DENVER MEDICAL BULLETIN

Official Publication of The Denver Medical Society

Volume 99/Number 3 March 2009

American Recovery and Reinvestment Act of 2009 (ARRA)

H.R. 1 (Conference Agreement enacted on 2/17/09)

Partial Summary of Major Health Care Provisions of the Stimulus Bill -- prepared by the AMA

Medicaid

$87 billion in additional federal matching funds is provided (from Oct. 1, 2008-Dec. 31, 2010).

- Increases Federal Medical Assistance Percentage (FMAP) for all states by 6.2%.
- Holds states harmless against a drop in their FMAPs for FYs 2009, 2010, and first quarter of FY 2011 (e.g., if 2008 FMAP is higher than 2009, the state gets the higher 2008 rate).
- States with large increases in unemployment would receive an additional FMAP increase. It is estimated that the conference agreement would provide about 65% of its spending via the hold harmless agreement and across-the-board increases, and about 35% via the unemployment-related increase.
- FMAP increases would not apply to other parts of state Medicaid programs that are based on enhanced FMAP (e.g., DSH, TANF, SCHIP, child/family services, etc.).
- States cannot use FMAP/high unemployment increases for rainy day/reserve fund.
- States must maintain the same eligibility standards, methodologies, and procedures that were in effect on July 1, 2008, in order to receive FMAP increase.
- States must comply with current Medicaid prompt pay requirements in order to receive FMAP increase.
- Extends through June 30, 2009, the current moratorium on 4 Medicaid regulations relating to provider taxes, targeted case management services, school-based services, and outpatient hospital services; states the sense of the Congress that the HHS Secretary should not promulgate as final the proposed regulations relating to cost limits on public providers, GME payments, and rehabilitative services.
- Provides for a temporary increase in state DSH allotments for FY 2009 and 2010.

Health Information Technology (HIT)

Provides approximately $19 billion for Medicare and Medicaid HIT incentives over five years.

- Officially establishes the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS to promote the development of a nationwide interoperable HIT infrastructure; President Bush already created ONCHIT by Executive Order in 2004.
- Establishes HIT Policy and Standards Committees that are comprised of public and private stakeholders (e.g., physicians) to provide recommendations on the HIT policy framework, standards, implementation specifications, and certification criteria for electronic exchange and use of health information.
- HHS would adopt through the rule-making process an initial set of standards, implementation specifications, and certification criteria by December 31, 2009.
- ONCHIT would be authorized to make available an

2009 Legislative Night a Big Success. . .Pages 4 & 5

HIT system to providers for a nominal fee.

- Provides financial incentives through the Medicare program to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) in a meaningful way (as defined by the Secretary and may include reporting quality measures). Authorizes ONCHIT to provide competitive grants to states for loans to providers.
- Medicare incentive payments would be based on an amount equal to 75% of the Secretary's estimate of allowable charges, up to $15,000 for the first payment year. Incentive payments would be reduced in subsequent years: $12,000, $8,000, $4,000, and $2000, after 2015. Physicians who report using an EHR that is also capable of e-prescribing would be eligible for EHR incentives only.
- Early adopters, whose first payment year is 2011 or 2012, would be eligible for an initial incentive payment up to $18,000. In 2014, the payment limit would equal $12,000. Adopters, whose first payment year is 2015, would receive $0 payment for 2015 and any subsequent year.
- For eligible professionals in a rural health professional shortage area, the incentive payment amounts would be increased by 10 percent.
- Incentives under the Medicaid program are also available for physicians, hospitals, federally-qualified health centers, rural health clinics, and other providers; however, physicians cannot take advantage of the incentive payment programs under both the Medicare and Medicaid programs. Eligible pediatricians (non-hospital based), with at least 20 percent Medicaid patient volume, could receive up to $42,500, and other physicians (non-hospital based), with at least 30 percent Medicaid patient volume, could receive up to $63,750, over a six-year period.
- Physicians who do not adopt/use a certified HIT system would face reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. E-prescribing penalties would sunset after 2014.
- Allows HHS to increase penalties beginning in 2019, but penalties cannot exceed -5%. Exceptions would be made on a case-by-case basis for significant hardships (e.g., rural areas without sufficient Internet access).

