



American College of Osteopathic Internists • Stay True to Why You Pursued Medicine

February
2022



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ABIM Program Director
Policy



In Honor of Black
History Month: Member
Spotlight



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Update Regarding the ABIM Program Director Policy

A Letter From Our President



Dear Colleagues:

As you may know, the AOA recently announced the resolution of a lawsuit against the American Board of Internal Medicine (ABIM). In 2016, ABIM announced an impending policy requirement that all residency and fellowship program directors be ABIM-certified to attest to resident competency to sit for ABIM certification. The implications of this policy included the requirement of AOBIM-certified program directors to obtain additional ABIM certification (multiple certifications if fellowship directors) by July 2022; or risk losing their jobs if the hospital systems required program directors to certify residents for allopathic or osteopathic board certification. Since the announcement of this ABIM requirement, over 100 osteopathic program directors have been either replaced with ABIM-certified program directors or were forced to obtain additional/duplicate certification in their specialty. It is important to note that this requirement applies only to internal medicine and its subspecialties, no other osteopathic certifications face the same requirements.

When the single graduate medical education accreditation system was announced in February 2016, a critical component of this system included the assurance that osteopathic physicians would be appropriately recognized as equal participants in the graduate medical education system—including in the roles of osteopathic board-certified program directors. All allopathic boards, except ABIM, continue to honor this understanding.

When the ABIM released its pending policy change, ACOI immediately began partnering with AOA to determine the best way to respond to this egregious infringement on practice and advocate for our program directors. ACOI's Deputy Executive Director, Tim McNichol, JD, contacted dozens of program directors and contributed hundreds of hours collaborating on this effort to reverse the ABIM policy. As announced earlier this month, AOA was successful in reaching a settlement for a two-year extension of the ABIM policy, allowing additional time for current AOBIM-certified program directors to sit for the ABIM exam.

As an osteopathic board-certified rheumatologist who founded a rheumatology program, and who has served as a program director for over fifteen years, I understand firsthand the implications of this policy and the outcome of this lawsuit.

Many dedicated and highly skilled program directors have already lost their positions, and more are certain to experience a similar fate in the coming years. While resolution of the lawsuit provides a brief delay in implementation of the policy for current program directors, it fails to address the underlying discrimination created by ABIM's policy.

While the outcome of this legal action did not resolve this issue as we had desired, it does not end the College's efforts to advocate on behalf of osteopathic internists and subspecialists. The ACOI will continue to explore all possible avenues to ensure the appropriate recognition of osteopathic internists and subspecialists. You may contact me or ACOI Deputy Executive Director Tim McNichol, JD at tmcnichol@acoi.org with any questions regarding this matter.

Sincerely,

Robert L. DiGiovanni, DO, FACOI
President
president@acoi.org

AMERICAN
OSTEOPATHIC ASSOCIATION

The following is a reprint of the American Osteopathic Association's announcement regarding the outcome of *AOA v. American Board of Internal Medicine*.

Announcement regarding ABIM program director policy

The AOA has important information to share with you concerning the American Board of Internal Medicine (ABIM) policy regarding the required program director attestation:

The American Osteopathic Association (AOA), seven osteopathic training program directors and the American Board of Internal Medicine (ABIM) have resolved the lawsuit regarding ABIM's requirement that clinical competence attestations come from ABIM-certified program directors.

ABIM will continue to accept attestations from current program directors of Single GME Accreditation System internal medicine residencies and fellowships who are not ABIM certified in 2022 and 2023, thus giving them two additional years to become certified by ABIM in their discipline.

Also, ABIM will waive its examination fee for one administration of its internal medicine certification examination and one administration on a subspecialty certification examination in 2022 or 2023 for any such program director.

Beginning in 2024, all clinical competence attestations must come from program directors who are ABIM certified in the discipline of their program.



