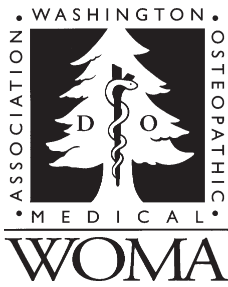

Washington D.O.

Winter 2012

4700 42nd SW, Suite 530 / P.O. Box 16486 Seattle, WA 98116-0486
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Project Echo Assists Providers with Pain Management

The University of Washington Division of Pain Medicine has introduced Project ECHO/UW Pain (Extension for Community Healthcare Outcomes), an expansion in content and scope of an effective videoconference-based consultative knowledge network providing specialty panel expertise to assist in the management of challenging chronic pain problems.

Each Wednesday, 12:00pm — 1:30pm PST, Project ECHO/UW Pain conducts collegial, interactive videoconferences, including:

1. Didactics on useful chronic pain topics for primary care providers.
2. Live case presentations from community clinicians
3. Interactive consultations for providers with a multidisciplinary panel of specialists.

During these videoconferences, you are **invited to present your difficult chronic pain cases** to our panel of pain specialists representing diverse pain expertise in the specialties of internal medicine, anesthesiology, rehabilitation medicine, psychiatry, addiction medicine, and nursing care coordination during each weekly session. Feel free to ask questions, even if you have not presented a case. The goal is to increase your knowledge and skills to treat chronic pain in your community practice.

Project ECHO/UW Pain will significantly increase access to multidisciplinary experts capable of prompt real-time treatment support in the care and treatment for the most challenging patients in pain. As already demonstrated at the **University of New Mexico's Project ECHO**, videoconference consultation improves outcomes and patient and provider satisfaction over geographically dispersed populations. Project ECHO/UW Pain will extend the University of Washington's world recognized best practice pain care approach to increased numbers of primary care and specialty care providers in rural, tribal, suburban, urban, and safety net populations throughout the widely dispersed geographic areas of the Northwest, extending pain care expertise throughout the states of Washington, Wyoming, Alaska, Montana, and Idaho.

Project ECHO/UW Pain will provide outreach and education using measurement based clinical instruments that can more precisely assess an individual patient's response to the many types of treatments provided as well as allow outcome assessment of effectiveness of treatments for individuals and for much larger population groups.

Project ECHO/UW Pain case conferences and short didactic presentations significantly reduces the effect of limited access to scarce pain specialty care throughout this wide geographic region and diverse demography by creating knowledge networks linked through the University of Washington. Project ECHO/UW Pain will also meet the need for easily accessible pain management consultations that are now required by the Washington State Department of Health regulations that specifically endorse the use of such innovative consultative approaches for chronic non-cancer pain patients with high risk and/or poor outcomes despite use of high dose opioids. For mor einformation go to http://depts.washington.edu/anesth/care/pain/echo/index.shtml.

Pain Management Update

Registration for the WOMA Spring Seminar, Pain Management Update for Primary Care, is now open. It will take place on Saturday, April 21 at the Doubletree Guest Suites/Southcenter. Featured speaker is **Scott Fishman, MD**, author of Responsible Opioid Prescribing – A Physician's Guide, and Chief of the Division of Pain Medicine and Professor of Anesthesiology at the University of California, Davis. Dr. Fishman will cover several topics, including the health crisis of prescription drug abuse and under-treated pain, assessment, treatment planning and ongoing risk management, prescription monitoring programs and tamper resistant drug strategies. **Paul B. Brown, MD** will provide information on rheumatology workup in primary care. Program co-chairs **Dan Wolf, DO** and **Lynda Williamson, DO** along with **Mike Quirk, DO** will provide a panel review of the new pain management rules and Prescription Monitoring Program.

This program is approved for 8 AOA Category 1-A credits, which will help meet the State CME requirements to exempt a prescriber from the rule provision to consult a pain specialist when prescribing 120 MED or more. Application for CME credit has been filed with the American Academy of Family Physicians. Determination is pending. To register go to www.woma.org.

Medicare Cuts Delayed Again

The implementation of the 27.4% cut in Medicare physician payments, scheduled to take effect on March 1 has effectively been delayed until January 1. The Congressional agreement extends current physician payment policy through the end of 2012. Medicare-participating physicians will now be subject to a 32 percent cut on January 1. The $18 billion cost over 11 years of this short-term delay is offset by cuts to other health care programs, including the Prevention and Wellness Fund - $5 billion, payments for clinical labs - $2.7 billion, limitations on Medicare bad debt payments to hospitals - $ 6.9 billion, rebasing Medicaid State DSH allotments - $4.1 billion, and a technical correction to the Disaster Recovery FMAP provision - $2.5 billion. The agreement also includes certain Medicare "extenders," including the continuation of the 1.0 floor on the work GPCI for all geographic locations, therapy caps, certain pathology services, ambulance add-ons, the outpatient hold harmless provision, and Transitional Medical Assistance (TMA).