Comparative Effectiveness Research (CER)

The government will increase funding for CER by $1.1 billion.

- Establishes the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER), an advisory board that will be comprised of up to 15 representatives of federal agencies—at least half will be physicians or other experts with clinical expertise.
- The FCC-CER will coordinate CER to reduce duplication of efforts and encourage coordinated and complementary uses of resources, coordinate related health services research, and make recommendations to the President and Congress on CER infrastructure needs.
- Both the Report on the Conference Agreement and that actual ARRA language provide that the FCC-CER will not mandate coverage, reimbursement, or other policies of public or private payers.
- CER will not include national clinical guidelines or coverage determinations as ARRA incorporates by reference the provisions in the Medicare Modernization Act of 2003 that explicitly preclude this.
- The Agency for Healthcare Research and Quality (AHRQ) will receive $700 million for CER; AHRQ must transfer $400 million to NIH to conduct or support CER.
- The Secretary of HHS will have the discretion to allocate the remaining $400 million for CER to accelerate the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies.

The Secretary of HHS will also be obligated to meet several requirements, including: contract with the IOM to produce and submit a report to Congress and the Secretary by June 30, 2009, that includes recommendations on the national priorities for CER; consider any recommendations of the FCC-CER; publish information on grants and contracts awarded with the funds within a

(Continued on page 6)

***Denver Medical Bulletin**: Randall M. Clark, MD, DMS President and Publisher / Nora E. Morgenstern, MD, Chair of the Board / Michael B. Keller, MD, President Elect / Naomi M. Fieman, MD, Treasurer / Kathy Lindquist-Kleissler, Executive Director / Barbara Kamerling, Program Director. The **Bulletin** is the official publication of the Denver Medical Society, established April 11, 1871, as the first medical society in the Rocky Mountain West. Published articles represent the opinions of the authors and do not necessarily represent the official policy of the Denver Medical Society. All correspondence concerning editorial content, news items, advertising and subscriptions should be sent to: The Editor, **Denver Medical Bulletin**, 1850 Williams Street, Denver, CO 80218. Phone (303) 377-1850. Fax (303) 331-9839. Web www.denvermedsociety.org. Email: dms@denvermedsociety.org. Postmaster: Send address changes to 1850 Williams Street.*

Telephone Communication for Physicians

By Governor Emeritus Mark Gorney, MD, FACS, Laura A. Dixon, BS, JD, RN, CPHRM, Director, Dept. of Patient Safety, Western Region, and Susan Shepard, MSN, MA, RN, Dir., Patient Safety Education, The Doctors Company

When carelessly conducted, telephone communications can lead to diagnostic errors and misunderstandings that culminate in medical malpractice claims and lawsuits. Telephone conversations may be inherently deceptive because reliable communication is incomplete without facial expressions and body language to clarify and qualify what the voice is expressing.

Once you offer medical advice on the phone, you can legally become the attending physician of a patient you have never seen. The best way to protect yourself from such potential liability is to practice effective telephone communication:

- Listen very carefully and pursue questions relevant to the medical problem.
- Obtain as much information as possible about the patient calling.
- Prescribe or advise by phone only when you know the patient's medical history.
- Accept a third party's description of a medical condition only when you have confidence in the third party's competence to describe what he or she sees.
- Ask the patient to repeat the instructions back to you to ensure his or her understanding.
- Be especially wary of calls concerning abdominal or chest pain, fever of unknown origin, high fever for more than 48 hours, convulsion, vaginal bleeding, head injury, dyspnea, casts that are too tight, visual alterations, or the onset of labor.
- Be particularly careful that the pharmacist understands all dosages and instructions for drug prescriptions given by phone. Spell out the drug when names are similar, and use individual numbers for dosages, e.g., "five zero" for 50. Include the reason for the use of the drug. Insist that the pharmacist repeat the information to you. Make sure the same is true of hospital nurses taking your orders.
- Be especially careful if you take a call for another doctor. In several instances, covering doctors have been held completely responsible for damages resulting from a telephone misdiagnosis while the original physician was exonerated.
- Provide your covering physician with a brief status report on your acute patients.
- Prescribe only the amount of patient medication required for the period you are covering another physician. Pain medications and narcotics should be refilled or ordered only in small amounts.
- Document all phone calls to and from patients and keep the medical record updated.
- Provide documentation of your coverage period to the absent physician.
- Be sure to record any hospital telephone conversations with nurses pertaining to a patient in the patient's hospital medical record.

Follow these telephone loss prevention measures to help you avoid giving inadequate information or experiencing a miscommunication:

- Always see the patient yourself when in doubt.
- Obtain the services of an interpreter if there is a language difficulty.
- Repeat instructions you give on the phone and then ask that they be repeated to you.
- Allow the caller both time and opportunity to ask questions.
- Make prompt referrals and follow up with the referred provider if the patient's medical problem is outside your specialty.
- Speak clearly and enunciate carefully.
- Verify patient compliance in a follow-up contact to ensure continuity of care.
- Be especially diligent when the caller is an unknown patient.
- Remember that drowsiness or fatigue on the part of either party is a giant step toward miscommunication.
- Document, document, and document again.

Disagreements about what was said are invariably a major problem when cases are tried. It is of prime importance, therefore, to obtain all of the necessary information on the phone. If you still feel there is any area of ambiguity, we strongly advise that you see the patient. An alternative is to have either a physician in the hospital or a licensed staff member check the patient. The critical point is that you must arrive at an accurate and totally reliable appraisal of the patient's condition either while you are on the phone or within a few minutes thereafter. Use standardized language when at all possible.

The information you received, what you advised, and the orders you gave must be immediately recorded to avoid future discrepancies about what was said. This is especially important when the phone call occurs after office hours or on weekends. During office hours, take steps to resolve the caller's questions and problems. The patient's problem should be appropriately addressed and the process should be documented. Office staff should tell the caller when the physician is most likely to return his or her call and follow up to ensure that the caller's questions and problems were resolved.

Effective communication is particularly important on the telephone. Physicians who use telephones carefully will reduce misunderstandings that can lead to legal action.

Legislative Night 2009

DMS physicians met informally with Denver metro state legislators over cocktails and hors d'oeuvres at the University Club January 27. Instant electronic feedback to healthcare policy questions engendered good natured but heated discussions.

Rep. Joe Rice, (Dist. 38) and
Rep. Mark Ferrandino (Dist. 2)

Sen. Morgan Carroll
(Dist. 29)

Ted Clarke, MD, Carlton Clinkscales, MD, Claudia Clinkscales,
and Ken Kolb

Mark Earnest, MD

Robert Brockman, MD, and
Rep. Beth McCann (Dist. 8)

Randall Clark, MD

Curtis Hagedorn, MD

Rep. Spencer Swalm (Dist. 37)

ARRA Summary

(Continued from page 2)

reasonable time of the obligation of funds for such grants and contracts and disseminate research findings from such grants and contracts to clinicians, patients, and the general public, as appropriate; ensure that the recipients of the funds offer an opportunity for public comment on the research; and annually report on the research conducted or supported through the funds.

Repeal Of The 3 Percent Withholding Tax

The conference agreement delays, from December 31, 2010, to December 31, 2011, implementation of the 3 percent withholding tax on government contractors (including Medicare providers) that was enacted under section 511 of the Tax Prevention and Reconciliation Act of 2005. Section 511, which was intended to ensure that government contractors file their tax returns properly and promptly, would be tremendously burdensome on physician practices with their relatively small operating margins and the AMA has been working actively in a coalition effort to promote its repeal.