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Insights From the Committee on Health Equity and Inclusion in Medicine

Give Us the Ballot

Timothy J. Barreiro, DO, FACOI



This month, Black History Month, serves as a remembrance of the sacrifices made to expand suffrage and voting rights to all. Bloody Sunday, recently commemorated by hundreds of members of Congress in Selma, Alabama, echoes an event and moment in American history where the nation's destiny was decided. Unknown to most, Martin Luther King, Jr. came to march from Selma to Montgomery, the state capital, to protest the death of a 26-year-old who was shot by police protecting his mother as she tried unsuccessfully to register to vote five times in Perry County. Ironically, this event took place at the Edmund Pettis bridge, named after a former Grand Dragon of the Alabama Ku Klux Klan. At the commemoration, the nation was reminded that the struggle for voting rights continues to be a contemporary battle. The signs that day read "voting rights are civil rights." Even today, the right and freedom to vote remains elusive.

In the face of fear, permanent harm, and even death, civil rights activists crossed the Edmund Pettis bridge. After the second Selma march, President Lyndon Johnson introduced the Voting Rights Act before a joint session of Congress. He stated, "It is wrong, deadly wrong, to deny any of your fellow Americans the right to vote in this country." The Act, which guaranteed Americans the right to vote, was an unfulfilled and overdue promise of the 15th Amendment, passed a century earlier.

In signing the legislation, President Johnson stated: "the vote is the most powerful instrument ever devised by man for breaking down injustice and destroying the terrible walls which imprison men."

Since 1965, the Justice Department and federal courts have stopped more than 3,000 discriminatory voting changes. Controversial provisions for voting remain salient in contemporary political discourse. Perhaps you have recently heard about challenges to voting, gerrymandering of districts, rules around how to register to vote, how and when to vote, moving local voting places, and how to count votes.

Civil rights leaders knew the battle for the ballot was a long journey. Martin Luther King, Jr., in his "Give us the Ballot" address at the Prayer Pilgrimage for Freedom in 1957 connected democracy, freedom and a better society with the ability to vote. He argued that voting could end human captivity and provide a beacon of light for freedom: "Many know that fairness at the ballot will lead to equality—allow for passage of laws that help humanity, transform the salient misdeed of injustice, promote the good deeds of citizens, and fill the void of inequities." Voting meant and still means a better and more just society.

What do voting rights have to do with health care providers?

As voting rights are being challenged today, physicians need to be politically engaged.

There is a need for strong leadership, committed to the ideals of racial justice and concern for those without a voice. Witnessing the tragic breakdown of law and order, physicians must repress the desire to separate ourselves from the social fabric in which our patients' lives are woven. Human interaction and a need for strong, courageous, and intelligent leadership is needed to advance and protect the most basic democratic process—the right to vote.

Civic engagement is an important social endeavor; physician status, education, and resources enhance our ability to contribute individual and collectively. With trust in science and the medical profession eroding, improved civic engagement may improve physician relationships with society. Equity and humaneness, central critical concepts in health care, desperately require physician input and participation in social and political life.

In general, what has been the physician response to modern martyrs, this voting rights legacy, the right to vote? Disappointingly, physicians are less likely to vote than the general public. Common reasons include lack of time, difficulties in registering to vote, and lack of knowledge about when and where to vote. Like our poorest and sickest patients, physicians too as a profession, share in a proclivity to not participate in the political process for many of the same reasons. Voting obstacles faced by our patients are our own obstacles.

Continued





Insights From Committee on Health Equity and Inclusion in Medicine

Give Us the Ballot *(Continued)*



Yet, physician engagement with the political ethos, through voting, can have a substantial role in shaping public policy, affecting population health, and improving care. Society expects our profession to be an important voice to balance inequities and promote ethical health policy. While physicians likely view their clinical work as having a social purpose, resulting in less civic participation, providers need to be more active in community—our local, state and federal life. What happens to patients in community impacts the health of our patients.

What is to be done? While physician voting rates pale in comparison to both the public and lawyers, physician power in the political process is not small. Voting is a major expression of civic participation and community engagement. Scholars argue that professionals elevate expectations with civic participation—they become role models and thought leaders—desperately needed in the face of the current pandemic.

Some physicians have ownership interests in the health care industry. Other physicians are motivated by their professional obligations—basic tenets of duty, advocacy and community. Whether a fiduciary duty or professional obligation, should we not be better stewards of the voting process? Medical organizations, including this ACOI newsletter, are one mechanism for political advocacy issues, keeping providers abreast of the current political climate and policy changes. Most would agree that medicine has a social contract with humanity.

Have we lost our way in promoting a more just and equitable society?