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The "Washington DO" is the official publication of the Washington Osteopathic Medical Association, published in February, May, August and November. Members are encouraged to submit articles for potential publication. Signed columns are, in all cases, the opinion of the author. For advertising information, please contact the WOMA executive offices at (206) 937-5358. Deadlines for ads and articles are the 10th of the month preceding the publication.

Meetings Notice

The **WOMA Board of Governors** will have its quarterly dinner meeting at 6:15 p.m. Saturday, December 3.

The **Washington Osteopathic Foundation Board** will meet prior to the WOMA board at 5:45 p.m., immediately after the WOMA Winter Seminar, at the Doubletree Guest Suites/ Southcenter, 16500 Southcenter Parkway, Seattle.

Agenda items should be submitted by March 23rd for consideration at either meeting.

WOMA Welcomes New Members

The following applications for membership were approved by the WOMA Board of Governors at their quarterly meeting held December 3, 2011:

Active
Louis Koussa, DO KCUMB' 1979
Rebecca Locke, DO LECOM'08
Edward Salco, DO KCUMB'80
Michael Sherfey, DO COMP'04
Susanne Wilhelm, DO COMP'08

Associate
Melissa Strange, DO

Student
Melissa Ambergo COMP'13
Hong-Danh Ngo COMPNW'15

PNWU 2015
Kathryn Abel
Traci Ackron
Erin Allen
Michael Anderson
Nicholas Auble
Shyam Bhansali
Jenna Borys
Elisha Bremmer
John Burger
Jordan Carr
Andrew Clark
Aaron Conger
Susan Cunningham
Allie Davis
Melanie Estrella
Teresa Frey
Faelin Fullmer
Ahren Geilenfeldt
Daniel Gragert
Matthew Hall
Jan Hallock
Joseph Hibbert
Nicholas Hoffman
Nathanael Hogg
Adam Hoopes
Melissa Horton
Patrick Johansing
Karsten Johnson
Tyler Kelin
Harrison Lakehomer
Quinh Le
D Livingston
Lauren Lucas
Brian Lynds
Kimberly Matz
Jordan McCoy
Nicholas Michael
Ryan Miller
Brian Moreaux
Madelien Mussman
Catherine Nelson
Jesse Nye
Thomas Orthmeyer
Caleb Patee
Sean Penberthy
James Pense
Katherine Peterson
Maryanne Pickett
Steven Pinther
Daniel Psoinos
Andrew Quisumbing
Kaleb Redden
Jennifer Ribar
Kyle Robins
Sarah Roth
Lindsey Ruppel
Danielle Saenz
Michael Salisbury
Amber Sinicrope
Lisa Soehren
Cory Sonnemann
Christopher Thomas
Michelle Tolle
Jackelin Tran
Leonel Trujillo
Chadron Vassar
Alyssa Vivas
T Williams
Andrew Woolf
Francisco Zaldana
Azedeh Zangench
Heather Zeznock

SOMA
2013
Dennis Linderman
Erika Mesick
Laura Turgano

2014
Stephanie Baumann
Helen Erickson
Mafiseh Haghoo
Zachary Kane
Juliet Morgan
Fumiko Naughton
Thuy Pham
Sutira Scheef

L&I Medical Provider Network Accepting Applications

The Department of Labor & Industries is now accepting applications for the statewide workers' compensation medical network that will launch in 2013. The new medical provider network is part of legislation passed last year designed to improve workers' outcomes after an injury. Current L&I providers must re-apply to join. After the network launches, injured workers will be able to see a non-network provider, but only for the initial visit. They must then choose a network provider for ongoing care. Complete information on the network and a copy of the program's new standards are available on the L&I website.

Medical providers can apply at www.JoinTheNetwork.lni.wa.gov .

Is Your CME Current?

This is the third year of the current AOA CME cycle. From January 1, 2010 to the end of 2012, AOA members are required to have at least 120 CME credits. Of this total, 30 CME credits must be obtained in Category 1-A, and the remaining 90 credit hours of the CME requirement may be satisfied with either Category 1-A, 1-B, 2-A, or 2-B credits. Physicians entering the program in mid cycle will have their credit requirements prorated. Your individual CME Activity Report outlines your total CME requirement and the amount of credits required in categories 1 and 2.

