What Physicians Can Expect as Chicago Prepares for an Unwelcome, but Potential, Disaster

p16
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FEATURES

16 Medicine and the Big One
No one ever really expects a disaster to happen, but here’s what physicians can anticipate as Chicago prepares for just such an unwelcome event. By Benjamin Mindell

20 Physician Compensation Stabilizes
Experts see growing optimism despite the turbulent reimbursement scene. And, surprisingly, primary care physicians are leading the way. By Bruce Japsen

PRESIDENT’S MESSAGE
2 Guns and Public Health
By Kathy M. Tynus, MD

STUDENT OPINION
3 Spotlight on Student Advocacy
By Anna Zelivianskaia

PRACTICE MANAGEMENT
4 Compliance: Compensation Agreements; ACA: A Trickle, Not a Flood; Performing a HIPAA Check-Up

PUBLIC HEALTH
8 CDPH Gives Docs Guidance

LEGAL
12 Regulating Wearable Devices
By Nina Kostyukovsky, JD

14 Proving Liability in False Claims Act Cases
By Michael Koon, JD, and Savannah Wiseman, JD

MEMBER BENEFITS
24 GME Discord and Debate
By Elizabeth Sidney

28 Physicist-Lawmaker on Board
By Elizabeth Sidney

29 ISMS Marches On
By Thomas Anderson, MD

30 Calendar of Events

30 New Members

31 Classifieds

WHO’S WHO
32 For the Love of Patients
Robert Kelsey, MD, is a busy man. He’s president of the Chicago Women’s Health Group, chief of staff at Northwestern Memorial Hospital, and a clinical assistant professor. Yet, patient relationships mean the most to him. By Cheryl England
MESSAGE FROM THE PRESIDENT

Guns and Public Health

For most of us, the Fourth of July weekend meant plenty to celebrate: the anniversary of our nation’s birth coinciding with the arrival of glorious (and long overdue) summer weather. But we had a lot to mourn: the spate of shootings here in Chicago. The latest tally is 82 people shot and 14 killed over the holiday weekend, with victims ranging in age from 7 to 66 years, many of them bystanders. Television news is reminiscent of movies, with chases and shootouts, helicopters flying overhead and vans unloading SWAT teams onto the streets. But real people are maimed and murdered in our midst, and the toll rises every day.

Though the underlying causes are complex, the one common denominator is guns. Legal and illegal guns are in the hands of criminals. And this likely will not change in the near future. Even talking about guns is problematic, because the issue has become so highly politicized in our culture with vehement and emotional arguments. But I would say this problem should be viewed as a public health issue and as physicians, we have an obligation to confront it.

Twice recently, patients have told me they were offended by a question on our health history form. It’s like many standard safety questions we learn to ask in medical school, such as, “Do you wear a seatbelt? Do you wear a helmet when you ride a bike?” You can guess which question upsets people: “Do you have a gun in the home?” While meant to spur discussion about how to safely keep guns in the home, instead it provokes defensiveness and anger. The distortion in our public discourse is so great that people believe that talking with their doctor about firearm safety violates their 2nd Amendment rights. And some state legislatures have sought to criminalize these discussions.

But now, in the State of Illinois, with the new concealed carry law, physicians are mandated to report any gun owners whom they suspect may be a danger to themselves or to others. But how can we have this conversation when patients are reluctant to even admit to their physicians that they own guns? This epic catch-22 has physicians caught in the middle.

Not only is our discussion stymied, but so is our effort to conduct research on gun safety. Current federal law reads: “None of the funds made available for injury prevention and control at CDC may be used to advocate or promote gun control.” Similar language was added to the National Institutes of Health budget. This restriction represents a lost opportunity to acquire information that directly affects public health and safety. Would more research allow physicians to better identify gun owners who pose a threat? Both the Chicago Medical Society and Illinois State Medical Society have policy in place encouraging research into gun violence by public health agencies.

Regardless of our individual views, we should be able to have rational, open discussions with patients about safe gun ownership and to research the magnitude and causes of gun violence. We can make important contributions in this area. Knowledge is power. As we’ve seen, the cost of ignorance is prohibitively high.

That’s why I urge you to support a new bill (HR 2612) in Congress by Rep. Carolyn Maloney (D-NY). The bill authorizes the appropriation of funds to CDC for conducting or supporting research on firearms safety or gun violence prevention. Please encourage your representatives to support HR 2612.

Kathy M. Tynus, MD
President, Chicago Medical Society
Spotlight on Student Advocacy

How doctors of tomorrow are stepping up to shape medicine’s future today

By Anna Zelivianskaia

THERE WAS the “golden age” of the 1920s, the “swinging sixties,” and the “me’ decade” of the 1970s. Now, will the early 21st century be remembered as the era of political disillusionment? Voting participation among young people has declined since the 1960s. Even motivated medical students are accused by older physicians of not being politically active. Given the persistent health inequities, insurance discrimination, and health care reform controversy, why aren’t medical students viewed as passionate advocates? While not every older physician has this view, the belief persists. In part, it becomes a self-fulfilling prophecy because one is more likely to cherry pick evidence in support of one’s beliefs. However, we must admit that there is some truth in that view, and all of us should be concerned; medicine is political and always will be. Fortunately, some students are stepping up to advocate and partner with other generations.

New Forms of Expression

Student political activism has many faces. For students who want to influence medical policy, writing and submitting resolutions through the Chicago Medical Society (CMS) to the appropriate bodies is a particularly important advocacy tool. We have the example of student Cindy Gregory, who authored a resolution on stethoscope disinfection practices. Her resolution was adopted by the Illinois State Medical Society (ISMS) in April. Cindy is a proud alternate AMA delegate from Illinois and a medical student at Southern Illinois University. She is joined by Eric Brandt, MD, a CMS member and delegate from the ISMS Resident and Fellow Section. His resolution, passed by the AMA House of Delegates in June, bans the use of artificial trans fats in all food products. These simple measures influence health professionals and members of the public. Resolutions also push relevant issues front and center for the next wave of physicians.

Another young activist, Christiana Shoushtari, provides a healthy dose of inspiration. A third-year medical student at the University of Illinois-Chicago, she partnered with CMS in personal discussions with U.S. Rep. Danny Davis to highlight the shortage of GME positions. She has advocated with both CMS and AMA on Capitol Hill in recent years, fighting for GME reform and medical student debt reduction. Here, Christiana shares her thoughts on these experiences.

AZ: What motivated you to reach out to the legislature?
CS: As a non-traditional medical student, I had decided to leave my federal employee position at HHS and pursue a career where I could help vulnerable and disenfranchised populations. But reality then hit: the limit on GME training positions and the $300,000 in loans now have me rethinking my career path. It seems that many medical students are either skeptical or just don’t understand how the political system works. If we could incorporate policy and government advocacy education within our training, more students would realize the opportunities and potential for long-lasting, powerful change within our communities. As the saying goes, “If you’re not seated at the table, you’re on the menu.”

AZ: Many students feel that the time commitment is not worth the small impact of student advocacy. What is your response?
CS: I think that argument comes from fear of the unknown and frustration. I urge those individuals to not get discouraged. Every little thing really does make an impact. Change is incremental and it happens when individuals consistently come together for a cause. Advocacy is not limited to organizing protests. Advocacy can be under the radar: it is letters, phone calls, emails; having conversations with your colleagues; attending public meetings, providing testimony, writing op-eds in your local paper. We have countless ways to get involved.

AZ: What tips do you have for students who want to advocate effectively?
CS: Be passionate. Find the issues that you care about the most and let your passion drive your work. You will need this passion to get through moments of frustration. Know your issue inside and out, including what your opponents are saying, and respect everyone, even those who oppose your views.

Compromise is not defeat; it is the starting point on a path toward achieving your goals. We need to see the bigger long-term picture. It took Congress over 10 years to finally repeal the SGR. The branding of “advocacy” by older generations limits its scope. Advocacy today looks different than it used to, with new forms of expression. Just as political issues change, so do our advocacy methods. We students must realize that all medicine is political. While there is an activation energy for effective advocacy, we have many ways to climb that hill. Organizations like CMS and AMA are there to help us engage in the political process.

Acknowledgement: A special thank you to Rahul Bhansali, an ISMS delegate and University of Illinois at Chicago medical student.

Anna Zelivianskaia is fourth-year medical student at the University of Illinois at Chicago. She can be reached at azeliv2@uic.edu.
The government’s increasing focus on financial relationships between physicians and other health care providers is reflected in a new fraud alert describing action by the Office of Inspector General (OIG) and the Department of Justice (DOJ). Both OIG and DOJ recently issued guidance and entered into settlements under the federal fraud statutes with physicians for illegal remuneration arrangements and agreements. The alert offers important take away items for physicians, as they find themselves subject to ever greater scrutiny.

**Fraud Alert Scope**

Issued June 9, OIG’s fraud alert addresses the issue of physician liability under the federal fraud statutes for illegal remuneration in compensation arrangements, such as medical directorships. Physicians should ensure that medical directorship compensation is based on fair market value for bona fide services that the physician actually provides, the alert emphasizes. OIG reports having recently entered into settlements with 12 individual physicians under OIG’s Civil Monetary Penalties Law for alleged “sham” medical director agreements and arrangements to provide office staff for referral-source physicians.

OIG also alleged that the same 12 physicians had entered into arrangements under which a health care entity paid the salaries of the physicians’ front office staff. Because these arrangements relieved the physicians of financial burdens they otherwise would have incurred, OIG took the position that these arrangements also constituted improper remuneration to the physicians.

These examples apparently are based on a $650,000 False Claims Act settlement in 2012 by a Houston imaging center involving alleged “sham” medical director agreements with referral-source physicians. After this settlement, OIG pursued cases against 12 physicians who had suspect medical director agreements and had been provided free office staff by the imaging center. OIG entered into settlements with these physicians from $50,000 to $195,000 under the Civil Monetary Penalties Law.

**Pursuing Physicians, Not Just Hospitals**

One clear take away from this fraud alert is that the government will pursue physicians who receive compensation under an arrangement OIG alleges is a violation of a fraud statute, and not just hospitals and other providers who compensate physicians under such arrangements.

A week after the OIG issued this new fraud alert, DOJ announced a $17 million settlement with a nursing home for alleged anti-kickback violations based on medical director arrangements. DOJ alleged that the nursing home had hired several physicians as “sham” medical directors who performed few or no actual services under the agreements to compensate the physicians for their referrals. DOJ commented that the physicians’ referrals increased “exponentially” after the payments began to the physicians under the medical director agreements.