No. Just give me and everyone else a ballot. 🗳️

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In Honor of Black History Month:

Spotlighting ACOI Fellow, Cynthia D. Owens, DO, FACOI

by Gina Kilker



Growing up in Detroit in a family with five children, Cynthia D. Owens, DO, FACOI, didn't think she'd be going to college, much less medical school. Her father, exhibiting what she calls "the old beliefs," thought it would be her brother, and not her, or her three sisters, who would go on

to higher education. But when her ambitions shifted as a teen from being a professional violinist to pursuing medicine, her father "changed his tune" as well, and was all in favor of her aspirations.

Early inspiration came from watching the medical drama, *Dr. Kildare*, in the 1960s when she was a child. Dr. Owens remembers being transfixed by the TV doctor who cared for people in their homes and conferred with families. She also loved watching the TV character consult with other on-screen physicians to discuss difficult cases. She also demonstrated her desire to care for others by sneaking animals in need into her house. "I would always adopt stray dogs and hide them in the basement and feed them and bathe them and repair whatever wounds they had."

That propensity to care for those who could not care for themselves is what propelled her to eventually earn her medical degree from Michigan State University College of Osteopathic Medicine in East Lansing, Michigan, in 1979.

She has since become certified in internal medicine, geriatric medicine and hospital medicine—her current focus.

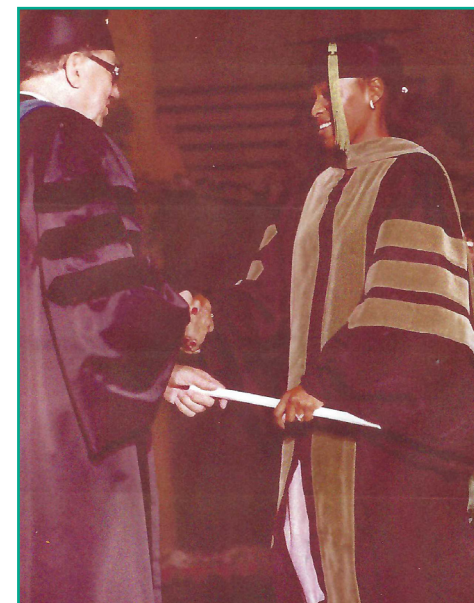
Pick Your Battles

In medical school she found herself in the minority—both as an African American and a woman. Thinking back on the four decades she has practiced medicine, and the trajectory of her career as an African American female physician, she references advice she received from her father, a veteran who would draw from his own experience facing racism in the military when he advised her to, "Be careful of the battles you choose to fight. If you're in the battle alone, you might get crushed. But if you have some support, then you have a better chance to win."

It was guidance that she thought about often as a medical student and as one of just a few women in her class. She observed she wasn't alone as either a female or an African American. She watched how other women handled being in the minority. She said she adopted a combination of styles she witnessed and admired from her female peers.

She recalls that she also intentionally worked to radiate authority through her appearance. "Sometimes I would dress in a power mode. I readied myself to self-protect from the racism and the sexism in the profession. In doing so, when I spoke, I spoke with authority."

Her peers not only influenced the demeanor she would adopt as she faced potential discrimination as an African American female physician, but also in choosing the path to become a DO. "There was one colleague who was a year ahead of us who introduced me to osteopathy. He would come to our pre-med meetings and give us information about why we should choose osteopathic medicine over allopathic medicine. It was through him that I became interested in becoming an osteopathic physician."



Dr. Owens receiving her degree from MSUCOM in 1979.

Continued





In Honor of Black History Month:

Spotlighting ACOI Fellow, Cynthia D. Owens, DO, FACOI

(Continued)

Proud of the Past; Ready for Future Change

With her unique perspective as an African American female triple board-certified osteopathic internist, has she ever found herself in a battle that she couldn't win? She emphatically says "no." Were there challenges along the way. Yes! She recalls being the only African American female on staff at the hospital she began working at in Pascagoula, Mississippi, in the early 1990s. "I could count on one hand the number of doctors that made me feel welcome. There were four."

She acknowledges that racism is still a battle in the country and believes that despite all the challenges there's much for African American physicians to take pride in. "Regardless of all the disparities that have occurred, African Americans have made a lot of strides in the field of medicine. We are inventors. We are researchers. We are great clinicians, and we provide mentorship for those coming behind us," she says.