In recognition that members of the AOA who hold specialty or subspecialty certificates in those specialties with less than 250 certificate holders may have difficulty accruing the necessary AOA 1-A credits required for membership, and to allow adequate time for the development of such programs, such members may apply ACCME or AAFP category 1 credits to their AOA 1-A credit requirement up to the maximum 15 credits for this CME cycle. This is for AOA membership only.

Specialty certification requirements for CME are different. Physicians who are board certified or board eligible are required to earn a minimum of fifty CME credits in their primary specialty in each three-year CME cycle. These credits may be earned in Category 1 or Category 2. CME sponsored by osteopathic specialty affiliates in the individuals declared specialty, will be applied to this requirement on an unlimited hour-by-hour basis.

CME sponsored by AOA CME Sponsors other than the individual's declared specialty affiliate may be awarded by the certifying board with jurisdiction up to a maximum of 25 credits per cycle. More information on CME requirements is available on the AOA website, www.osteopathic.org or call your specialty organization.

Washington State has different requirements which must be met for licensure. Licensed osteopathic physicians and surgeons must complete one hundred fifty hours of continuing education every three years as of their license renewal date which is also their birth date.

Certification of compliance with the requirement for continuing medical education of the American Osteopathic Association, or receipt of the AMA physicians recognitions award or a current certification of continuing medical education from medical practice academies shall be deemed sufficient to satisfy the requirements of the Board of Osteopathic Medicine and Surgery. Original certification or recertification within the previous six years by a specialty board will be considered as evidence of equivalent compliance with these continuing professional education requirements.

WOMA has four CME programs scheduled for 2012 providing a total of 49 category 1-A credits. See the CME list on page 8.

Getting to Know You

WOMA is pleased to welcome the following new Active members:

Louis Koussa, DO graduated from KCUMB in 1979. He completed a rotating internship at Doctors Hospital of Stark County, Ohio in 1979. He practices emergency medicine in Kennewick.

Rebecca Locke, DO is a 2008 graduate of LECOM. Her postgraduate training took place at Southern Colorado Family Medicine Residency, Pueblo, CO from 2008 to 2011. She practices family medicine in Othello.

Edward Salco, Jr, DO graduated from KCUMB in 1980. He interned at Southeastern Medical Center and completed his Family Medicine residency at University of Kansas. He practices Emergency Medicine–Family Medicine in Kennewick.

Michael Sherfey, DO is a 2005 COMP graduate. He did his orthopedic surgery residency at Botsford Hospital, MI and an adult reconstructive surgery fellowship at the Texas Hip and Knee Center in Fort Worth. He is an orthopedic/adult joint reconstructive surgeon in Kennewick.

Susanne Wilhelm, DO graduated from COMP in 2008. She completed her postgraduate training at Tacoma Family Medicine in 2011 and is practicing in Anacortes.

Unified Counties Waive WOMA Members

Do you belong to a unified county medical society? Those in Washington require their physicians to belong to the Washington State Medical Association (WSMA). Several years ago, WOMA worked with the unified county medical societies to change their bylaws to allow DOs who wished to belong to WOMA instead of WSMA

Many of the county medical societies do not publicize this choice to their osteopathic physician members.

Some osteopathic physicians have indicated that, though they would prefer to belong to WOMA, their county medical society requires them to pay dues to WSMA and they have limited funds for professional memberships. We just want those DOs to know that, if desired, they have a choice.

For further information, contact Kathie Itter at 206-937-5358 or email kitter@woma.org.

CMS May Delay ICD-10 Implementation

You could get more time to prepare for the industry switch to ICD-10. CMS announced it would reconsider the current ICD-10 timeline, in which the entire health care industry would have to comply by Oct. 1, 2013.

CMS plans to "re-examine the pace" of implementing ICD-10, marking the first public indication that the 2013 implementation date is not as firm as CMS has repeatedly said it is.

CMS declined to specify what types of changes to the timeline CMS would consider or whether the 2013 deadline, announced in 2009, will definitely get pushed back to accommodate provider concern. However, CMS will make an announcement on the matter in the next few days.

The level of detail in the ICD-10 code set is crucial to thwarting fraud and communicating patient information with other countries, and CMS is still committed to a full and successful ICD-10 implementation. However, there is concern from providers that they won't be ready in time.

After months of standing firm on the 2013 deadline, this is the first time CMS has expressed a willingness to work with providers on reconsidering the implementation date.