Another take away from this new OIG fraud alert and these settlements is that physicians should consider reviewing their medical director agreements for similar compliance concerns under the federal fraud statutes and regulations. Finally, this activity by OIG and DOJ indicates that physicians should expect to see more scrutiny of their compensation and financial arrangements with other health care providers to whom they make referrals.

A copy of this new OIG fraud alert on physician compensation arrangements can be found on the OIG website at [www.oig.hhs.gov](http://www.oig.hhs.gov).

**Compliance: Compensation Agreements**

Federal government targets illegal remuneration to “sham” medical directors

By Clay J. Countryman, JD

Compensation to these physicians under medical directorship arrangements constituted improper remuneration under the Anti-Kickback Statute, OIG commented. Several reasons account for this determination. For one, the compensation did not reflect fair market value for the services to be performed by the physicians, and the physicians did not actually provide the services described in the agreements.

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The information in this article is intended for informational purposes only, and should not be construed as legal advice on the topics addressed.

Clay J. Countryman, JD, is a partner with Breazeale, Sachse & Wilson, LLP, in Baton Rouge, La. He can be reached at Clay.Countryman@bswllp.com.
A Trickle, Not a Flood

Contrary to predictions, the ACA has not produced a flood of new patients

MORE THAN A YEAR after the Affordable Care Act’s coverage expansion provisions took effect, physicians have not seen a sharp increase in the number of new or sick patients scheduling appointments, according to a report from athenahealth and funded by the Robert Wood Johnson Foundation. The ACAView report, “Observations on the Affordable Care Act: 2014,” shows that contrary to predictions, physician practices are not being flooded by sicker-than-average, newly insured patients. So far, the increase in patient load is moderate, and new patients do not differ much from established patients in terms of chronic conditions and use of health services. The report draws on near real-time data from a subset of athenahealth’s network of more than 62,000 health care providers and 62 million patients. Key findings include:

• New patient visits to primary care providers (PCPs) increased only slightly from 22.6% of all appointments in 2013 to 22.9% in 2014. Although the proportion of new patient visits rose only slightly, health care providers are conducting a higher proportion of more comprehensive patient evaluations.

• Visits for comprehensive evaluation and management of new patients, including taking a patient history, conducting a physical exam, and making medical decisions, rose proportionally from 6.7% in 2013 to 7% in 2014.

• Overall, new patients had no more complex conditions nor were they sicker than those in 2013. In fact, the percentage of visits for patients with complex medical needs declined from 8% in 2013 to 7.5% in 2014.

• The ACA has decreased the overall proportion of uninsured patients receiving care in physician offices, especially in states with Medicaid expansion. From 2013 to 2014, the proportion of visits by uninsured patients in Medicaid expansion states fell from 4.6% to 2.8%, a relative decrease of 39%. In the non-expansion states, the proportion of visits by uninsured patients fell from 7% to 6.2%, a relative decrease of only 11%.

• The proportion of uninsured individuals with stable physician relationships who obtained insurance after ACA implementation increased much more in the expansion states (from 34.8% to 57%) than in non-expansion states (from 27.8% to 36.5%).

• Before Medicaid expansion, uninsured adults between 35 and 64 years were significantly less likely to obtain insurance compared with those between 18 and 34. The ACA has all but eliminated these age disparities, particularly in the Medicaid-expansion states.

• The proportion of Medicaid patients in the Medicaid-expansion states has increased as has the share of commercially insured patients in the non-expansion states. The ACA has changed the physician payer mix substantially. In non-expansion states, the proportion of visits from commercially insured patients increased from 72% to 74%. In expansion states, the proportion of visits from Medicaid patients rose from 12.8% to 15.6%.

• Despite the fact that the number of individuals enrolled in Medicaid increased by 1.5 million in non-expansion states, the number of Medicaid enrollees seen in physician offices in non-expansion states actually decreased by 10.8%.

To view the full report, visit: www.athenahealth.com/acaview.
After a major overhaul in 2013 and 2014, HIPAA has become increasingly difficult for practices to maneuver and understand. While compliance is a day-to-day task, an annual review of policies and procedures as well as staff training is necessary to minimize the risk of breaches and to put you a step ahead in case of an audit.

HIPAA applies to Protected Health Information (PHI). PHI is any information regarding health status, provision of health care, or payment for health care services that can be linked to a specific individual. HIPAA also applies to electronic PHI (ePHI). Covered entities, including health plans, health care clearinghouses, health care providers as well as other business associates who may come in contact with PHI, must be HIPAA-compliant.

Many organizations have taken big steps in protecting the privacy and security of PHI, most noticeably by instituting Business Associate Agreements (BAAs), which bind both the covered entity as well as certain business associates such as CPA or law firms in sharing equal liability for the breach of PHI. BAAs hold the business associate directly liable under HIPAA and subject to civil and, in some cases, criminal penalties for making uses and disclosures of PHI that are not authorized by the contract or required by law. A business associate also is subject to civil penalties for failing to safeguard ePHI under HIPAA.

While establishing BAAs is a large part of becoming HIPAA-compliant, there are also other administrative, physical and technical safeguards to put in place, as well as the job of conducting a security risk analysis. The following is a condensed explanation of these safeguard standards from the U.S. Department of Health and Human Services.

Risk Analysis and Management
The administrative safeguards standards require covered entities to perform a risk analysis. Here are some but not all of the activities they must perform:

- Evaluate the likelihood and impact of potential risks to e-PHI.
- Implement appropriate security measures to address the risks identified in the risk analysis.
- Document security measures and, when required, the rationale for adopting those measures.
- Maintain continuous, reasonable, and appropriate security protections.

Risk analysis should be an ongoing process, in which a covered entity regularly reviews its records to track access to e-PHI and detect security incidents; periodically evaluates the effectiveness of security measures put in place; and regularly reevaluates potential risks to e-PHI.

Administrative Safeguards
Security Management Process: A covered entity must identify and analyze potential risks to e-PHI, and it must implement security measures that reduce risks and vulnerabilities to a reasonable and appropriate level. This can be initiated with the security risk assessment.

Security Personnel: A covered entity must designate a privacy and security officer.

The Scoop on PHI
WHAT DOES protected health information include? Here’s the official list:

A. Names
B. All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Census Bureau:
   a. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people.
   b. The initial three digits of a zip code for geographic units containing 20,000 or fewer people is changed to 000.
C. All elements of dates (except year) directly related to an individual, including birth date, admission date, discharge date, date of death; all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
D. Telephone numbers
E. Fax numbers
F. Electronic mail addresses
G. Social Security numbers
H. Medical record numbers
I. Health plan beneficiary numbers
J. Account numbers
K. Certificate/license numbers
L. Vehicle identifiers and serial numbers, including license plates
M. Device identifiers and serial numbers
N. Web Universal Resource Locators
O. Internet protocol address numbers
P. Biometric identifiers, including finger and voice prints
Q. Full face photographic images and any comparable images
R. Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) above.
Information Access Management: A covered entity must implement policies and procedures for authorizing access to e-PHI only when such access is appropriate based on the user’s or recipient’s role.

Workforce Training and Management: A covered entity must provide appropriate authorization and supervision of those who work with e-PHI and must train all staff on security policies and procedures. Appropriate sanctions must be applied against staff who violate policies and procedures.

Evaluation: A covered entity must perform a periodic assessment of how well its security policies and procedures meet HIPAA requirements.

Physical Safeguards
Facility Access and Control: A covered entity must limit physical access to its facilities while ensuring that authorized access is allowed.

Workstation and Device Security: A covered entity must implement policies and procedures to specify proper use of and access to workstations and electronic media. A covered entity also must have in place policies and procedures for the transfer, removal, disposal, and re-use of electronic media, to ensure appropriate protection of ePHI.

Technical Safeguards
Access Control: A covered entity must implement technical policies and procedures that allow only authorized persons to access ePHI.

Audit Controls: A covered entity must implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use e-PHI.

Integrity Controls: A covered entity must implement policies and procedures to ensure that e-PHI is not improperly altered or destroyed. Electronic measures must be in place to confirm that e-PHI has not been improperly altered or destroyed.

Transmission Security: A covered entity must implement technical security measures that guard against unauthorized access to e-PHI that is transmitted over an electronic network.

Many documented HIPAA breaches could have been prevented. Ignorance provides no excuse in an audit. With the proper management of security risk assessment items, establishing BAAs, and implementing and monitoring safeguards, your annual HIPAA check-up should be successful. For more information, visit www.hhs.gov.

Nicole George is a healthcare consultant with PBC Advisors, LLC, a firm that provides business and management consulting and accounting services to physician practices and hospitals. For more information about PBC Advisors, visit www.pbcgroup.com.

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PUBLIC HEALTH

CDPH Gives Docs Guidance

Getting bugged over ticks and mosquitoes By Scott Warner

TIS THE SEASON to be bitten, and the Chicago Department of Public Health (CDPH) is suggesting that physicians be on the alert for patients who might be exposed to mosquito-borne West Nile virus (WNV) and tick-carried Lyme disease.

Cortland Lohff, MD, medical director for the environmental health program at CDPH, pointed out key concerns and strategies in dealing with the mosquito/tick conundrum. "We have seen human cases of West Nile virus every summer in Illinois since 2002. In 2014, there were 44 such cases including four deaths in the state. This should be a reminder that physicians need to be on the alert for patients who may have this disease and that patients need to be educated about ways to reduce their risk of this disease."

Dr. Lohff says CDPH diligently monitors for WNV, collecting and testing mosquitos from June 1 through Sept. 30 every year, and using that data to inform further monitoring or control activities. “If our data suggest the risk of human infection is increasing, we may decide to spray in certain neighborhoods to help reduce that risk,” Dr. Lohff says. The CDPH alerts residents to the spraying, and provides information on how citizens can prevent bug bites and mosquitos from breeding.

While approximately 80% of people infected with WNV don’t show symptoms, and approximately 20% of those infected will develop West Nile fever, less than 1% will develop meningitis, encephalitis or acute flaccid paralysis.

Dr. Lohff also expressed concern about another mosquito-borne illness, chikungunya virus disease, which is transmitted by the Yellow Fever mosquito or the Asian tiger mosquito. In 2014, there were a total of 2,792 reported cases in the United States; 2,781 were associated with travel outside the United States, while 11 were acquired locally in Florida.