After her nearly four decades in medicine she takes pride in the recent dialogue around African Americans. "We're now talking about a century-old problem of racism in the profession – and many people are now willing to look at it and develop programs within the different medical schools to address the unconscious bias that exists so prevalently in medicine that we all have. And from discussion comes action!"

It is from that hopeful perspective she is looking toward the future and the responsibilities ahead to create change.

"There's so much that we need to erase; just dealing with the statistics that have been wrong and too many people thinking that African Americans have a genetic makeup that's completely different which is the reason why they're more prone for different diseases. So much of that needs to be revamped; it's going to take a long time for that to happen—we need to start by rewriting the textbooks."

For her own actions she believes that her focus on being the best physician she could be allowed her to excel. "When I'm working, it's like having the blinders on a horse. It just forces you to look straight in front of you. You don't look to the right or to the left, you just seem focused on what you're doing. And that's what I've done all these years."

So what is Dr. Owens' advice for students today? "I will tell them to never forget their reason for going into medicine; remember you are not alone, and remember to care about your colleagues – ask the five words that could change their day, 'How are you doing today?'"

She says it is also important to recognize that it is not a field where you will receive a lot of thank yous, yet she proclaims she wouldn't trade it for anything. "I still think it's a beautiful profession to be a member of. It's still a childhood dream that came true for me!" 



How We Address Unconscious Bias in Healthcare

Charlene A. LePane, DO, FACOI and Suzy M. Espinosa, BA, MSHIA, DHSc(c)

Upon graduation from medical school, during what is commonly known as a “white coat ceremony,” physicians (DOs and MDs) take an oath which signifies a passage from student to practitioner of medicine. These recitations bind providers to their vocation. Within these oaths are captured the ancient, but still relevant promises to not harm patients, to strive for their general welfare, and to abide by the sciences that have molded the practice of medicine. Modernizations of these oaths attempt to take into account the ethical issues of contemporary medical practice and society. A concept that is continuing to mold the content of these oaths and evolving the dialogue of medical ethics, is cultural competence. In order to deliver culturally competent care, we must discuss topics such as unconscious bias and the continual development of a medical practitioner’s knowledge, attitude, and skills.

Unconscious biases are present within every human being. Our observable environments are constantly asking us to make associations between ideas, places, things, and people. We sometimes unknowingly develop opinions during this continual recalibration of perceptions. The trick is to be aware of this part of thought formation. Development of this awareness is a skill to be continually honed—it is not a static thing.

Conversely, conscious bias is an explicit form of bias based on one’s discriminatory beliefs and values. Our brains are continually processing and discriminating, making judgments to change lanes, avoid difficulty, and choose x treatment over y.

Discriminating thought is healthy and vital to our survival. Discrimination in a social sense, of course, is not. When the brain’s skill to discriminate bleeds into ideological and belief systems, we leave ourselves open to behaving in discriminatory ways. If left unchecked, unconscious biases could solidify into the conscious realm of discrimination. Conscious and discriminatory bias actively goes against the very ethos of medical practice. Assessing conscious as well as unconscious biases with healthcare providers involves a continuous commitment to provide the tools to exercise the “awareness muscle.” This is where we can use recommendations from respected organizations such as Franklin Covey, as a pathway for providers to lead self, lead others, and lead results.

Assessment of bias is not a straightforward exercise. A good bit of published literature demonstrates a worldwide prevalence of unconscious bias surrounding issues of race/ethnicity, patients with HIV, patients with disabilities, gender, low socioeconomic status, older age, obesity, and patients with polysubstance abuse. Clinical judgment of providers and their behavior toward patients is affected by these biases. The difficulty in calculating these effects demonstrates a significant need for the development and teaching of strategies to mitigate the effects of unconscious bias. One such way to subjectively calculate behavior is to task each provider with performing a deliberative reflection on their own potential for bias.

Our strategy to counter bias should require an intentional approach that operates parallel to our strategy to increase diversity, equity, and inclusion. Because of the developmental nature of these efforts, we must adopt a long-term strategy with measurable way points. We can start with affecting change so that providers begin to lead themselves, then lead others, and finally to lead results.