PNWU Update

By Dean Robyn Phillips-Madson, DO, MPH

PNWU is the grateful recipient of the generous donation by John and Priscilla Cadwell, of the Cadwell Student Center, worth $2 million. The Cadwells have been strong supporters of PNWU and the COM since they first visited the campus with their daughter, Marie, a member of the inaugural Class of 2012. The Cadwells have been generous with their time and treasure, and we are very grateful to them.

Interviews will continue over the next two months for applicants for the Class of 2016. Application numbers have hit a record high of 2500. The Multiple Mini-Interview format has been well-received by faculty and applicants, and gives a broader perspective than the former interview process consisting of teams of two, consisting of one faculty and one staff member.

PNWU-COM is anticipating its first AOA residency program match on February 13th, and NRMP match on March 16th. Fourth year students have mixed feelings of excitement and anxiety as they wait for the results. Military students have matched into their residency programs, all of them receiving their first or second choices. Several students have pre-matched into residency programs, the last year that such an opportunity will exist in the MD or DO match systems.

PNWU-COM is well-positioned to meet the proposed standard changes for accreditation of COMs by the Commission on Osteopathic College Accreditation (COCA) which includes demonstrating planning and progress for adequate residency programs for COM graduates. Additional residencies are being planned in the Northwest, and there is significant progress to dually accredit some existing primary care programs in the region. The final COCA site visit prior to full accreditation occurs February 22-24.

A new PNWU president has been chosen, and will be publically announced as soon as the contract has been finalized. We are grateful to Dr. Butler and "first lady" Gloria Butler for coming out of retirement and providing calm and steady leadership over the past two years. PNWU has thrived under Dr. Butler's direction during this transition to a permanent president.

COMs See Continuing Applicant Increase

Due to raised awareness and increasing numbers of colleges of osteopathic medicine and branch campuses, record-breaking numbers of prospective medical students have been applying to the nation's osteopathic medical schools for the sixth consecutive year. With application closing in April for the 2012-2013 academic year, more than 14,860 applicants have sought acceptance to 26 osteopathic medical schools and four branch campuses, a 6.65 percent increase over last year's figures at this time, and already more than the total number of applicants at the close of last year's application cycle. Application growth was recorded at all schools, with to-date percentage increases ranging from 4.36 to 18.11 percent.

The number of applications submitted to PNWU increased 15.6% from 1948 in 2008 (the initial class) to 2251 in 2011 (the current first year class).

Some 20 percent of all U.S. medical students are studying at osteopathic medical schools; more than 20,000 osteopathic medical students are currently enrolled. This figure is projected to steadily increase, with an estimated 5,300 DOs graduating each year by 2015. With more than half of graduating DOs entering one of the primary care specialties (general internal medicine, family practice or pediatrics), the growing interest in osteopathic medical education may help mitigate future primary care physician shortages.

DO License Renewals Online Soon

On December 16, 2011, the Department of Health began implementing online renewals using a phased approach. Currently, four professions (surgical technologists, Pharmacy Technicians, Naturopaths and Licensed Social Work Associate-Independent Clinical) may renew online. Over the course of the next 17 months DOH will roll out additional professions for online renewal. Renewal notices of impacted professions will include information about the online renewal option. In addition, the renewals Web page will display the updated list of professions able to renew online. Only Visa and MasterCard will be accepted and will have a small convenience charge added to cover costs. **Credential holders will not be able to renew online if:** their credential has already expired; they are currently in any other status such as military, inactive, or retired; they want to change status from active to military, inactive, or retired; they have an address change; or they have a name change. Please see information below to update your address.

It is very important to keep your contact information current! DOH must have your current mailing address in their system for you to renew online. Your renewal notices and updated credentials are mailed to the address on file. The United States Postal Service will not send your renewal notice or credential to a forwarding address.

If your contact information is not current in the DOH system, please contact the Health Services Quality Assurance Call Center at:
Post Office Box 47865
Olympia, WA 98504-7865
Phone: 360.236.4700
Fax: 360.236.4818
Email: hsqa.csc@doh.wa.gov
Be sure to provide them with your email address.

Do you Know a Special DO?

Do you know a DO who is involved in community outreach, medical missions, youth sports and/or other programs? Has there been a mentor or preceptor who has been exceptionally helpful to you and others? Colleagues, staff, patients, students and family members are encouraged to submit nominations for WOMA's Physician of the Year. We need to hear from you about the special DO in your community.