More details on the health care provisions in the American Recovery and Reinvestment Act of 2009 (ARRA) at **http://www.ama-assn.org/ama/pub/legislation-advocacy/current-topics-advocacy/hr1-stimulus-summary.shtml**

Save the Date—April 20, 2009

The First Saint Joseph Hospital Foundation
Humanitarian Lectureship

The Many Manifestations of Child Abuse

Speaker: Jay Grosfeld, MD
Indiana University School of Medicine

Saint Joseph Hospital

CU School of Medicine Alumni Invited to Join Medical Students

The Evening With Alumni is a series of informal dinners that brings CU School of Medicine Alumni and current medical students together to discuss shared interests. The goals of the series are to provide opportunities for fraternization between students and alumni of the CU School of Medicine; to create an intimate environment for students to learn from alumni; and to foster a connection between alumni and the School of Medicine

A short panel discussion is followed by dispersal for dinner and informal small group discussion. The next Evening With Alumni is Wednesday, April 22nd, from 5:30-7:00 PM on the Anschutz campus. The theme is "Choosing a Specialty".

Please email Ramnik (Ricky) Dhaliwal if you are interested in attending. ramgwu05@gmail.com

CLASSIFIED ADS

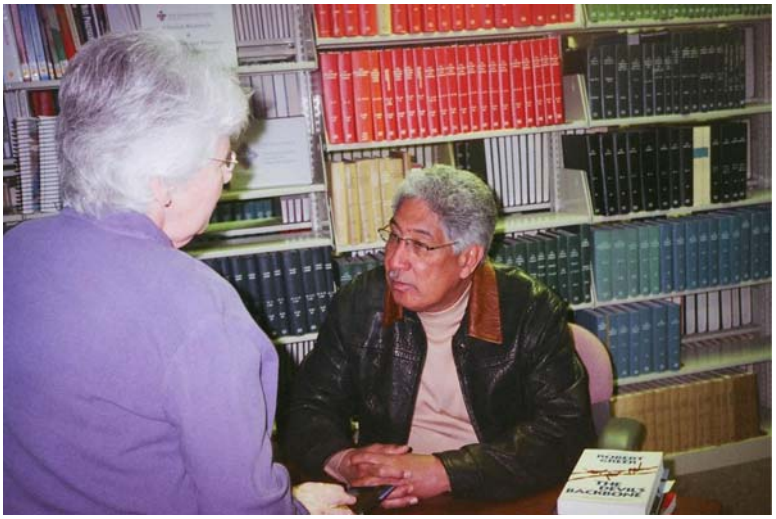
Medical Office Space Available

SOUTHLANDS AREA. Space available for medical/dental professionals in Southlands area: Available summer 2009. Building ownership, next to schools. Biggest growth potential in the Denver area. Please direct all questions to Alisa at ammswo@hotmail.com or (720) 217-1944.

Professional Opportunity

SEEKING MD/DO PHYSICIANS – semi-retired, retired, active – with active Colorado license for part-time medical chart review for growing company based in Denver. Contact Dr. Paul Bregman at mdbregman@msn.com or (303) 953-0727.

Denver Medical Library Hosts Physician Authors Events



Dr. Greer talks with former DML librarian, Sue Coldren

Robert Greer, MD, University of Colorado pathologist and author of **Blackbird, Farewell,** was featured at the first DML booksigning in January. Dr. Greer gave a lecture about his book to a crowd of about 30 at the Library.

DMS member/authors are also invited to debut their new books at a DML event this year.

Dr. Johnny Johnson, CMS Board member, and
Dr. Carol Stamm, DML Board member

Dr. Ray Blum, DML Board President, and
Dr. Fred Platt, DML Board member

DON'T FORGET!

As a Denver Medical Society member, you can subscribe at Denver Medical Library to remote access for over 7000 full text journals and other databases for only $100 a year.