A final consideration is to expand the thinking to involve the whole care team. Providers must work seamlessly with their clinician colleagues and treat patients from all cultural backgrounds. These changes will only be as effective as the breadth of the seeds we sow now. We have a tremendous opportunity to weave this work into our already embedded and well-espoused service standards as providers who serve the sick.

In summary, the overarching strategies to mitigate bias in our encounters with patients should include education and interactive feedback. We must incorporate these strategies into our service standards and make them part of the ground rules of our onboarding and continued professional improvement. To be considered one of the most trusted and essential health partners to the communities we serve, it’s imperative we promote greater diversity, equity, and inclusion with consistency over time. Developing a program to train our healthcare providers is just the first step in extending to our patients a future of respect, understanding, dignity, and empathy. This is what our white coats demand. ●



Leveraging the Unique Influence of Physician Leadership Skills & Knowledge

A Conversation with Karen J. Nichols, DO, MACOI, about Physician Responsibilities in Leading Beyond the Bedside



Check out the latest episode of ACOI's podcast series, *Docs off the Clock*, featuring **Karen J. Nichols, DO, MACOI**.

The latest episode of ACOI's podcast series, *Docs off the Clock*, features Karen J. Nichols, DO, MACOI and her passion for effective physician leadership. She shares her thoughts on why it is crucial for physicians

to tap their education and relationship building skills to exert the leadership that only they can provide in moving health systems forward and in shaping the government's approach to healthcare.

"From my perspective, every single physician is a leader. It's what we're trained to do and how we approach every patient. And the interesting perspective is that as a physician, we bring a particular view to medicine that is not part of how other leaders are trained in medicine," says Dr. Nichols. "So it's really important that physicians be involved in leadership. We have a responsibility to move into other arenas and serve as leaders with our physician background."

Dr. Nichols breaks down for listeners the importance of understanding how there are some learned clinical skills that are easily translated into leadership skills and other skills that physicians possess but don't recognize and develop. She advises physicians to take advantage of leadership opportunities provided by the ACOI and others because "you can always learn more."

One place where physicians can learn more is [her new book](#), "Physician Leadership, the 11 Skills Every Doctor Needs to Be An Effective Physician Leader." She details how the clinical skills physicians have mastered can help them become amazing leaders and why some of those skills don't automatically translate into being a skilled leader. She also discusses the challenges physicians face in developing those skills and how to overcome them.

Tune in to *Docs off the Clock* to hear more about physician leadership from one of ACOI's pioneers in women's medicine. Dr. Nichols was the first woman to serve as ACOI's President, leading the organization from 2000-2001.

Don't forget to check out [our previous episodes](#), available wherever you get podcasts!



What is Docs off the Clock?

Discover the ACOI's podcast series where our members and other experts share their knowledge on a variety of topics relevant for physicians today. Made for busy doctors who may only have a few minutes to listen in the car, on a jog, or even on a lunch break between patients, each podcast episode is designed to enrich members with information especially for them. Spend a few minutes with [Docs off the Clock](#) and get some quick tips from our guests who share their thoughts on subjects like practice management, physician wellness, specialty medicine geared toward internists, updates on the COVID-19 pandemic, CME attainment, and more. It will soon become your favorite podcast!



In Memoriam



It is with great sadness that we report the passing of W.W. Stoever, DO, MACOI on February 9, 2022. Dr. Stoever was an active member of the ACOI from 1969 until his passing and served as ACOI President from 1991-1992. In 1994, he became one of the first Master Fellows in ACOI history.

Dr. Stoever graduated from the Kirksville College of Osteopathic Medicine in 1961 and went on to be board certified in both Internal Medicine and Cardiology. He spent his entire career in Tulsa, OK, at the Oklahoma State University Medical Center and had a great love for teaching residents and fellows.

Dr. Stoever is remembered by his peers as follows:

“We lost a legend today. Dr. Stoever was my mentor, my hero and my friend.”

— Damon L. Baker, DO, FACOI, ACOI Board Member

“W.W. Stoever had a huge impact on my career. I learned so much from him. He was also the person who nominated me for a position on the ACOI board, when I was only four years out of residency. They truly broke the mold when he was born. He is sorely missed!”