Letters of nomination, explaining why the DO should be considered, should be sent to Kathie Itter, Executive Director at PO Box 16486, Seattle, WA 981116, faxed to 206-933-6529 or emailed to kitter@woma.org. The deadline for nominations is March 30th.

2012 Legislative Update

Below is a list of bills that WOMA has been monitoring. Two are of particular concern: **HB 2366** if passed, would require all osteopathic physicians and most other health care providers to attend a six-hour CME program on suicide assessment, treatment and management every six years. Physicians are well-trained in this area and mandated CME will be done at the expense of CME that physicians would choose to better treat their specific patient population. The Legislature, when creating health professional boards and commissions, charged them with establishing and administering requirements for CME as may be necessary or proper to ensure public health and safety as a prerequesite to granting and renewing licenses. WOMA is recommending that the Legislature leave the decision on required CME for suicide assessment and prevention to the Boards and Commissions and consider instead a public awareness campaign with help from the media. This bill passed the House and is currently ischeduled for a hearing February 22nd at 8:00 a.m. the Senate Health and Long Term Committee. You are encouraged to contact your state senator and encourage a "no" vote on this. **HB 5978** creates a Washington State Fraud Claims Act which includes Qui Tam "bounty hunter" language. It allows anyone to file a suspected fraud lawsuit against a Medicaid provider, even if the Attorney General decides not to pursue action. It has passed the Senate and is scheduled for public hearing on February 15 in the House Committee on Judiciary at 8:00 AM in anticipation of other legislative action. Call your members of the House of Representatives and encourage them to defeat this bill.

WOMA 2012 Bills Monitored as of February 13, 2012:

HB 2227 – Establishment of Medical Assistant Registration (Rules)
Creates four new professions: medical assistant-certified, medical assistant-registered, Medical assistant-hemodialysis technician, and medical assistant-phlebotomist. No person may practice as one of the new professions unless he or she is appropriately certified or registered. A medical assistant-certified, medical assistant-hemodialysis technician, or a medical assistant-phlebotomist credential is transferable among different practice settings. A medical assistant-registered credential is not transferable to other practice settings. Certified health care assistants are converted to medical assistants upon renewal of their certifications in the following manner: a category C, D, E, or F health care assistant will automatically become a medical assistant-certified; a category G health care assistant will automatically become a medical assistant hemodialysis technician; and a category A or B health care assistant will automatically become a medical assistant phlebotomist. The health care assistant credential is eliminated effective July 1, 2016.

HB 2228 – Medications for uninsured (Rules)
Allows practitioners and medical facilities to donate prescription drugs and supplies to pharmacies for redistribution without compensation or the expectation of compensation to individuals who meet certain criteria. Requires pharmacies and medical facilities that elect to dispense donated prescription drugs and supplies to give priority to individuals who are either at or below two hundred percent of the federal poverty level or who are uninsured.

HB 2306 Pathology Services Billing
Authorizes clinical laboratories and physicians providing anatomic pathology services to present claims for payment to direct patient-provider primary care practices

HB 2315 –Physician Assistants DEAD
Removes approval of practice plan by BOOMS and MQAC and replaces with a delegation agreement between PA and DO or MD which is kept on file at the practice and available to the Board upon request. Allows a DO to enter into delegation agreements with multiple PAs and forbids the Board to limit the number of PAs with which a DO may enter into an agreement.

HB 2316 – DEAD
Pertains to Mental Health and STD patients

HB 2318 – Patient Decisions Shared DEAD
Requires certificate of patient decision aids.

HB 2319 Affordable Care Act (Rules)
Furthers state implementation of the health benefit exchange and related provisions of the affordable care act.

HB 2330 Pregnancy Termination (Rules)
Requires a health plan that provides coverage for maternity care or services to also provide a covered person with substantially equivalent coverage to permit the voluntary termination of a pregnancy

HB 2343 Controlled Substances DEAD
Addresses electronic communication of prescription information for certain controlled substances.

HB 2366 Suicide Assessment & Treatment (Rules)
Requires that osteopathic physicians and many other providers must complete six hours of training in suicide assessment, treatment, and management every six years as part of their continuing education requirement Training must be approved by the disciplining authority which may specify minimum training and experience necessary to exempt a practitioner from the training requirement.

HB 2515 PAs and ophthalmic related services DEAD
Authorizes the performance of opthalmic-related services by physician assistants when under the employment of or supervision by a medical doctor or an osteopathic physician.