Though unusual, both mosquito species have been identified in the Chicagoland area. “As a result,” Dr. Lohff said, “disease acquired during travel to an endemic area could result in local transmission if an infected person is bitten by one of these mosquito species during the viremic phase of illness (seven days from illness onset); the infected mosquito may then transmit the virus to one or more people during a subsequent bite.”

Dr. Lohff said that most people infected with this virus will develop symptomatic disease, characterized by acute onset of fever and polyarthralgia. “Joint symptoms are typically bilateral and pain may be debilitating.” Asking patients about their travel history can help in identifying the disease, Dr. Lohff said.

Moving from mosquitos, Dr. Lohff said there are an increasing number of reports of tick-spread Lyme disease in Chicago. During the years 2008-2013, the number of Lyme disease reports received by CDPH increased from 78 in 2008 to 141 in 2013 (for a total of 648 reports). Of those, 94 cases were confirmed and met the Lyme disease case definition.

At Northwestern Medicine, infectious diseases specialist Michael Angarone, DO, says that during the summer a person presenting with a febrile illness who has known exposure to mosquitos or ticks should be evaluated for WNV, Lyme and other vector-borne infections. “Many of these
infections do not require treatment (viral infections like WNV) and will resolve on their own,” he said.

“An infectious diseases doctor can help with the diagnosis and reassurance that the infection will run its course and that very few individuals develop severe illness.”

In terms of infections like Lyme or other bacterial vector-borne infections, Dr. Angarone says an infectious diseases doctor can help not only with the diagnosis, but also with recommending the most appropriate therapy for the infection. “Unlike the viral infections, the bacterial vector-borne infections, like Lyme, can be treated and should be treated.”

When patients are bitten by a tick or still have the tick on their skin, an infectious diseases doctor can help with the identification of the tick and determine the likelihood of disease transmission, and what disease could be transmitted. (Not all ticks transmit the same illnesses and not all ticks transmit illness.)

Physicians are encouraged to report cases of WNV and Lyme disease. Reports should be entered in INEDSS, or can also be called into the CDPH Communicable Disease Program 312-746-5925. 

West Nile Virus and Lyme Disease

THE INCUBATION period for West Nile Virus is typically two to six days, but ranges from two to 14 days and can be several weeks in immuno-compromised people. An estimated 70-80% of human WNV infections are subclinical or asymptomatic. Most symptomatic people experience an acute systemic febrile illness that often includes headache, weakness, myalgia or arthralgia. Gastrointestinal symptoms and transient maculopapular rashes also are frequently reported. Less than 1% of infected people develop neuroinvasive disease, which typically manifests as meningitis, encephalitis, or acute flaccid paralysis. There is no specific treatment for WNV disease; clinical management is supportive.

To help avoid mosquito bites, the Illinois Department of Public Health (IDPH) offers these guidelines for physicians to give their patients:

• Minimize being outdoors when mosquitos are most active, especially between dusk and dawn. Anyone who goes outside during these times should take precautions. Even if mosquito numbers seem low, it only takes one bite from an infected mosquito to transmit the virus.
• Make sure doors and windows have tight-fitting screens. Repair or replace screens that have tears or other openings. Try to keep doors and windows shut, especially at night.
• Eliminate or refresh every couple of days, all sources of standing water where mosquitos can breed, including water in bird baths, ponds, flowerpots, wading pools, old tires, and any other receptacles.
• When outdoors, wear shoes and socks, long pants and a long-sleeved shirt, and apply insect repellent that contains DEET, picaridin, oil of lemon eucalyptus or IR 3535, according to label instructions.

Consult a physician before using repellents on infants.

Lyme disease, caused by the bacterium *Borrelia burgdorferi*, is transmitted to humans through the bite of infected blacklegged ticks (or deer ticks, *Ixodes scapularis*). Typical symptoms include fever, headache, fatigue, and a characteristic rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system. Lyme disease is diagnosed based on symptoms, physical findings (rash) and the possibility of exposure to infected ticks. Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics.

To help avoid tick bites, the IDPH offers these guidelines for physicians to give their patients:

• Wear light-colored, protective clothing—long-sleeved shirts, long trousers, boots or sturdy shoes, and a head covering. Tuck trouser cuffs into socks. Tape the area where pants and socks meet so ticks cannot crawl under clothing.
• Apply insect repellent containing 10-30% DEET primarily to clothes and sparingly to exposed skin. Use repellents containing permethrin to treat clothes (especially pants, socks and shoes) but not the skin.
• Walk in the center of trails so weeds do not brush against you.
• Check yourself, children and other family members every two to three hours for ticks. Most ticks seldom attach quickly and rarely transmit a tick-borne disease until they have been attached for four or more hours. If your pets spend time outdoors, regularly check them for ticks, too.
• Remove any tick promptly. Do not burn the tick with a match or cover it with petroleum jelly. Do not use bare hands. The best way to remove a tick is to grasp it with tweezers as close to the skin as possible and gently, but firmly, pull it straight out. Do not twist or jerk the tick. If tweezers are not available, grasp the tick with a piece of tissue or cloth or whatever can be used as a barrier between your fingers and the tick. If the mouthparts do break off, do not become alarmed; once the mouthparts are removed from the rest of the tick, the tick can no longer transmit the Lyme disease bacteria. If you want to have an intact tick identified, put it in a small vial of rubbing alcohol and contact your local health department for assistance.
• Wash the bite area and your hands thoroughly with soap and water, and apply an antiseptic to the bite site.
• Make sure the property around your home is unattractive to ticks. Keep your grass mowed and keep weeds cut.
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Regulating Wearable Devices

Patients increasingly rely on these products to improve their health, but recent legislation will determine their use in the health sector **By Nina Kostyukovsky, JD**

**AS OF OCTOBER** 2014, at least one in five Americans owned an activity-tracking wearable device, such as a Fitbit or Jawbone, and more than 80% of consumers reported eating healthier, exercising smarter and accessing more convenient health care as important benefits of wearable technology. While wearable devices have been around for some time, manufacturers are constantly making innovations, and many of the current models are so sophisticated that they can record a person’s physical activity, heart rate, geographic location, and even sleep hygiene from the wearer’s wrist 24 hours a day. As the data that wearable devices collect become more personal, entrepreneurs and regulators will face several challenges in trying to strike a balance between encouraging the public to make healthy choices and protecting patients’ privacy and safety. The Office for Civil Rights (OCR) and Food and Drug Administration (FDA), working under the U.S. Department of Health and Human Services (HHS), will play a major role in deciding how wearable devices can be used in the health care sector.

“As the data that wearable devices collect become more personal, entrepreneurs and regulators will face several challenges in trying to strike a balance between encouraging the public to make healthy choices and protecting patients’ privacy and safety.”

**Privacy and Personal Health Information**

OCR enforces privacy and security standards for health information set by HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The rules that implement these laws apply to health plans, health care clearinghouses, and health care providers, collectively referred to as “covered entities” working with protected health information (PHI)—individually identifiable health information that a covered entity creates or receives. Wearable device manufacturers are not ordinarily exposed to HIPAA liability, because they are not covered entities, and their products and services work directly with the consumer, keeping covered entities out of the loop. Nevertheless, as fitness trackers continue to gain in popularity, technology companies looking to cash in on the trend may find themselves navigating an unfamiliar regime of complex regulation.

Ordinarily, businesses are free to make their own rules for handling information that falls outside the scope of HIPAA. Many companies have privacy policies, but only California and Connecticut actually require companies to publish those policies.

In contrast, PHI is subject to the HIPAA Privacy Rule, which prohibits a covered entity from using or disclosing the PHI except in a few narrow circumstances. Covered entities cannot simply force patients to sign their privacy rights away; they must obtain express authorization from the patient for each non-conforming use or disclosure. This authorization may be revoked at any time, and cannot be made a condition of treatment. The patient must sign a separate document for each separate use or disclosure requiring authorization. Alternatively, the covered entity can remove identifying data from the PHI before disclosing it, but the HIPAA Privacy Rule sets a high burden for what constitutes “de-identification.” Covered entities must also comply with the HIPAA Security Rule, which imposes administrative, physical, and technical safeguard requirements for electronic PHI.

While most developers of wearable devices make general promises about privacy and security, none of the major consumer fitness trackers makes any claims about HIPAA compliance. Some have even been known to include social networking features that allow users to share their fitness data with friends, which in some cases, have been sent to the public by default. Since misuse of PHI is subject to a strict liability standard, developers wishing to bridge wearable devices with covered entities should tread lightly. Two recent developments in health law amplify this concern.

**New Liability for Business Associates**

The HITECH Act changed how HIPAA applies to a covered entity’s “business associates.” A business associate is someone who creates, receives, maintains, or transmits PHI on behalf of a covered entity. Prior to the HITECH Act, HIPAA’s Privacy and Security Rules only applied to business associates indirectly, by requiring covered entities to sign a contract with their business associates, mirroring the requirements of the Privacy and Security Rules. The HITECH Act extended the HIPAA Security Rule and portions of the HIPAA Privacy Rule to apply to business associates, making them directly liable for violations.

As a result, OCR can directly penalize developers who, if serving as business associates, mishandle PHI when providing fitness tracker interfaces for covered entities. The rule also extends to subcontractors of the covered entity or business associates.
Rewards for Individuals in Wellness Programs

The other development is the implementation of new regulations under the Affordable Care Act (ACA). Prior to ACA, group health plans were prohibited from discriminating against individual participants, with an exception for rewarding individuals who complete wellness programs. ACA extended the nondiscrimination rule and its wellness program exception to the individual market, and raised the maximum reward for health-contingent wellness programs from 20% to 30%. A health-contingent wellness program is one that “is based on an individual satisfying a standard that is related to a health status factor.”

Wearable devices provide a novel way of running these programs. For example, self-insured BP, PLC, (British Petroleum) offered free Fitbit devices to its 14,000 employees, and rewarded those who walked at least one million steps in a year with insurance premium discounts. Another example involves a health insurance startup in New York that offered wearable fitness trackers to its 17,000 members and sent them daily fitness goals, adding a dollar toward an Amazon gift card for each goal met.

If ACA’s new incentives prove effective, the technology industry may see significant demand from health plans seeking ways to integrate fitness trackers into their wellness programs. Nevertheless, developers who want to start writing applications for covered entities will need to be sensitive to the nondiscrimination issue.