— Karen J. Nichols, DO, MACOI, ACOI Past President

“Dr. Stoever was held in high esteem by his contemporaries of which I am one. Condolences to his family.”

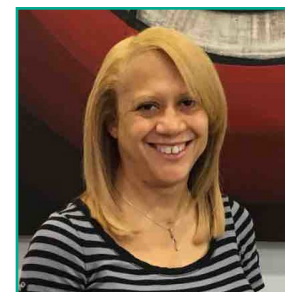
— Anthony J. Malcoun, Sr., DO, MACOI, ACOI Past President

“Dr. Stoever was one in a million. His love of Osteopathic Medicine, teaching and ACOI was beyond amazing. He definitely will leave a great legacy with all those he taught!”

— Susan B. Stacy, FACOI, ACOI Director of Administration and Meetings

Wellness Spotlight: Janet Cheek, DO, FACOI

It has been a trying two years with so many of our members working long hours and finding it challenging to enjoy hobbies or take time to take care of themselves. So, what are members doing to enjoy their free time? During #ACOIZ2021 we checked in with ACOI member, Janet Cheek, DO, FACOI, and asked her how she winds down. She said she loves to cook and that her boyfriend is always happy to try out her recipes as she experiments in the kitchen. She also told us how she has stayed connected to her community outside her hospital work:



“During the height of the COVID-19 pandemic I stayed active by being extremely involved in the community. I’m a committee chairperson on the Rotary Club and I am on my HOA board. I am a founding society member of the Tulsa Ballet too. So even during the pandemic, we were doing Zoom ballet shows, Zoom meetings of the ballet, and doing Zoom meetings for my Rotary Club. Our Rotary Club never stopped. We did virtual meetings throughout the entire pandemic. We were the only club in the area for our district that didn’t stop and did not miss a meeting.”



Government RELATIONS

Timothy McNichol, JD



Washington in Brief

While numerous matters remain before Congress, it is likely to focus on a must-pass governmental spending package over the next few weeks. The House and Senate recently approved bi-partisan legislation to extend funding for the government beyond February 18. This legislation maintains current funding levels through March 11. This will allow for continued negotiations on a comprehensive spending package to fund the government through the remainder of the fiscal year. It is likely that the Senate will follow suit shortly. It is also expected that the President will announce his nomination to replace retiring Supreme Court Justice Stephen Breyer in the coming weeks, setting off a confirmation battle in the Senate. The ACOI will continue to closely monitor issues of importance to physicians and the patients for whom they provide care. ●

Senate Confirms FDA Chief

The US Senate narrowly confirmed Dr. Robert Califf, a cardiologist, as Commissioner of the Food and Drug Administration (FDA) by a vote of 50-46.

The vote was mostly along party lines. Opposition to his nomination came from both sides of the aisle due to concerns over his role in the approval of opioids, ties to the pharmaceutical industry, and his position on access to birth control. Dr. Califf previously served as FDA Commissioner in 2016. He replaces acting FDA Commissioner Janet Woodcock and becomes the first permanent head of the agency in 13 months. Dr. Califf spent most of his career at Duke University School of Medicine where he founded the Duke Clinical Research Institute. ●

More Than \$2 Billion Distributed in Provider Relief Funds

The Department of Health and Human Services (HHS) recently announced the release of more than \$2 billion in Provider Relief Fund (PRF) Phase 4 General Distribution payments. The payments were made by the Health Resources and Services Administration (HRSA) to more than 7,600 providers across the country. In a statement released by HHS, it notes that this most recent funding brings total funds provided to providers to offset the impact of the COVID-19 pandemic to over \$18 billion in PPF and American Rescue Plan Rural (ARPR) funds in the last three months.