HB 2599 Suspension of pain management rules DEAD
Requires the DO, MD, DPM, DDS and ARNP boards and commissions to suspend, for a period of three years following the effective date of the act, the pain management rules adopted under chapter 209, Laws of 2010

SSB 5310 False Claims Against the Government DEAD
A person who knowingly presents a false or fraudulent claim for payment to the government is liable to the government for a civil penalty between

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$5,000 and $10,000 plus three times the amount of damages the government sustains. The bill includes Qui Tam language.

SB 5966 Health Care Authority Ombudsman (2nd Reading)

Establishes the volunteer position of health care authority ombudsman within the office of the insurance commissioner.

HB 5978 – Medicaid Fraud (2nd Reading)

Medicaid Program Provisions. The crime of Medicaid theft is moved from the theft statutes to the section relating to Medicaid false statements. The statute of limitations for prosecuting Medicaid theft and Medicaid false statement cases is ten years. The director of the Health Care Authority (HCA) and the AG may assess civil penalties of up to three times the amount wrongfully obtained. The Medicaid Fraud Penalty Account is established. All receipts from civil penalties collected by the HCA and the AG and all receipts received under settlements that originated under the Federal or State False Claims Acts must be deposited into the account. The account is subject to appropriation, and may only be used for Medicaid fraud enforcement activities and the cost of Medicaid services. In order to be paid for Medicaid services, providers of durable medical equipment must also be providers under the federal Medicare program. A person who presents a false Medicaid claim for payment or approval is subject to a civil penalty of between $5,500 and $11,000 and treble damages received by the state. This penalty may be reduced to double damages if the person cooperates with the AG's investigation. If the person is found to have fraudulently billed for services, their insurer is not obligated to pay claims on the person's behalf. The AG must make a good faith investigation of false Medicaid claims and may bring civil actions, subject to funds appropriated for this purpose. The AG may contract with private attorneys and local governments in bringing fraud actions. Whistleblowers who report to the HCA that their employer has fraudulently obtained or attempted to obtain Medicaid benefits or payments may not be subject to workplace reprisal or retaliatory action.

State False Claims Act. A State False Claims Act is created, permitting qui tam actions. A person, known as a relator, may bring a civil action on both their own behalf and that of the state alleging submission of a false Medicaid billing. The relator must serve a copy of the complaint on the AG and the complaint must be filed in camera. The AG may intervene in the qui tam action and the relator may continue as a party to the action. If the AG does not intervene, the relator may proceed with action unless dismissed by the court. A qui tam action may not be brought if it is based on a proceeding in which the AG is already a party. The court may dismiss an action if the action is publicly disclosed in a federal criminal, civil, or administrative hearing in which the AG is a party or in a government report or by the news media. If the relator has been retaliated against, the relator is entitled to relief necessary to make the employee whole. This includes reinstatement, two times the amount of back pay with interest, and special damages. The AG is to report annually on the number of cases brought under qui tam actions and their results, delineated between those brought by the AG and those brought by relators without AG participation.

If the AG Intervenes in the Qui Tam Action. The AG may move to dismiss the action if the relator has been given notice and opportunity for a hearing or settle the action if the court determines that the settlement is fair and reasonable. The court may put limitations on the relator's participation if the court determines that such participation would interfere with the action or is repetitious, irrelevant, or to harass. The court may limit the number of witnesses called by the relator and the amount of their participation. If the defendant shows that unrestricted participation of the relator would be for purposes of harassment or cause undue burden or expense, the court may limit participation by the relator. The relator will receive between 15 percent and 25 percent of the proceeds of the action or settlement, depending on the extent of the relator's participation and as determined by the court. If the court determines that the action is based on information other than that provided by the relator, the relator may be awarded no more than 10 percent of the proceeds. Payments to the relator must be from the proceeds and the relator is due reasonable expenses, plus reasonable attorneys' fees and costs. All expenses, fees, and costs will be awarded against the defendant if the AG Does Not Intervene in the Qui Tam Action. As requested by the AG, the relator must serve copies of all pleadings and depositions on the AG. The court may permit the AG to intervene at a later date upon a showing of good cause. The relator will receive between 25 percent and 30 percent of the proceeds of the action or settlement, as determined by the court. The relator must also receive an amount for reasonable expenses, attorneys' fees, and costs. All expenses, fees, and costs will be awarded against the defendant. If the defendant prevails, the court may award to the defendant reasonable attorneys' fees and expenses if the court finds the claim was clearly frivolous, clearly vexatious, or brought primarily for the purposes of harassment.