Wellness Claims, Safety and Reliability

In addition to privacy and security concerns, health application developers and wearable device makers will need to take steps to ensure that their products are safe and reliable in order to avoid the FDA’s strict regulation under the Food, Drug, and Cosmetic Act of 1938 (FD&C Act). In January 2015, the FDA issued draft guidance to help industry and FDA staff determine whether an app or wearable device falls under the scrutiny of the FD&C Act. Although the FDA has not yet officially recommended this guidance, the comment period ended on April 20, 2015. Like other FDA guidance documents, this guidance “does not establish legally enforceable responsibilities,” but instead, “describes the Agency’s current thinking on a topic and should be viewed only as recommendations.”

The guidance states that the FDA does not intend to apply its premarket review and post-market regulatory requirements to “low-risk general wellness products.” The FDA’s Center for Devices and Radiological Health (CDRH) will apply a two-part test to determine whether a product is a low-risk general wellness product: 1) the product must make only general wellness claims; and 2) the product must not present inherent risks to a user’s safety. The latter issue is fairly clear cut: products that penetrate the skin, require special quality controls (lasers or tanning beds), raise novel questions of usability (pregnancy tests), or raise a questions of biocompatibility, present an inherent risk to a user’s safety, and therefore fail the test.

“The FDA does not intend to apply its premarket review and post-market regulatory requirements to ‘low risk general wellness products.’”

Product Claims and Promotion

Manufacturers of wearable devices are more likely to get into trouble with the “general wellness” test. A general wellness product cannot make claims that go beyond sustaining or offering general improvement to a general state of health. This means that the product is not allowed to reference specific diseases or conditions, unless “it is well understood that healthy lifestyle choices may reduce the risk or impact the disease or condition.” Even then, the product should be limited to promoting, tracking, or encouraging choices which, as part of a healthy lifestyle “may help reduce the risk of” or “may help living well with” the disease or condition. For example, it is acceptable for the makers of the Fitbit to advertise that its default goal of 10,000 steps per day will help users decrease their risk of heart disease, because this level of physical activity is generally understood to improve cardiovascular health. Wearable device manufacturers can still get the point across by choosing their words carefully. Rather than referring to a disease, the product may refer to symptoms (managing stress rather than treating anxiety), or to an organ associated with the disease (improving brain health rather than preventing Alzheimer’s disease).

The Future of Wearable Devices

Technology companies have shown they are not afraid of disrupting heavily regulated industries. But as wearable devices begin to enter the health care sector, only time will tell whether they can thrive in one of the most heavily regulated industries in the country.

Nina Kostyukovsky, JD, is an associate in the Washington, DC, office of Debevoise & Plimpton, LLP. She focuses on regulatory defense, internal investigations, and complex class actions. She may be reached at nkostyukovsky@debevoise.com.
Proving Liability in False Claims Act Cases
Recent case highlights use of statistical sampling to determine the odds rather than claim by claim analysis  By Michael L. Koon, JD, and Savannah Wiseman, JD

THE FALSE CLAIMS ACT (FCA) is the most effective civil litigation tool federal prosecutors have for separating health care defendants from their money. In fiscal year 2014, the Civil Division of the Department of Justice (DOJ) collected nearly $6 billion in settlements and judgments under the FCA; $2.3 billion of this amount came from health care resolutions. The trend of ever-larger FCA recoveries by the DOJ is not new. As the DOJ’s most recent annual summary noted, more than half of all monies collected by the DOJ since the 1986 amendment of the FCA have come in the last five years. What is new is a very recent trend by federal district courts to make it even easier for the government to prove cases against health care defendants by allowing relators to use statistical sampling to prove FCA liability. The Life Care Case In United States ex rel. Martin v. Life Care Centers of America, Inc., the government alleged that a chain of skilled nursing facilities submitted false claims to Medicare for medically unnecessary services. Rather than identifying these false claims, however, the government sought to establish liability through analysis of a small sample of submitted claims and extrapolate the findings to the more than 154,000 claims the government maintained were at issue. Over the objections of the defendant, the Court, on Sept. 28, 2014, sided with the government. Discovery is continuing in the case, which remains pending.

“In Life Care, the government’s argument for extrapolation was not that it was otherwise unable to prove its case; rather, the argument was that proving its case in light of the large number of claims in dispute was too much trouble.”

History of Statistical Sampling Statistical sampling and extrapolation have been permitted in FCA cases to calculate damages once the government and/or relators have established liability in contested cases, or in cases in which liability is established through a default judgment. In United States v. Cabrera-Díaz, for example, the Court entered a default judgment against physician defendants accused of submitting false claims to Medicare after they failed to appear. Relying on the “numerous cases involving Medicaid and Medicare overpayments [endorsing] proof of damages through the use of statistics and statistical sampling,” the Court agreed to calculate trebled damages based on an extrapolation of audited claims.

Prior to Life Care, however, courts permitted extrapolation of evidence as proof of FCA liability only in rare circumstances, such as when evidence of specific false claims demonstrated systematic and widespread fraud. For example, in United States v. Krizek the defendant psychiatrists were accused of submitting false claims for hourly-based fees covering more than 24 hours in a given day. While the government could identify claims the defendants presented to Medicare and Medicaid for reimbursement, it could not prove that these claims—and not those of privately insured claims—were the claims billed after the defendants had already billed for 24 hours of service. After noting that it would be “virtually impossible for the government to establish liability on any twenty-four-hour day that included private pay patients,” the Court concluded that the government could extrapolate the number of false claims based on a methodology established by a special master.

Similarly, in United States ex. rel. Loughren v. Unum Provident Corp., the relator sought to introduce expert testimony that relied on statistical sampling of false claims to extrapolate an estimate of the total number of false claims submitted to the government for reimbursement. After holding a “bellwether” trial on a sample number of alleged false claims, the Court concluded that extrapolation was a reasonable method for determining the number of falsely submitted claims as long as the expert’s statistical methodology satisfied the Daubert standard for reliability.

Brave New World of FCA Litigation Life Care departs from earlier FCA statistical sampling cases such as Krizek and Loughren by permitting the government and relators to rely exclusively on statistical sampling to prove liability in the absence of a compelling argument that a plaintiff could not otherwise efficiently proceed. In Life Care, the government’s argument for extrapolation was not that it was otherwise unable to prove its case; rather, the argument was that proving its case in light of the large number of claims in dispute was too much trouble. The Court, in excusing the government from actually identifying what it claimed was false in each disputed claim, observed that neither the language nor the history of the FCA “suggest that statistical sampling is an improper vehicle by which to litigate FCA claims.” The Court then concluded, in an observation at odds with the enormous recoveries made by the government under the Act, that categorically “limiting FCA enforcement to individual claim-by-claim
review would open the door to more fraudulent activity because the deterrent effect of the threat of prosecution would be circumscribed.”

Given the broad holding on such a critical issue, the Life Care decision would clearly and quickly spawn additional attempts by FCA plaintiffs to sidestep traditional proof requirements. Barely six weeks after the Life Care decision, the U.S. District Court for the District of Nevada approved a relator's proposal to use statistical sampling to estimate the number of false claims submitted by a hospital accused of improperly billing for inpatient services that the relator argued should have been billed as outpatient claims. The relator had produced selected data on these inpatient admissions, but demanded a complete set of the data from the defendant for the purpose of creating an extrapolation model to estimate the total universe of falsely submitted claims. In granting the relator's request, the Court declined to rule on the ultimate admissibility of the extrapolation evidence, but noted that the “production of all data will result in more cost-effective litigation.”

In April, in a brief opinion citing Life Care, the U.S. District Court for the Middle District of Florida concluded that “no universal ban on expert testimony based on statistical sampling applies in a qui tam action (or elsewhere), and [that] no expert testimony is excludable in this action for that sole reason.”

**Superior Knowledge Advantage**

For the government and relators, Life Care provides an argument that the difficulties associated with “claim-by-claim” analysis of numerous health care transactions should not stand in the way of efforts to establish liability when a common scheme or practice is alleged. When the challenged activity is longstanding, or when the plaintiff believes the activity impacts large numbers of claims, Life Care suggests that a showing of impracticality may be well-received if the Court and parties must deal with anything other than a subset of the whole claim universe. To make the most of this argument, plaintiffs must be prepared to support both the model they propose for analysis and extrapolation and the need for that model, through competent expert testimony.

Until the issue reaches the appellate level, attorneys and practitioners must assume that the government and relators may now be able to satisfy their burden of proof on liability by using statistical sampling and extrapolation. One advantage defendants should have is superior knowledge about how their businesses operate. When faced with arguments to use statistical sampling to prove liability, this superior knowledge can be particularly useful. First, this knowledge can be used to challenge the need for statistical sampling. To the extent the disputed claims can be analyzed through data queries or otherwise, there is no need to interject the difficulties that accompany even well-intentioned sampling and extrapolation. Indeed, sampling complicates rather than assists the fact-finder in determining liability.

In defending against extrapolation-based liability, attorneys need to find ways to keep the proof focused on specific claims. For example, in a recent matter involving an academic medical center, the defense included the creation of a link between two otherwise incompatible software programs that allowed the voluminous claims at issue to be readily separated into those that were—and those that were not—implicated in a relator's case, thus obviating the need for any sampling or extrapolation.

“Life Care departs from earlier FCA statistical sampling cases by permitting the government and relators to rely exclusively on statistical sampling to prove liability in the absence of a compelling argument that the plaintiff could not otherwise efficiently proceed.”

When the nature of the allegations does not permit efficient analysis of the entire universe of disputed claims—and arguments for dismissal on that basis have failed—defendants in FCA actions may need to focus on effective, early challenges to the data selected for use in a proposed statistical sample. They may also challenge the appropriateness of its applicability across multiple years or different facilities.

Practitioners may use their superior knowledge of their operations to show that the proposed sampling protocol carries an unacceptable margin of error or introduces other defects in the relator's extrapolation. Finally, when the question confronting the FCA defendant is how—rather than if—sampling will figure in the proof, defendants may need to develop their own alternative extrapolation models as well as challenge the models the government and relator propose.

The Life Care decision is not the final word on the use of statistical sampling and extrapolation in FCA litigation. The opinion does, however, clearly put these practices “in play” in FCA matters. Practitioners on both sides of FCA cases should consider the impact of statistical sampling and extrapolation-based liability on their pending cases, and on FCA jurisprudence generally.
MEDICINE AND THE BIG ONE
What doctors can expect during an event no one hopes will ever happen

By Benjamin Mindell

The broad categories of what might hurt us are the starting points for a lot of chilling possibilities: explosion, fire, infrastructure collapse, shootings, chemical release, infectious disease and epidemic, and severe weather.

