

Keystone Surgeon



keystone chapter
american college of surgeons

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President's Message

By Aaron D. Bleznak, MD, FACS



In the mid 1980s, as a fourth year surgical resident in charge of a private surgical service, I often made rounds with Dr. G, a somewhat cantankerous but very talented surgeon in private practice. He was often prone to tirades against the hospital administration, the faculty surgeons, the internists (especially those who did not refer to him), and other members of the medical “establishment” at our university system. Despite this, I chose to see his patients rather than assigning one of the junior residents because he performed a large number of complex cases and was willing to allow the chief to perform the surgery, provided he or she was involved in the preoperative care.

On this particular day, he asked me to accompany him across the street to a nearby nursing home facility, where we proceeded to arrange for a half dozen elderly, debilitated individuals to be transferred to the medical center to undergo gastrostomies, hernia repairs, or cholecystectomies. It was my impression that many of these patients were going to accrue very limited, if any, benefits from their surgeries due to limited life expectancies from co-morbid conditions. In fact, we spent much of our time explaining surgeries to the families and obtaining consents from them since the elderly patients were incompetent to provide their own consent.

As we were leaving the unit, after filling his OR schedule for the next week, Dr. G. began to rant against the pending changes in Medicare reimbursement, the Resource Based Relative Value Unit. He explained how this would limit payments to surgeons and how unfortunate I was to be going into practice after the “Golden Age” of Medicare reimbursement. RBRVUs were, of course, developed to try and control the soaring Medicare expenditures (although it has clearly proven to be a flawed system) and more appropriately distribute income between specialists and primary care providers. Nevertheless, they were being initiated to provide a disincentive to what I had just been party to — the performance of marginally beneficial or even unnecessary medical intervention for profit.

As I looked at Dr. G. while he was continuing to bemoan the changes in medical reimbursement, I couldn't help but think how ironic his tirade was — he was part of the reason for these changes and wasn't even aware. I never again rounded with Dr. G, passing off even his advanced cases to younger residents and I elected to not rotate through his service during my fifth year.

I recalled this incident last week. I had just finished a conversation with several of our residents regarding the multitude of issues impacting medicine as a whole and surgery in particular, such as the proposed changes in maintenance of certification, the ongoing malpractice issues, scheduled cuts in Medicare reimbursement, and the Medical Assistance situation in Pennsylvania. As I was walking back to my office, I wondered if the residents listening to my “tirade” thought it ironic — here was a surgeon lamenting a situation that, to at least some degree, he and his

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3rd Annual Scientific Meeting Highlights

By Anthony D. Dippolito, MD, FACS



Dr. Aaron Bleznak, MD, FACS, president, presents president's plaque to Dr. Richard Close, MD, FACS, immediate past president

The 3rd Annual Scientific Meeting of the Keystone Chapter of the American College of Surgeons was held May 13–14, 2005 at The Chateau Resort & Conference Center in Tannersville, Pennsylvania. More than 80 attended the one and a half day conference.

Attendees heard scientific presentations on robotics in surgery, ultrasound in surgery, trauma to the pancreas, active specific immunotherapy for colon cancer, intra abdominal hyperthermia chemotherapy for peritoneal surface malignancy, and bariatric surgery. Additionally, Frank R. Lewis, MD, FACS, of the American Board of Surgery, discussed future directions of the Board, including maintenance of certification, and Tracey Glenn, CPC, CPC-H, CCS-P, of PMSCO Healthcare Consulting, provided a surgical coding update, both of which attendees found very helpful. Finally, Christian Shalgian, Manager, Legislative Affairs, American College of Surgeons, provided attendees with an update on legislation at the national level.

There were twelve resident papers presented, as well as three posters, at the meeting. The resident awards were as follows:

1st Place Abstract Presentation — Mary Heyrosa, MD, Lehigh Valley Hospital, for her presentation titled, “Percutaneous Tracheostomy, a Safe Procedure in the Morbidly Obese;”

2nd Place Abstract Presentation — Sunil Patel, MD, Lehigh Valley Hospital, for his presentation titled, “Early Failure of Polyurethane Vascular Access Grafts for Hemodialysis;” and

1st Place poster — Raja Gopaldas, MD, Easton Hospital, for his poster titled, “Novel Technique of Laparoscopic Intracorporeal Knot Tying — A Simplified Approach for Junior Resident.”

I am grateful to those companies that supported, financially and otherwise, our annual scientific meeting. They are: Bard Biopsy Systems, Ethicon Endo-Surgery, Merck & Company, Inc., W.L. Gore & Associates, Inc., PMSCO Healthcare Consulting, Sanarus Medical, Inc., SonoSite, Inc., U.S. Surgical, and Wyeth Pharmaceuticals.

