospital stays, operations, allergies, injuries and treatments.
 - o Current medications and supplements, including calcium and vitamins.
 - o Family history, with a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk.
 - o The CMS defines social history to minimally include a history of alcohol, tobacco and illicit drug use; diet; and social and physical activities.
- **Limited Physical exam.** This must include measuring the patient's height, weight and blood pressure, as well as a visual acuity screen and other factors based on the patient's medical and social history.
- **Potential risk for depression review.** This review must include a patient's past experience with depression or other mood disorders, based on the use of an appropriate screening instrument, for patients without a current diagnosis.
- **Functional ability and level of safety assessment.** This should be based on the use of an appropriate screening instrument.
- **Electrocardiogram (ECG).** The exam covers performance and interpretation of an ECG.
- **Education, counseling and referral.** The exam covers these services as deemed appropriate based on review results and evaluation services.
- **The exam also covers education, counseling and referral-including a written plan,** such as a checklist-to help patients get appropriate screening and other preventive services covered separately under Medicare Part B.

The exam is billed using CMS-specific G codes. A physician will always bill G0344 for the exam itself and an additional code for the component of the ECG completed by the physician. CMS recognizes that not all physicians can perform an ECG in their office. Physicians can make alternative arrangements to make sure an ECG is performed, then include ECG results in the patient's record to complete-and bill for-the initial preventive exam.

The following are the HCPCS codes to be used:

- G0344: Initial, face-to-face visit service limited to new beneficiary during the first six months of Medicare enrollment.
- G0366: Electrocardiogram, routine ECG with at least 12 leads with interpretation and report, performed as a component of the initial exam. (You must report G0344 and G0366 if you furnish the complete initial exam.)
- G0367: Tracing only, without interpretation and report, performed as an initial exam component.
- G0368: Interpretation and report only, performed as an initial exam component.

BILLING BY THE HOUR? – USING TIME TO BILL FOR AN E/M VISIT

For many physicians, it just seems as though the entire system would be easier if they could just bill like attorneys or plumbers: by the hour. In some cases, evaluation and management codes can be determined by time. In order to select a code level based on time, the physician must spend at least 50% of the time counseling or coordinating care for the patient. The level is based on the typical times found in the CPT books (e.g. 50 minutes with 50% time counseling or coordinating care is considered to be a 99214). In this case, the documentation of history, exam, and medical decision-making is not relevant at all to the selection of the code. The physician should still be documenting for the purposes of patient care. In addition to this documentation, the physician should indicate in the record the total time spent with the patient and explicitly state that the time was spent on counseling or coordination of care. The visit would still have to be medically necessary, so the physician should document a chief complaint or reason for the counseling. Remember that the length of the visit does not directly drive the code unless that time was spent on counseling or coordination of care.

JOIN THE ASSOCIATE LEADERSHIP NETWORK

Associate members of the College who want to learn more about activities geared toward Associates have the opportunity to join the new Associate Leadership Network (ALN). Members of the ALN will receive periodic updates from the Council of Associates regarding issues pertaining to residents and subspecialty fellows as well as opportunities for Associates that arise within the College.

If you are interested in joining the ALN, please send your name and e-mail address to jsiegrist@acponline.org. All contacts must be current ACP Associate members. If you are currently in a fellowship training program, please include what specialty, the name of the training program, the year you joined the Fellowship program and expected year of completion.

**Visit the Chapter Website at:
www.acponline.org/chapters/nh**