Infectious disease is a perennial concern in Chicago. So is severe weather, especially when it’s too hot or too cold. The city is luckier in other areas. Tornadoes certainly hit the suburbs, but very rarely strike within the city limits—there are about a dozen on record going back to the late 1800s, and that includes some glancing blows. There is flooding in Chicago, but nowhere near Hurricane Katrina proportions. The New Madrid seismic zone extends into the tip of southern Illinois, but the risk of serious earthquakes for Chicago is extremely low.

Chicago, like other major U.S. cities, is at heightened risk for an attack by terrorists. If they attack, they’ll likely draw from the same categories as unintended disasters. An explosion or chemical release might come by accident or design. Infrastructure breakdowns encompass both a collapsing bridge and a cyberattack. A deadly biological event could be a runaway flu epidemic or an anthrax attack.

Ever since the duck-and-cover days, the city has been seen as a target for atomic weapons. Ground detonation of a terrorist-sized device—10 kilotons, with cruder bombs, much lower in yield, still packing a considerable punch—would likely leave a Loop-sized footprint of total destruction downtown. Major damage and radiation sickness would extend beyond that, and the casualty count would be horrific.

After An Attack

As to Chicago’s disaster preparedness for such an event, “the city’s public safety community has been engaged in a planning process with FEMA’s Region V headquarters for several years now to plan for and build capacity for such a scenario,” Dr. McKinney said, noting that such an attack would have consequences reaching well beyond the city limits. “In terms of how well our 72-hour self-sufficiency will hold up, that’s a capability that we’ve built, but it’s important to understand that certain scenarios will automatically draw the attention and support of the federal government,” Dr. McKinney said. “This is one of those scenarios, particularly with the heavy federal presence that currently exists here.”

Very large U.S. disasters, in terms of lives lost and destruction, are fresh in our memory. The combined toll for the Sept. 11, 2001, attacks was nearly 3,000 killed, and Hurricane Katrina claimed more than 1,800 lives. But those are among the outliers on this nation’s disaster list. The blast that shattered Oklahoma City’s Alfred P.
Murrah Federal Building in 1995, and the largest terror event on U.S. soil until 9/11, killed 168. Eighty-four others in that attack were injured seriously enough to require hospitalization. Another 364 were treated and released from emergency departments and 237 received their care in the offices of private physicians.

Some events defeat a medical response before it has the chance to truly begin. Nearly all the people who died in the 9/11 attacks did so before rescue and treatment were even a possibility. A poignant part of the 9/11 narrative was of doctors and nurses waiting for seriously injured victims who would never arrive. In New York alone, 36,000 units of blood were donated, but 9/11 casualties required less than 260 units. The Pennsylvania airplane crash left no survivors. One hundred and eighty four victims died in the Pentagon attack, which, in the words of one study, “produced few severely injured patients. The regional hospitals were back to normal function the day after.”

When Casualties Arrive
Depending on the disaster, there may be many people who crowd into a hospital for treatment but who are not in need of any acute medical care. In 1995, before the Oklahoma City bombing and Chicago’s deadly summer, there was the Tokyo subway sarin gas attack. Thirteen people were killed. One thousand people were hospitalized. But the most striking feature is that the great majority of the 5,000 people who presented themselves at hospitals for treatment—most made it in on their own—subsequently were deemed not injured by the attack.

Joseph A. Barbera, MD, teaches crisis and emergency management at George Washington University. The school is located in the nation’s capital, which in 2001 saw both the Pentagon and anthrax postal attacks. In a “typical explosion or gunfire, or things like that, it’s pretty easy for a person in the vicinity to figure out whether they are injured or not,” Dr. Barbera said. But when “you have a vapor or somebody is talking about an infectious particle or disease, the average person doesn’t know how to evaluate themselves.”

What’s needed in that instance is “good information not false reassurance,” he said. “If you don’t want a large number of people coming for care, then our systems have to be able to rapidly acquire the information about the incident and provide guidance,” for example through social and mass media.

As individuals with physical wounds make it to the hospital, often the first to show up will do so under their own power and be among the less seriously injured. As they and more seriously wounded casualties arrive, the pressure will be on clinicians to rapidly evaluate patients, the severity of whose wounds may not be immediately obvious. “Whether it’s an intentional bomb blast or whether it’s an unintentional explosion it can be very difficult to figure out who the most severely injured are,” Dr. Barbera said. “Someone who has lost part of a limb but has a tourniquet on and is screaming in pain could be in a less life-threatening condition than someone who is sitting there quietly with a very small penetrating wound to their chest that could be a piece of shrapnel that hit their heart.”

Fast-working clinicians are important, but so are support staff with quick hands. Dr. Barbera gave the example of inhalation injury, with perhaps 20 or more patients needing to be checked for upper airway injury. What’s needed is “someone who is very good with a flexible scope,” he said, but so is bringing “the personnel and resources down to the emergency...
department that can clean that scope quickly, so that you can have two or three scopes and be rotating and go through and check everyone's airway fairly rapidly.”

Along the way, it will be responders who turn up to receive treatment. “You can expect in any kind of large-scale incident to have responders involved in the casualty count at some point,” he said, adding that it raises an issue of prioritization that should be worked out in advance. “If all other things are equal—so if you are not delaying lifesaving intervention for some—do you prioritize fire, EMS, and police personnel so that they can be rapidly seen and returned to the scene, or so the responders know that when they are at great risk that they also have the best available backup?”

In relatively short order, the medical implications of a disaster can spread far from the hospital campus. “Often we find that what people forget about is that when a health system is disrupted for whatever reason, we have people with long-term critical issues. They require constant access to medicines. If they are diabetic, if they have hypertension, they require some kind of attachment to a means of fulfillment of those medicines,” said Andrew Schroeder, PhD, director of research and analysis at Direct Relief, an organization that provided aid after Hurricanes Katrina and Sandy, and conducts humanitarian missions in other countries. “It's actually those longer-term issues that can suddenly become acute, and if you only associate emergencies with acute issues you'll miss this large issue around disruption in the system and what that means for people.”

But the larger community is also a source of resiliency after a disaster, said Dr. Schroeder. “People tend to band together in emergencies and take exceptional actions to help one another and we see this everywhere that we work,” he said. “Immediately, the first response by people who are just affected in an extreme event is to pitch in and help their neighbors. They search for those in need of care. Often people immediately volunteer to work for response organizations. They may have never considered it until that point.”

**Physician Resiliency**

For their own sake and that of their patients, physicians also must have a plan to bounce back. Cecilia F. Rokusek, EdD, is an assistant dean at Nova Southeastern University’s College of Osteopathic Medicine, and program manager for the school’s Institute for Disaster and Emergency Preparedness. In that role she provides continuing education for physicians, and one of her messages to doctors is to plan for the resiliency of their private practices.

“If your practice is wiped out, do you have a place to go? Do you have a back-up system in two places for your medical records? Do you know that you would set up shop in one month, two months? How would you reach your patients?” she asked, going down a checklist of top concerns. “Those are all things that come into planning on a personal level as well as a professional level.”

For those delivering the essential care in the immediate wake of a disaster, their planning should take into account an element that weighs on both their personal and professional responsibilities—their families. “Personal preparedness is what you as an individual have in your home, within your family, within your circle of your significant other, and those immediately close to you, that would allow you to leave if you had to if there was a disaster and/or go to work if there was a disaster,” said Dr. Rokusek.

Her personal disaster planning includes “go packs” with essentials for herself, her husband and their cat. Fifty dollars, in singles, for gas money—just in case credit cards can’t be used—are always in her car. She lives in South Florida, but has friends in Georgia, and family beyond, with whom she knows she can stay if her house is in the path of the next hurricane or tornado. That kind of preparation for refuge is often overlooked, but it can provide a doctor with piece of mind. “If you are a physician, say, and working in an emergency, does your family know what to do and are you comfortable working because you know they are safe?” Dr. Rokusek asked.

Not only doctors but also nurses and other hospital personnel with children in school, especially single parents, Dr. Barbera said, should “have a plan in place so that someone will automatically know where you are and that you have important work, so they can just confirm to you that they are picking the kids up and will be okay.”

Family communication is important in an emergency, but call volume can quickly overwhelm mobile circuits; landlines are more reliable. Texts might have a better chance of getting through than mobile calls. Long-distance calls might connect when local ones won’t, so family members should carry the number of a designated out-of-town relative who can relay messages. Email is another option. Have pre-arranged family meet-up spots. “You want to be able to say everything is okay in my life. I can focus on what I need to do professionally,” Dr. Barbera said.

It’s something he experienced firsthand. At home on 9/11, he turned on his television in time to see the second tower hit. Assuming correctly that Washington was likely to be next, he headed off to the hospital. “I left the house knowing that we had a plan in place,” he said. “My wife was going to be at Nova Southeastern, you know what I mean? My wife was going to be at Nova Southeastern, you know what I mean?”

**Benjamin Mindell** is an award-winning writer and the former editor-in-chief of American Medical News. He lives in Chicago.
Physician Compensation Stabilizes
Experts see growing optimism despite the turbulent reimbursement era By Bruce Japsen

Even as private insurance companies and government health programs move away from fee-for-service medicine to value-based care, potentially squeezing physician reimbursement, compensation is somewhat stable and rising faster than overall inflation, according to new 2015 analyses on physician pay. Perhaps the biggest shift for physician pay under the Affordable Care Act will come from Medicare. Earlier this year, the U.S. Secretary of Health and Human Services under the Obama Administration committed to shifting half of the program’s Medicare dollars away from fee-for-service medicine by 2018. This means doctor pay will be increasingly based on outcomes and performance measures rather than volume.

Primary Care Leads the Way
So far, the shift to value-based care is more common in the primary care profession, where total compensation is generally rising faster than in most specialties, according to new reports on doctor pay out this summer. For example, The Medicus Firm’s annual survey and the 2015 Medical Group Management Association (MGMA) survey show primary care compensation up between 3% and 4% in 2014 while compensation of specialties on average rose between 2% and 3% during the same period in both surveys.

“The optimism among many physicians is pleasantly surprising, due to news of reimbursement cuts and overhead increases.”