The Annual Scientific Meeting is being moved to November in 2006 and will be a one day meeting. Please keep an eye out for further information later this year. We hope to see you there! ●

2005

Meeting Sponsors and Exhibitors

The Keystone Chapter of the American College of Surgeons wishes to extend its gratitude to the following corporate participants in the 3rd Annual Scientific Meeting:

Educational Grants

Merck & Co, Inc.

Exhibits

Bard Biopsy Systems
Ethicon Endo-Surgery
W.L. Gore & Associates, Inc.
PMSCO Healthcare Consulting
Sanarus Medical, Inc.
SonoSite, Inc.
U.S. Surgical
Wyeth Pharmaceuticals

Annual Business Meeting Highlights

The Annual Business Meeting of the Keystone Chapter of the American College of Surgeons (ACS) was held May 13, 2005 at the Chateau Resort and Conference Center in Tannersville, Pennsylvania. The following officer and councilors were re-elected for three-year terms:

Collin L. Myers, MD, FACS — Secretary/Treasurer
 John J. Pagan, MD, FACS — Region 1 Councilor
 John S. Monk, Jr., MD, FACS — Region 3 Councilor
 John J. Lukaszczyk, MD, FACS — Region 5 Councilor
 Joseph P. Bannon, MD, FACS — Region 8 Councilor
 John E. Widger, MD, FACS — Councilor At Large

Robert J. Sinnott, DO, FACS, who completed the term of Linda L. Lapos, MD, FACS, was elected to a three-year term as a Region 5 Councilor.

Dr. Bleznak informed members that Dr. John Pagan had testified on behalf of the Keystone Chapter ACS on May 12 at a hearing on House Bill 503. HB 503 would level the playing field for physicians and health insurers in managed care contracting.

Dr. Bleznak reported that the Chapter's membership dues have fallen by about 25 percent from the previous year. He indicated that maintaining and increasing membership is of extreme importance and that Dr. Edwin Shearburn, chair of the Membership Committee, would be working on this with his committee. ●

Legislative Update

Representative Curt Schroder (R-Chester County), Representative Mike Turzai (R-Allegheny County), and Representative Tom Quigley (R-Montgomery County) have introduced legislation that would reform the courts and the legal liability system in Pennsylvania. The bills include:

- House Bill 423, introduced by Representative Turzai, calls for Caps on non-economic damages.
- House Bill 132, introduced by Representative Turzai, provides modifications to the doctrine of joint and several liability.
- House Bill 324, introduced by Representative Schroder, would put limitations on the recovery of punitive damages.
- House Bill 1752, introduced by Representative Quigley, would further provide for collateral sources in the Mcare Act.

House Bill 503 would level the playing field for physicians and health insurers in managed care contracting. Dr. John Pagan testified on behalf of the Keystone Chapter ACS at a House of Representatives Insurance Committee hearing on May 12, 2005. ●

2004-2005 Council

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EMTALA Panel Examines On-Call Requirements

Excerpted with permission from the June 24, 2005 issue of ACS NewsScope, American College of Surgeons

A government advisory group met June 15–17 to examine issues related to the physician on-call requirements of the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient anti-dumping statute. The EMTALA Technical Advisory Group (TAG) was created to provide advice and recommendations to the Centers for Medicare and Medicaid Services (CMS) concerning regulations related to EMTALA and their application to hospitals and physicians.

In comments submitted to the TAG, the American College of Surgeons strongly urged the advisory committee to reject any legislative or regulatory efforts to require surgeons to take call as a condition of Medicare participation or as a stipulation to obtain hospital privileges. Opposition from the majority of the panel members who believed such a proposal would lead to a dramatic reduction in physicians participating in the Medicare program and

result in an access to care problem for seniors and the disabled, led the TAG to vote to recommend that CMS not require physicians to serve on-call as a condition of Medicare participation.

During its annual meeting, which is slated to take place in the fall, the EMTALA TAG will consider additional proposals to address the shortage of on-call specialists and will continue to examine other related EMTALA issues, such as the problem of inappropriate transfers and the impact specialty hospitals have on EMTALA-mandated care. The EMTALA TAG is composed of 19 members, including four ACS Fellows: general surgeon Richard Perry, MD, FACS, Phoenix, AZ; pediatric surgeon David Tuggle, MD, FACS, Oklahoma City, OK; orthopaedic trauma surgeon James Nepola, MD, FACS, Iowa City, IA; and neurosurgeon John Kusske, MD, FACS, Orange, CA. For more information, contact ccolgan@facs.org. ●

President's Message

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generation had created and in which their generation would now have to practice.