SB 6048 – Nursing Home Use of Recycled Prescriptions DEAD

Requires the department of social and health services, in association with the department of health, to establish a prescription drug recycling program that permits nursing homes to share unused prescription drugs and to accept donations of unused prescription drugs from prescription drug manufacturers and health care practitioners.

SB 6049 – Cancer Drug Repository DEAD

Requires the department of health to: (1) Establish a cancer drug repository program for accepting donated cancer drugs and dispensing the drugs to authorized residents; and (2) Establish

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and maintain a participating facility registry for the program.

SB 6051 – Collection and Redistribution of Unused Prescription Drugs DEAD

Allows unused prescription drugs to be donated to health care facilities or participating practitioners and allows the facilities or practitioners to accept and redistribute the donated prescription drugs. Requires the department of health to maintain and publish a current listing of participating health care facilities and participating practitioners.

SB 6107-Medicaid Managed Care DEAD

Requires contracts with Medicaid managed care plans to include a requirement that certain patients be placed in an automatic review process with the primary care provider.

SB 6115 – Workforce Training DEAD

Requires the workforce training and education coordinating board to convene a health care personnel shortage task force.

SB 6212 Electronic Communication of Controlled Substances DEAD

Authorizes electronic communication of prescription information for controlled substances

SB 6227 Medicaid fraud hotline (2nd Reading)

Requires the Medical Quality Assurance Commission to fund a toll-free Medicaid fraud hotline.

SB 6237 Medical Assistants (2nd Reading)

The designation of health care assistant is changed to medical assistant. Beginning July 1, 2014, medical assistants must be certified in order to practice as a medical assistant. The DOH must adopt minimum requirements for entry into the medical assistant profession and establish a career ladder so that medical assistants can, through experience and education, increase their skills and the procedures in which they are permitted to assist. Once certified, medical assistants may only practice in the category of medical assistant for which they are certified, but they may receive training under the supervision of a health care professional in another category of medical assistant. Certified medical assistants must be at least 18 years of age or older, have satisfactorily completed a medical assistant program approved by the Secretary, and demonstrate evidence of completing the education and training requirements for the category of medical assistant for which they are seeking certification.

SB 6265 Medical Use of Cannabis DEAD

Regulates the medical use of cannabis through nonprofit patient cooperatives, collective gardens, local government regulation of nonprofit patient cooperatives and collective gardens, security requirements for the transportation of cannabis, affirmative defense and arrest and prosecution protections, establishment of a voluntary registry within the department of health, and modification of the state institute for public policy study.

SB 6270 Third Party Reimbursement DEAD

Prohibits a licensee, subject to the uniform disciplinary act, from being required to participate in any public or private third-party reimbursement program as a condition of licensure.

SB 6394 Health Care Professionals Transparency DEAD

A new section is added to the Uniform Disciplinary Act requiring a health care professional that holds a doctorate degree to identify the type of license, registration, or certification they hold in all advertisements containing their name.

SB 6447 State Work study Funding DEAD

Legislature intends to add a surcharge to business and professional licenses to help generate revenue for the state work-study program. An additional 3 percent surcharge must be added to any fees established by the Secretary of DOH associated with licensing or regulation of processional, occupations, or businesses administered by DOH

SB 6466 Medicaid and CHIP DEAD

Implements waste, fraud, and abuse detection, and prevention and recovery solutions to improve program integrity for Medicaid programs and the children's health insurance program. Creates efficiency and cost savings through a shift from a retrospective "pay and chase" model to a prospective prepayment prevention and detection model.

SB 6589 Requiring a direct patient-provider primary care practice services option for public employees DEAD

Beginning with the 2012 open enrollment, PEBB must offer at least one self-insured plan in which participants receive primary care services from a direct practice. Any plan offered must include coverage for services not provided by the direct provider so that the total coverage is comparable to other self-insured plans offered through PEBB. The direct fee to the direct practice must be paid by PEBB rather than the individual subscriber

Payment Delays Due to 5010?

Complaints about cash flow problems are beginning to mount and it appears the transition to HIPAA Version 5010 may be behind it. Since the transition deadline of January 1, there have been growing reports of data disruptions and claims rejections with both Medicare Administrative Contractors and commercial plans. Recently, the Centers for Medicare and Medicaid Services (CMS) announced a 90-day extension to the compliance deadline from Jan. 1 to March 31, 2012 to allow more physician practices the time to implement the new electronic billing-coding standard without risk of penalties. If you have implemented Version 5010 and have experienced any payment slowdowns since January 1, please contact the AOA at govt-issues@osteopathic.org.