The average 2014 total compensation for primary care doctors was $241,273, which was up 3.56% from $232,989 in 2013, MGMA figures show. Meanwhile, the average total compensation for specialists last year was $411,852, a 2.39% increase from $402,233 in 2013, according to MGMA.

The Medicus Firm showed the percentage increase in income for primary care doctors (internists, pediatricians and family physicians) up 3.71% in 2014. Internists, for example, made $239,000 on average in 2014, which was up 3.4% from 2013, according to Medicus. Meanwhile, the average percentage increase for all other 13 specialties in the Medicus survey was 2.6%.

“Salary results often reflect the demand, and the increase in primary care salaries for 2014 over the previous year likely correlates with the increased needs for primary care,” Jim Stone, president at The Medicus Firm, an Atlanta-based national physician recruitment and staffing company, said in a statement to Chicago Medicine.

It’s a trend that has been escalating for some time now as government payers, private commercial insurers and employers emphasize paying their providers to keep their patients well and in less expensive outpatient settings. The Obama Administration’s announcement that Medicare payment will shift away from fee-for-service medicine means 50% of payments to doctors will eventually be tied to performance, health outcomes of their patients and to other measures by 2018. This makes referral patterns of primary care doctors much more important and they are therefore being rewarded for it, compensation analysts say.

Though the vehicle that will be paid by Medicare may vary from an accountable care organization (ACO) to a medical home, it’s clear that reimbursement for each and every test or procedure on a fee-for-service basis isn’t the way of the future and may soon be something for the health care history books. “It’s no longer just about the number of office visits to your practice,” Halee Fischer-Wright, MD, who is a pediatrician and MGMA’s chief executive officer, said in an interview with Chicago Medicine.

Value Overtakes Volume
State Medicaid programs including Illinois’ as well as the Cook County Health & Hospitals System are moving aggressively toward value-based models that include care coordination. These state and local governments are handing off more of their uninsured and Medicaid patients to private health plans to administer.

Under such an approach, health plans work with patients to assign them a primary care doctor. The arrangement financially rewards family physicians, internists and pediatricians. “Payers are moving from paying per illness to more effective wellness which would decrease visits and increase quality,” Dr. Fischer-Wright said. “In the transition, it will squeeze physicians who are used to working on a productivity model.”

Doctors will not be able to escape these changes because they are underway at the Centers for Medicare and Medicaid Services (CMS), and are being adopted at an even faster rate by private health insurance. Take Aetna, for example, which recently announced plans to buy Humana in a deal that will vault the combined entity into the top three health insurers across the country. “Value based contracting now represents approximately 30% of Aetna’s medical spend with a goal to achieve 75% by the end of the decade,” Aetna Chief
Year-to-Year Physician Salary Comparison (MGMA)

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<th>TOTAL COMP</th>
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Source: MGMA

2015 Physician Salary Survey Results (Medicus)

The Medicus Firm, an Atlanta-based national physician recruitment and staffing company, performed a salary survey among a variety of physician specialties this year. The results show increases across the board, except in the area of general surgery. The average 2014 compensation for internists, pediatricians and family physicians was up 3.4% from 2013. The other 13 specialties combined averaged 2.6%. This correlates closely with MGMA results shown above.

<table>
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<tr>
<th>SPECIALTY</th>
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Source: The Medicus Firm
Executive Mark Bertolini told analysts and investors on the company’s recent first quarter earnings call.

Aetna now has more than 60 contracts with ACOs across the country. “We have almost a million members in patient-centered medical homes, which is 38% growth since the beginning of 2014 and over 760,000 members in what we call our high-performance networks,” Aetna’s Bertolini said.

Already, at least one in every 10 dollars paid to primary care doctor practices is based on performance, outcomes or other value-based arrangements, according to MGMA. Nearly 11% of primary care doctor compensation was based on quality in 2014, including reimbursement in ACOs and primary care medical home models, MGMA’s data shows. This compares to just 3% of primary care physician compensation based on quality in 2012 and 6.7% in 2013, MGMA figures show.

“For fifty percent of payments to doctors will eventually be tied to performance, health outcomes of their patients and to other measures by 2018. This makes referral patterns of primary care doctors much more important and they are therefore being rewarded for it.”

For specialists, the move to value-based compensation is a bit slower. Just 7% of compensation was based on quality measures in 2014 compared to 4.6% in 2013 and less than 2% in 2012, MGMA data shows. “In two to three years I think this will grow to the 25% to 33% range,” Dr. Fischer-Wright said. Her prediction is likely to come true if Medicare and private insurers have their way.

Currently, just 20% of payments from Medicare are paid via alternative payment models like bundled payments, patient-centered medical homes and ACOs, a rapidly emerging care delivery system that rewards doctors and hospitals for working together to improve quality and to rein in costs. In these models, doctors and hospitals take on more risk for streamlining the care, improving quality and eliminating bureaucratic inefficiencies.

For example, the Medicare Shared Savings Program pays doctors through an ACO. If the providers in the ACO achieve better outcomes, they divvy up the money with Medicare or the insurance company that owns the Medicare Advantage plan. The ACOs rely heavily on primary care doctors and their staffs, nurse-practitioners and pharmacists for outreach to patients, making sure they adhere to their prescriptions or wellness programs, stay healthy and out of the expensive hospital setting.

In Chicago, all major payers, including Blue Cross and Blue Shield of Illinois, Aetna and its Coventry subsidiary, and UnitedHealth Group are all negotiating more performance measures into contracts with doctor practices, using a variety of incentives.

Despite all the new models, doctor pay analysts say physicians seem okay with the reimbursement trends. “Physician compensation seemed to remain fairly stable overall,” Medicus’ Stone says. “Physicians seemed a bit more optimistic about their income for 2014 and 2015,” Stone added. “This optimism among many physicians is pleasantly surprising, due to news of reimbursement cuts and overhead increases.”

A Buyer’s Market

Some of this optimism can be attributed to the love hospitals and health systems are heaping onto doctors amid a nationwide physician shortage. Hospitals are increasing what they pay doctors they hire as employees, offering more incentives and richer compensation packages, physician recruiters and doctor pay analysts say.

“The physician shortage is increasing demand and hospitals are paying more,” said MGMA’s Dr. Fischer-Wright. “It’s a buyer’s market. Every system needs primary care physicians as they shift to value-based care models.”

In the Medicus analysis, the only specialty to show a contraction in compensation was general surgery, which saw average compensation fall 1.1% to $349,000. There were, however, specialties with less than 1% compensation increases in 2014 that included medical oncology/hematology, gastroenterology and urology.

The Medicus analysis comes from a sampling of more than 2,680 providers representing specialties in 47 states who completed an online survey. Medicus’ 12th annual survey was taken in April and May of this year so the payment shift underway in the Medicare program is only beginning. “There are always some fluctuations here and there from year to year, but we haven’t seen any alarming decreases or persistent stagnation in any one specialty in the past one to three years,” Stone said.

The Medicus firm said they are also seeing demand for certain other specialties aside from primary care, which could boost compensation. “Demand for psychiatry and emergency medicine doctors is picking up steam as well,” Medicus Firm’s Stone said.

Bruce Japsen is an independent health care journalist and regular contributor to Chicago Medicine who also writes for Forbes. He is the author of the book, “Inside Obamacare: The Fix For America’s Ailing Health Care System.” He also contributes analysis on health, business and political topics to WBBM Newsradio and WTTW television in Chicago and Fox News Channel’s Forbes on Fox. He can be reached at brucejapsen@gmail.com.
Communication saves lives.
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When Pamela felt a flutter in her chest and feared she might faint, she went straight to the ER. Emergency physician Dr. Singh discovered a suspicious finding on Pamela’s EKG, and sent an image of the recording to the on-call cardiologist via DocbookMD. The cardiologist quickly confirmed SVT, a condition requiring immediate medical intervention. The potentially life-threatening episode was resolved within minutes—rather than hours—and Pamela was safely discharged home. All thanks to some quick thinking and the secure mobile app, DocbookMD.

DocbookMD is a free benefit of your CMS membership.
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A Medical Resident Responds

The Chicago Medical Society’s Tina Shah, MD, assumes a unique position on the training frontlines. She’s a medical resident and researcher at the University of Chicago and immediate past chair of the AMA’s resident and fellow section. On Capitol Hill she participates in talks led by CMS on physician workforce expansion. She’s also one of the rare medical trainees to actually give personal testimony to a key legislative leader, in this case, Senator Richard Durbin. Here, Dr. Shah addresses some of the controversies in GME.

Q: Earlier this year, Health Affairs posted an article about the 2015 Match results. The author notes that current U.S. residency positions exceed the number of applicants graduating from U.S. allopathic and osteopathic medical schools. He concludes that fears of an impending crisis are overblown given that only 23,000 U.S. seniors were in competition for 30,411 first-year positions. The article goes on to discuss other factors accounting for a student’s failure to match. How would you respond to that?

A: The availability of first-year training positions doesn’t translate into having the capacity to fully train an independent board-eligible physician. Many specialties start in PGY-2 year (anesthesia, radiation oncology, ophthalmology, and surgical specialties) and matching into PGY-2 and the years beyond is independent of matching into a PGY-1 year. There is a true “failure to match” because after PGY-1, fewer training positions are available.

It’s misleading to not look at the number of positions needed to complete all the required years of specialty training. Most specialty societies and reputable organizations like the Association of American Medical Colleges (AAMC), American Hospital Association (AHA), and American Medical Association (AMA) are concerned about the IOM report.

There is no credible evidence to support the position we have sufficient numbers of residency positions. With the siphoning off of existing funding, which supports our current training positions, we do not and will not have enough GME positions to produce a workforce with the expertise to provide the superior care that embodies the health sector here.

Illinois provides rich training due to the number of excellent undergraduate teaching institutions. The Chicago area’s six medical schools and one osteopathic program are producing physicians ready to complete their training in residency. Overall, the view for U.S. medical graduates who re-apply for the match is grim. As each year passes after medical school, the chances of matching into a training program drops.

Q: How can program directors and educators help students through the match process?

A: Medical school educators can help and do help in many phases of the process. The first step is to help troubleshoot any issues that arise while students are in medical school. In this age group, many life changes occur, including marriage, birth of children, caring for elderly loved ones, and emergence of mental illness.

Schools need to develop and maintain robust support systems to help students deal with life events and other stressors. Second, educators need to give students a realistic view of the match process, which varies greatly by specialty. The more the match process can be made transparent, the better.