I bring this up because I believe, as Dr. Thomas Russell has said, that we must acknowledge that we and our colleagues have participated in creating the legal, economic, and social problems that confront American medicine. This is not to say that it is entirely our fault or that we must “suffer these slings and arrows” as penance. But if we fail to inspect and take responsibility for our contribution to these issues, we will miss opportunities to correct the situation and we will distance ourselves from those we serve, our patients, who should be our greatest allies.

Secondly, I cannot believe that it is possible for our students to be constantly reminded of how bad the current medical situation is without either becoming disenchanted regarding their career choice or distrustful of the source. It has been my perception that each generation of surgeons believes that the pleasure of practicing medicine has deteriorated during their careers. I don't believe that this is attitude which we wish to instill into our trainees.

Eva Singletary, the outgoing president of the Society of Surgical Oncology, gave a wonderful speech at the 2005 meeting on the subject of mentoring. In it, she spoke of the need to set the right examples for our trainees. It is my opinion that there is a line between educating our residents about the challenges confronting our profession and bemoaning what has been unfairly thrust upon us. After my recent epiphany, I know that I will work to change my attitude when interacting with residents and medical students. I will try to admit our part in creating the current medical issues, work to change the situation as best as possible, and acknowledge that this is still the profession I would choose were I to repeat my life.

As Dr. Russell reminds us, we need to constantly work towards improving both the quality of the care we provide and the safety of the environment in which we provide it. This is the responsibility of a professional organization and it is a task that we can do internally. We can and should try to improve the reimbursement, regulatory, and medicolegal issues we face, but our ability to do so is limited by outside forces. John Wooden, the famed UCLA basketball coach,

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Reminder — Report Malpractice Suits to State Board

Act 13 (the Mcare Act) requires physicians to report to their licensure board (either the State Board of Medicine or the State Board of Osteopathic Medicine) within 60 days of the occurrence of the following:

- Notice of a civil malpractice lawsuit;
- Notice of a disciplinary action against the physician by the licensing authority of another state;
- Any controlled substance conviction; and
- Any arrest for a criminal offense such as homicide, assault, sexual offenses, and controlled substance violations.

Reports must include:

- Physician's name and business address;
- The date the physician was served;
- The court where the case was filed;
- The Docket number (the number assigned by the court);
- A brief description of the allegations;

- A copy of the civil complaint or court documents relating to a disciplinary action, controlled substance conviction, or criminal offense arrest; or
- You may use the Act 13 self-reporting form on the Mcare Web site (www.oit.state.pa.us/mclf).

Your report should be sent to:

State Board of Medicine
Attn: Mcare Reports
P.O. Box 2649
Harrisburg, PA 17105-2649;

or

State Board of Osteopathic Medicine
Attn: Mcare Reports
P.O. Box 2649
Harrisburg, PA 17105-2649

Failure to report will result in a fine of \$1,000. ●

Primary Limits for Malpractice Insurance Will Not be Raised in 2006

According to Insurance Commissioner, Diane Koken, a study by the Pennsylvania Insurance Department has indicated that there is not sufficient capacity to shift a greater proportion of medical malpractice coverage to the private market from the state Mcare Fund. In accordance with Act 13 (Mcare Act), the Insurance Department used the independent actuarial firm,

Pricewaterhouse Coopers, LLP, to analyze the basic insurance coverage capacity in the medical malpractice insurance marketplace. This study showed that since the passage of Act 13, there have been improvements in the medical liability marketplace from a capacity standpoint, however the market conditions do not show sufficient additional capacity to support a step up in basic insurance limits at this point. ●

Mark Your c a l e n d a r s

October 16–20, 2005

American College of Surgeons 91st Annual Clinical Congress

Mosccone Convention Center
San Francisco, California

April 29–May 2, 2006

American College of Surgeons Spring Meeting

Wyndham Anatole, Dallas, Texas

November 2006

The Keystone Chapter, American College of Surgeons is moving its annual meeting to the beginning of November. Additionally, it will be a one-day meeting.

AMA Urges Physicians to Support Bills to Stop Medicare Cuts

The American Medical Association (AMA) is encouraging physicians to ask their representatives to co-sponsor House Bill, H.R. 2356, which would set a Medicare physician payment increase for 2006 at no less than 2.7 percent, instead of the 4.3 percent decrease projected by the current formula. In addition, it would replace the current Medicare physician payment update formula with one

that increases the update each year, beginning in 2007. The Medicare Payment Advisory Commission (MedPAC) has recommended these changes.