Bear Droppings...............

by Loren H. Rex, D.O.

Well, here we are at the new lot where the circus will magically appear as if rising from the weeds or perhaps on a nice football field or playground. In reality, there is a lot more to it than just arriving, setting up the tent and giving a performance. As I said in an earlier column, the sponsor for the date has a lot to do with how smoothly the show date goes. Vacant lots are probably the least amount of trouble but are also usually the smallest of the venues. Fair or Rodeo grounds are the best since you usually have electricity and water on the grounds. The problem with football fields or playgrounds is that it is always possible to do some serious turf damage, especially if it is wet. But all the above are sort of the luck of the draw and we have a show to get ready.

Circus trucks are specialized and the Curley Machine Shop in Hugo, Oklahoma could make anything anyone could dream up and pay for. The first truck to arrive should be, assuming no breakdowns, the pole truck. As you might suspect, it carries the poles for the tent and also the stakes to hold the tent down. Contrary to popular opinion, you have to hold a tent down so it doesn't blow away. The poles hold it up. We were once in a Mid-West storm and had to drop the tent as soon as we got the people out and believe me, it is hard to get a wet tent off of all the seats and equipment.

In some ways, the most important person in the whole process is the Boss Canvas man. He will walk around the lot looking for problems and deciding in his mind how to make everything fit. I was on shows with different size tents but the ones I was around ranged in size from 200 feet by 70 feet to 280 feet by 90 feet. That was a lot of canvas to have to deal with in all sorts of weather conditions. The best Boss Canvas man I can remember was a guy named Red Fokker. No one actually knew how old he was since no one was old enough to remember when there wasn't a Red Fokker and that included people in their 80"s. I could write columns on Red. He was truly a character.

After Red decided how to place things which included a Side Show tent, Cook House Tent, Midway with concession tents and where the "backyard" would be, he started using a tape line to lay out the Big Top: no Big Top no Circus. Flags were used to spot where the ends and sides of the Top would be. Next, the pole truck was moved along the center of where the tent would be and the poles placed so the tent could be raised. There are two types of Circus tents; Push Pole and Bail Ring. Bail ring are monsters that require a lot of working men to raise and take a lot of time. Push Pole, like we had required far fewer people and a good Elephant. Good Elephant is a contradiction in terms from my point of view. Once the center poles were out, what are known as quarter poles are laid where they needed to be. Although there may be more than one row of quarter poles, they are still referred to as quarter poles. Finally the side poles are placed around the perimeter of where the tent will be.

The next truck to arrive should be the Canvas or as it is sometimes called the spool truck. Just as it sounds, the truck has a large spool that winds the tent on to the truck. It also usually pulls the cook house trailer since there are around 50 people that need to be fed. The Big Top crew had coffee and rolls or toast before they pulled off the last lot. Everyone else was on their own, unless for some reason they got up early enough to make it to the cookhouse.

The canvas truck was now aligned with the flags for the top and part of the tent unwound so that its ropes could be tied to stakes and the top unrolled onto the ground. Once the top is unrolled, there is the small issue of unrolling the tent from side to side. Try and imagine how easy that is to do with a wet tent that is really heavy. Back in the "old days", "my era", there would be kids that had ridden their bikes to the lot to try and get tickets to the show by working to set everything up and they were really a big help. Everyone grabbed a tent rope and pulled to spread the canvas out. When this was done, it was time to carry stakes and place them around the perimeter at each rope, also called guy lines. It is now time for the stake driver.

This truck that was also the water truck had an apparatus on the back that made life a lot easier when driving a stake into the ground. When everything went right, you pulled back on a handle which made two rollers come together and a large weight was lifted 6 feet or so from the ground. You then placed a steel stake under the heavy weight and released the handle while hoping that none of your body parts had managed to make it in between any of the moving parts. Since the ropes were about 6 feet apart, driving stakes was not a short process and when they had to be done by hand it was really hard work with a #16 sledge hammer. And now each rope has to be half hitched around its stake and the tent is ready to put into the air.

In the next episode we will use an Elephant to raise a tent.

Bear

2012 CME Calendar

April 21, 2012
Pain Management Update
Seattle
8 Category 1-A Credits

June 21-24, 2012
99th Annual Northwest Osteopathic Convention
Blaine, WA
25 Category 1-A Credits
Anticipated

September 15, 2012
OMM
Yakima
8 Category 1-A CME Credits
Anticipated

December 1, 2012
Health Matters: Mars and Venus Men's & Women's Health Update
Seattle
8 Category 1-A CME credits
Anticipated