Third and finally, educators should strongly urge their students to advocate in Congress about the real issues trainees face. Students want to learn how to be capable serving physicians but the current system places limits on their being able to get the required training without running into insurmountable debt.

Q: What’s your advice to current students, and to graduates who didn’t land spots in 2015?
A: I empathize and urge them to talk to their mentors in their medical school, especially their deans. After not matching, there is a small window in which it may be possible to get at least a first-year training position, in a process known as “scrambling.”

Unfortunately, we don’t have a formalized pathway to help medical school graduates who don’t match. That’s why I advise them to connect with their mentors and deans as early as possible and ask for help.

Q: What happens to graduates who don’t match? What kind of work do they end up with?

A: I have several friends in this predicament. They often choose to work for “free” as research assistants in order to build a resume for the next match cycle, or switch careers because they need to support their families. It’s disheartening to see colleagues who are passionate about caring for patients have to let go of their dreams, especially when there is a real need for more physicians in the United States.

Q: A friend of yours had a year or two of residency training before her program closed, and she had a hard time finding a new spot, but got lucky. How often are trainees left in the lurch because of program cuts?

A: This question speaks to a lack of transparency in our physician training process. While I am not aware of a source that can tell us the magnitude of residents whose programs close, as chair of the AMA-RFS, I heard about these scenarios monthly. The problem is real and there is no systemic support for those trainees who find themselves suddenly out of a training position due to institutional reasons. These residents are left to figure out their next steps by themselves.

Q: Primary care and family medicine positions increased by 5.5% and 6.5%, respectively, in 2015. Perhaps as many as 60% of internal medicine and pediatrics trainees will go on to sub-specialize or become hospitalists. How can we get an accurate view of graduates entering primary care?

A: Assessing the number of medical graduates who ultimately end up as outpatient primary care physicians can be difficult. Physicians in recent generations seem to be more flexible. I know colleagues who sub-specialized and later developed a practice that is mostly primary care, for example, as an infectious disease specialist, who, in addition to focusing on HIV patients, serve as primary care doctors. Some residency graduates may work as hospitalists and transition to outpatient settings later on in their careers.

While there do seem to be more opportunities to complete training in primary care, at the same time, increasing the primary care workforce is multifaceted. Competing interests among various provider types, balancing reimbursement against medical school debt, and physician satisfaction are just a few factors that determine how many graduates choose primary care.

**Match Measurements**

The NRMP algorithm launches thousands of students each year into residencies across the country. Designed to produce an ideal match, the algorithm crunches numbers and compares rank order lists with programs’ choices. And on several counts, the 2015 Main Match was the most successful ever, offering a record 30,212 positions, and achieving a fill rate of 99.4%. More applicants, at 34,905, were in competition for 27,293 first-year and 2,919 second-year residency spots. U.S. allopathic seniors, who comprised 18,025 of active applicants, numbered 651 more than last year.

U.S. osteopathic students and graduates, whose numbers rose to 2,949, up 200 from last year, had a match rate of 79.3% to first-year programs, the highest yet. Participating couples, at 1,035, did well also, with a 94.8% match. For both U.S.-IMGs, and non-U.S. IMGs, match rates held steady; 6,301 out of 12,380 foreign medical school graduates landed a spot. U.S.-citizen IMGs matched at 53.1%, and non-U.S. citizen IMGs at 49.4%.

Another indicator of success is the alignment of applicant preferences with those of residency programs. For the 18,025 U.S. allopathic seniors submitting program preferences, 16,932 matched to first-year programs, achieving an overall match of 93.9%. Among matching U.S. seniors, 51.6% landed their first choice for training, and 78% got one of their top three choices. For all U.S. allopathic graduates, the Match rate was 43.6%.

This year saw the addition of 615 new first-year positions spread out in internal medicine, family medicine, pediatrics, ob-gyn, and psychiatry, according to NRMP. Overall, internal medicine programs offered 6,770 positions, 246 more than last year, with 98.9% of positions filled, nearly half of them with U.S. seniors.

Looked at broadly, increases from 2014 include: 940 more registered applicants; 651 more U.S. allopathic seniors submitting rank order lists, and 533 more matched to PGY-1 positions.

The growth in active applicants reflects the greater numbers of U.S. seniors and graduates, both allopathic and osteopathic. With higher medical school enrollments and the opening of new schools, the trend will only increase.

**More Remain Matchless**

In 2015 a higher number of unmatched U.S. allopathic seniors went on to compete for unfilled spots. Totaling 1,093, this group entered NRMP’s Supplemental Offer and Acceptance Program (SOAP). The frantic and chaotic SOAP scramble offered 1,306 unfilled positions. When counting all unmatched U.S. allopathic seniors with unmatched osteopathic applicants, IMGs, and prior graduates,
Legislation is One Remedy

YOUR CHICAGO Medical Society strongly endorses the Resident Physician Shortage Reduction Act of 2015. This bill is part of a multi-pronged approach to increase the number of residency spots now that medical schools are expanding enrollment by 30%. Introduced by U.S. Rep. Joseph Crowley, D-NY, and U.S. Sen. Jon Tester, D-Mont., the Act outlines provisions for new residency slots and funding. Here are highlights:

- Medicare-funded residency positions could increase by 15,000 over the next five years.
- Of the 3,000 new spots created each year, at least 1,500 must be used in shortage specialty residency programs, as defined by the Health Resources and Services Administration. This distribution would apply until the National Health Care Workforce Commission issues a report on specialty shortages.
- Factors like neighboring medical schools and the number of residency applicants for a particular program will influence the distribution of new residency slots.
- Programs will be prioritized for new position funding in the following order: hospitals in states with new medical schools; hospitals that have exceeded their resident cap at the time of enactment; hospitals that are affiliated with VA medical centers; hospitals that emphasize training in community health centers or community-based settings or in hospital outpatient departments; and hospitals that are determined to be meaningful users of EHRs for the fiscal year.
- The Act calls for additional research on specialty shortages and diversity in GME. As such, the National Health Care Workforce Commission would be required to conduct a study of the physician workforce. The study would identify main specialties that disproportionately lack physicians; the results would be used to determine which specialties receive priority for residency spots under new GME funding.
- The Act also directs the U.S. comptroller general to conduct a study on diversity in health care, which would look at new ways to increase the number of physicians in practice from rural, lower income and underrepresented minority communities.

upwards of 8,600 unmatched PGY-1s vied for fewer than 1,200 SOAP spots. All but 64 of the 1,306 SOAP positions went unfilled. In 2015, the number of entrants in SOAP rose by 381 from last year. Ultimately, more than 250 graduating U.S. allopathic seniors did not match to a residency position in 2015. That number troubles medical educators. As teaching institutions ramp up enrollment by 30% to meet projected physician shortages, many predict a surge in unmatched applicants since residency slots aren’t increasing at the same pace. While states and medical schools have funded some new spots, Medicare-sponsored training positions remain capped at 1997 levels, close to 94,000.

For medical students still in the pipeline, the match can mean a change in career plans. Students who don’t match may re-enter the match the following year or continue to seek a residency position. Others re-enter with a different specialty or take a research year, or even give up their dreams of becoming a physician.

Forces Shaping Demand
Organizations like AAMC project national shortages of anywhere from 46,000 to 90,000 physicians by 2025. Predicted shortfalls in primary care range between 12,000 and 31,000 physicians by 2025, while demand for non-primary care physicians will exceed supply by 28,000 to 63,000 physicians.

Overall, total physician demand is projected to increase by 86,700 to 133,200 (11-17%), with population growth and aging accounting for 112,100 (14%) of the increase, according to a report prepared for the AAMC by global information company IHS, Inc. By comparison, physician supply will likely increase by 66,700 (9%) if labor force participation patterns remain unchanged, with a range of 33,700 to 94,600 (4-12%), reflecting uncertainty about future retirement and hours worked patterns. Up to one-third of all practicing physicians could retire within the next decade since physicians between ages 55 and 64 comprise 26% of the active workforce.

Expanded medical coverage under the Affordable Care Act, once fully implemented, will likely increase demand by about 16,000 to 17,000 physicians (2.0%) above that resulting from changing demographics, the IHS data show. The Congressional Budget Office estimates that eventually 26 million people will have medical insurance who would otherwise be uninsured in the absence of ACA.

Taking into consideration health and risk factors of the population likely to gain insurance and estimated changes in care utilization patterns associated with gaining coverage, IHS estimates that demand for physician services will increase by 2.0%. The increase is highest for surgical specialties (3.2%), followed by primary care (2.0%), medical specialties (1.7%) and “all other” specialties (1.5%). Within these broad categories, there are differences in the impact of the ACA for individual specialties, according to IHS.
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After years of sequestration and stagnation, the National Institutes of Health could see big funding infusions in 2016. The 21st Century Cures Act, passed overwhelmingly this July in the U.S. House, now awaits Senate action. The Chicago Medical Society (CMS) applauds this rare bipartisan move. CMS continues to lobby hard for the Act’s passage as well as new Medicare-supported residencies. Serving seven teaching institutions and a burgeoning medical district, CMS links physician workforce expansion with biomedical research. Both form key planks in our advocacy platform.

CMS outreach builds support for various GME expansion bills. One of the lawmakers who signed on early is U.S. Rep. Bill Foster of Illinois, with whom CMS maintains an ongoing relationship. The physicist-entrepreneur-cum-lawmaker, who represents the 11th District, made his second visit to CMS when he spoke before a packed crowd on June 22.

A rarity in Congress—the only PhD scientist and the lone physicist—Rep. Foster understands the perils, political and financial, facing academic researchers today. The Harvard-educated lawmaker spent most of his career at Fermi National Accelerator Laboratory. Today Rep. Foster serves on the House Committee on Science, Space, and Technology and on the Financial Services Committee. He participates in the full spectrum of science policy issues.

From this vantage point, Rep. Foster has insight into the under-investment in biomedical research. “Congress doesn’t understand the damage that’s done when you jerk around research budgets,” he said. Unlike a highway, which can be built on a year-by-year basis with delays, biomedical research can’t wait. “When you have a bad two or three years of funding for research, you lose a generation of researchers. We had several very good years in the early 2000s, mostly because of The America COMPETES Act, a bipartisan commitment to increase funding,” Rep. Foster said. The short-term political incentives of getting elected have led to the nation’s under-funding of basic scientific research, he says. This is especially worrisome because China’s total expenditure in this area will surpass ours sometime in the next decade, Rep. Foster predicts. “You can be a hero if you balance the budget by cutting education and research, and you don’t have to pay the political price for the damage it does to our economy 10 or 30 years downstream.”