The AMA is also recommending that physicians contact their senators to cosponsor S. 1081, which would set a 2.7 percent payment increase in 2006 and a 2.6 percent increase in 2007. ●

National Provider Identifier Now Available

The Centers for Medicare & Medicaid Services (CMS) has announced the availability of a new identifier for use in standard electronic health care transactions. The National Provider Identifier (NPI), which implements a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), will replace health care provider identifiers that are in use today in standard transactions. Many health plans, including Medicare, Medicaid, and private health insurance issuers, and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007. Small health plans have until May 23, 2008. After those compliance dates, health care providers may use only their NPIs to identify themselves in standard transactions, where the NPI is called for.

You can apply for your NPI in one of three ways:

- Through a web-based application process. The web address is <https://nppes.cms.hhs.gov>.
- Prepare a paper application and send it to the entity that is assigning the NPI (the Enumerator), beginning July 1, 2005. A copy of the application, including the Enumerator's mailing address, is available on <https://nppes.cms.hhs.gov>. You may also call the Enumerator for a copy. The phone number is 1-800-692-2326.
- With your permission, an organization

may submit your application in an electronic file. This process will be available in the fall of 2005.

The transition from existing health care provider identifiers to NPIs in standard transactions will take place over the next couple of years. Some health plans may require you to begin using your NPI prior to the May 23, 2007 deadline.

From January 3, 2006 through October 1, 2006, CMS will accept an existing legacy Medicare number or an NPI as long as it is accompanied by an existing legacy Medicare number. October 2, 2006 through May 22, 2007, CMS will accept an existing legacy Medicare number and/or an NPI. This will allow for 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007. Beginning May 23, 2007 CMS systems will only accept an NPI. ●

President's Message

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once said "Do not let what you cannot do interfere with what you can do." I will work to remember that saying and I encourage you all to do the same. ●

American College of Surgeons Announces Establishment of Foundation

Excerpted with permission from the July 1, 2005 issue of ACS NewsScope, American College of Surgeons

The newly formed American College of Surgeons Foundation officially begins operation July 1, 2005. Formed solely for the purpose of raising funds to support the work of the College, the Foundation is governed by a five-member Board of Directors appointed by the Board of Regents. An immediate goal of the new Foundation is to double the amount of funds that are available for scholarships and fellowships. Initial Foundation Board members are: Edward R. Laws, MD, FACS, President; Thomas R. Russell, MD, FACS, Medical Director of Development; John L. Cameron, MD, FACS, Treasurer; Richard B. Reiling, MD, FACS, Secretary; and Oliver H. Behrs, MD, FACS, Board Member. Tax-deductible gifts to the Foundation are invited from Fellows and friends of the College. Additional information is available from fholzrichter@facs.org. ●

CMS Responds to Inquiry on Status of Pay-for-Performance

Excerpted with permission from the July 1, 2005 issue of ACS NewsScope, American College of Surgeons

On June 24, Mark McClellan, MD, PhD, Administrator of the Centers for Medicare & Medicaid Services (CMS), sent a letter to congressional health policy leaders responding to several questions regarding the agency's efforts to develop and implement quality measures for use in a pay-for-performance (PFP) system for determining Medicare reimbursement. In the Letter, Dr. McClellan provided an overview of current efforts under way within CMS to link payment to quality measures across the spectrum of health care services. With respect to surgery, Dr. McClellan highlighted the American College of Surgeons efforts to work with CMS on the Surgical Care Improvement Program (SCIP). In discussing the initial hospital quality measures that CMS developed in conjunction with the Hospital Quality Alliance (HQA), Dr. McClellan stated that CMS and HQA had been able to reach a consensus "because [the] measures are widely viewed as meaningful

elements of quality, they are clinically valid, and they are feasible and not too costly to collect."

Similarly, the College's own discussions regarding pay for performance have centered on developing initial quality measures that are widely accepted, clinically valid, feasible, and inexpensive to collect. As was evident at the ACS Leadership Conference in Washington, DC, earlier this month, the College has been and continues to be actively engaged in discussions about linking payment to quality, both at CMS with Dr. McClellan and his staff and on Capitol Hill with congressional leaders and their staffs, to ensure that any proposed PFP measures for surgery build on the College's efforts to improve surgical quality through such initiatives as SCIP and the National Surgical Quality Improvement Program (NSQIP). For copies of the CMS letter and enclosures, as well as the initial congressional letter, contact sfriesen@facs.org. ●



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