Bottom line: Rep. Foster says voters need to very consciously elect people who are willing to take on short-term political pain for the long-term best interests of the country.

Implications of Human Genome Editing

As the only PhD scientist in Congress, U.S. Rep. Bill Foster finds himself the lightning rod for a different kind of research revolution: precision editing of the human genome. He hears frequently from scientific authorities warning that the U.S. must start considering the implications.

In less than 10 years, Rep. Foster says, research labs may have the technological capability to alter the human gene line. And there’s no legal or ethical framework for these rapid developments. “It’s likely there will be early wins, like getting rid of sickle cell anemia, but there is a huge set of gray areas between ‘getting rid of defects’ and performance enhancements,” Rep. Foster notes. The field is not something the U.S. will control by itself because the technology has been widely dispersed. Given the fact that the U.S. produces few genomic PhDs compared to other countries, it’s not clear the nation can even lead.

“Getting ahead of the technological curve is difficult because editing the human genome is a 70-year experiment, while the rate of progress on the technology curve is much faster,” Rep. Foster adds.

In this brave new world, Rep. Foster says the public will depend on advice from the medical community to know what is safe, what is wise, and what isn’t.
Despite impasses in Springfield, we scored significant wins

By Thomas Anderson, MD

ILLINOIS POLITICS in the summer of 2015 have so far resembled the well-worn refrain of a camp song: “Second verse, same as the first—a whole lot louder, and a whole lot worse!” The legislative session grinds on with no end in sight, and physicians and patients statewide wonder how our state’s budget crisis and other issues can be resolved.

Rest assured, ISMS members, even though our elected lawmakers remain stuck in the mud, your Illinois State Medical Society is not. By way of proof, I offer a variety of items that will make your heart—and perhaps your pocketbook—swell.

First, a significant win for physicians in the Illinois Supreme Court, where the fair distribution of settlement funds awarded to accident victims was at stake. Physicians often provide care to uninsured accident victims, filing liens to allow for reimbursement for that care when the patient wins or successfully settles a personal injury suit. In the case of McVey v. MLK Enterprises, trial lawyers tried to prevent health care professionals from receiving the full reimbursement allowed under the Illinois Health Care Services Lien Act by subtracting attorney fees and costs from the settlement first, then limiting health care liens to a percentage of whatever is left.

ISMS stood up for physicians, submitting an amicus brief with the Illinois Hospital Association arguing that health care liens and attorney fees and costs should all be calculated fairly, from the gross amount of the settlement. The Supreme Court saw things our way, ruling 7-0 to give physicians their fair share.

Our success this year reached even beyond the borders of our state, with the announcement that Medicare will begin to reimburse physicians for conversations held with patients about advance care planning. As medical technologies and techniques grow advanced and more complex, it has never been more important for physicians to talk with our patients about their wishes. Now Medicare recognizes the value of those discussions as well—and it’s all thanks to ISMS. In 2014, ISMS successfully advocated for the creation of two new CPT codes to cover conversations with patients about advance care planning. We are the first state medical society to initiate new CPT codes, and we are proud to report that our ultimate goal has been reached. We expect that private payers will soon begin reimbursing for these codes as well.

Of course, state legislative advocacy is still a mainstay of ISMS’ effectiveness, and even though the legislative session is not yet over we can report several significant victories. Among many other successes, this year ISMS:

• Stopped a trial lawyer attempt to overturn the Medical Studies Act, which protects the confidentiality of peer review meetings and related documents.
• Negotiated greater flexibility for certain advanced practice nurses while still maintaining the collaborative agreement requirement.
• Prevented a mandate on physicians to provide estimates of patients’ health care costs and act as insurance navigators for the patient.
• Blocked scope-of-practice expansions for podiatrists and pharmacists.
• Averted licensure of lay midwives and naturopaths.
• Initiated a bill to allow temporary licenses for out-of-state team physicians.
• Successfully supported reforms to clarify physician reporting requirements related to the firearm concealed carry law.
• Achieved compromise on objectionable opioid prescribing legislation, including the removal of onerous provisions that would have criminalized the practice of medicine, placed numerous mandates and restrictions on physicians, and granted the IDFPR broad authority to obtain and use prescribing habits of physicians as reported by the Prescription Monitoring Program (PMP).

For in-depth information about these items and many other areas of ISMS activity in the General Assembly this year, download our End-of-Session Report from www.isms.org. Tri-fold brochures are also available summarizing our key victories. As always, ISMS will keep our members up-to-date as we handle the significant issues that remain, including the state budget, workers’ compensation and more.

Thomas Anderson, MD, is president-elect of the Illinois State Medical Society.
Calendar of Events

AUGUST

19 ICD-10 CM: Introduction to the Basics of ICD-10-CM Diagnosis Coding for Physician Practices Intended for all physicians, practice managers, physician executive staff, and medical office staff. A successful transition to ICD-10 CM by Oct. 1, 2015, will require careful planning and coordination of resources. Numerous provider and health plan databases and applications will be affected—including applications where diagnosis or procedure codes are captured, stored, analyzed or reported. In this session, participants will learn the steps to correctly select ICD-10-CM diagnosis codes, understand the conventions and rules related to the ICD-10-CM alphabetic index and tabular list, apply the basic general coding guidelines and selected chapter-specific guidelines of ICD-10-CM, and review clinical examples applying ICD-10-CM codes. Speaker: Nelly Leon-Chisen, RHIA, director, coding and classification, American Hospital Association, Chicago. Registration/breakfast: 9:30-10:00 a.m.; presentation: 10:00 a.m.–1:30 p.m. Location: Westlake Hospital, 1225 W. Lake St., Melrose Park. Up to 3.5 CME credits; $149 per person for CMS members; $249 for non-members or staff. Price includes coding book. Register online at: www.cmsdocs.org or contact Rachel at rbahena@cmsdocs.org or call 312-670-2550, ext. 338.

19 CMS Board of Trustees Meets every other month to make financial decisions on behalf of the Society. 9:00-10:00 a.m. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

27 How to Implement New Technology to Practice for Better Outcomes and Patient Care This event is hosted by the Illinois Society of Plastic Surgeons. 6:30 Cocktails and Registration; 7:00 p.m. Dinner and Lecture; Speaker: Brian Kinney, MD; University Club, Millennium Room, 76 E. Monroe St., Chicago. Members may attend at no cost. To RSVP, please call 312-670-2550 or email aalletto@cmsdocs.org.

SEPTEMBER

8 CMS Governing Council Meeting The Society’s governing body meets four times a year to conduct business on behalf of the Society. The policymaking Council considers all matters brought by officers, trustees, committees, councilors, or other CMS members. 7:00–9:00 p.m., Maggiano’s Banquets Chicago, 111 W. Grand Ave. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

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The Chicago Medical Society welcomes its newest members. We are now 21 voices stronger!

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For the Love of Patients

It’s the relationships that mean the most to this obstetrician-gynecologist

By Cheryl England

Despite his many high profile positions, obstetrician and gynecologist Dr. Robert Kelsey still gets his biggest motivation and boost of energy from seeing his patients.

T’S A GOOD thing obstetrician and gynecologist Robert Kelsey, MD, only needs four to six hours of sleep each night. This busy physician wears many hats as president of the Chicago Women’s Health Group, chief of staff at Northwestern Memorial Hospital, and assistant professor of clinical obstetrics and gynecology at the hospital. That, plus he still manages to see a full slate of patients, including surgical cases, each week.

“It does take an incredible amount of organization to get everything done correctly,” he admits. “Fortunately, I’ve been able to surround myself with great people who can help keep me organized. Also, I’ve gotten pretty good at time management.”

As an example, Dr. Kelsey spends any extra minutes between patients or meetings completing medical records, reviewing lab results or replying to essential emails. Plus he allocates one day a week solely to the administrative parts of his jobs so that he can spend the rest of his week doing what he loves best—seeing patients. “I don’t know where I’d be without my computer and smartphone,” he says. “I’m constantly checking my schedule so I can be prepared for what is coming up.”

Dr. Kelsey, however, didn’t start out knowing that medicine would be his calling. “I got out of college and was kind of fumbling around deciding what to do,” he says. “I ended up working in a hospital in labor organization. I loved working there because the hospital attracted very compassionate people. I realized the only difference between them and me was some education.”

After receiving his medical degree from the University of Illinois College of Medicine in 1985, Dr. Kelsey did his residency training at Northwestern, where he has stayed. Early on, Dr. Kelsey became quite active at Northwestern, serving on a variety of committees as peer review and quality management. “It’s a funny thing,” he laughingly says, “the more involved you are, the more people ask you to do!”

It didn’t take long before the medical staff asked Dr. Kelsey to become the secretary and treasurer, then vice chief of staff, and finally, chief of staff. Meanwhile, the Chicago Women’s Health Group began growing from its initial stage where Dr. Kelsey was one of two physicians to its current status with six physicians, four mid-level providers and a total team of 30 people. “My first partner retired, essentially leaving me with the business,” says Dr. Kelsey. “It’s a good thing I’ve come to enjoy administration as well as patient care. Together they let me use my brain in different ways.”

Outside of work, Dr. Kelsey is an avid outdoorsman who enjoys running, camping, hiking, bike riding and a slew of other activities. In addition, Dr. Kelsey goes to Guatemala once a year with the Faith and Practice Group to provide medical services in underserved areas.

But the thing that keeps him going at work is seeing his patients. “More than anything I’m happiest at work when I’m seeing my patients,” he says. “I’ve delivered babies from women who I delivered when they were babies. I get to know the women and their families. Being able to help people start a family is an unbelievably intimate and rewarding experience. No matter what happens in the political landscape, I believe that the special relationship between a physician and patient will stay intact.”

Dr. Kelsey’s Career Highlights

IN 1981, DR. KELSEY graduated from the University of Illinois with a BS in biology, with the highest departmental distinction. He has also been honored as Phi Beta Kappa and with the Book of Academic Honors at U of I. He has served in leadership positions on numerous committees at Northwestern, including as chair of the credentials committee. He is also a fellow of the American College of Obstetricians and Gynecologists.
“As physicians, we have so many unknowns coming our way...

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