According to Secretary Xavier Becerra, “Provider Relief Fund payments have served as a lifeline for our nation’s heroic health care providers throughout the pandemic, helping them to continue to recruit and retain staff and deliver care to their communities.” Additional information about these funds is available [here](#). ●

Resident Training in Rural and Underserved Areas Expanded

The Department of Health and Human Services (HHS) announced it will provide \$19.2 million to help support and expand residency training programs in rural and underserved communities. The recently announced funding is part of the American Rescue Act and will be awarded by the Health Resources and Services Administration through the Teaching Health Center Graduate Medical Education (THCGME) program. It is estimated that the announced funding will support approximately 120 full-time resident positions. This will support the growth of the primary care workforce and provide additional opportunities for health care providers to train in underserved communities. Additional information is available [here](#). ●

Continued





Government RELATIONS (Continued)



Guidance on Civil Rights Protections for People with Disabilities Announced

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) recently announced new guidance to help health care providers know their obligations under federal disability rights laws during a public health emergency (PHE). According to the released guidance, federal civil rights laws continue to apply during a PHE, such as the COVID-19 pandemic. As a result, health care providers remain subject to enforcement actions for discrimination that occurs on the basis of disability. The guidance states in part, “When allocating scarce resources or care in a public health emergency, covered entities must analyze the specific patient’s ability to benefit from the treatment sought, free from stereotypes and bias about disability, including prejudicial preconceptions and assessments of quality of life, or judgments about a person’s relative ‘worth’ based on the presence or absence of disabilities.” Additional information on the recently released guidance is available [here](#).

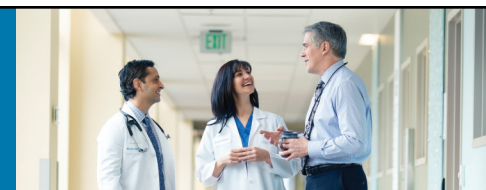
Washington Tidbits

Trouble on the Potomac

On February 28, 1844, the USS Princeton, commissioned just months earlier, made its way down the Potomac River with more than 400 passengers on board. The naval ship was equipped with a brand-new 27,000-pound cannon nicknamed the “Peacemaker.” After two successful firings of the cannon, a fateful decision was made to fire the barely tested cannon a third time for the gathered guests.

The third firing of the cannon occurred not far from Mount Vernon in honor of George Washington. Tragically, the cannon exploded killing six and injuring more than 20 others. Fatalities included Secretary of State Abel Upshur and Secretary of the Navy Thomas Gilmer, among others. Those surviving the tragic mishap, among others, were former First Lady Dolley Madison and then US President John Tyler.

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CODING CORNER

Split and Shared Visits

Jill M. Young, CPC, CEDC, CIMC



The published changes for billing Medicare for split and shared visits have garnered a lot of attention as of late. To this end, I have spent a great deal of time educating providers about the new requirements that will assist in efforts to properly document and bill for these services.

The 2022 Medicare Physician Fee Schedule Final Rule provides detailed information on the new requirements that will take effect in 2022 and 2023. These changes are significant and may impact the flow of patient care and chart documentation, which may require adjustments to your practices. There are also potential financial implications related to this change.

Practices that utilize nurse practitioners (NPs) and physician assistants (PAs) often rely on split or shared visits. Current Procedural Terminology (CPT®) 2021 defines a split or shared visit as the following:

“A visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time.

Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).”

CPT’s definition, however, did not address several areas of importance to the Centers for Medicare and Medicaid Services (CMS). Therefore, in the Final Rule, the Centers for Medicare and Medicaid Services (CMS) additionally defined a split or shared visit as:

- An evaluation and management (E/M) visit, furnished in a facility setting
- The facility setting was defined so as to exclude the office, nursing facility [not skilled nursing facility], and assisted living setting for split or shared visits (the definition excluded locations where “incident to” services are allowed)
- Performed by a physician and a non-physician provider (NPP) in the same group
- A substantive portion of the visit was finalized as “more than half of the total time spent by the physician and NPP performing the split (or shared) visit”

As always, proper documentation is key.

Documentation is required by the billing provider to identify who was involved in the patient encounter. This ties the two notes for a particular service billed in a manner not previously mandated. All aspects of this re-definition of policy begin January 1, 2023, while 2022 will be a year of transition with two definitions of substance allowed.

The importance of this change is significant. In 2023, to verify that a split or shared visit has been billed under the correct provider, a simple review of the documentation must be conducted to identify two providers and the amount of time spent by each. This assumes the collective documentation supports the level of service billed.

CMS gave physicians a break in 2022 by allowing both the new definition of substantive and one similar to what was in place in 2021. The substantive portion of the visit for 2022 only will be defined as **completely** performing one of the three key components (history, exam, or medical decision making (MDM), or more than half of the total time spent by the physician and NPP performing the split or shared visit. CMS clarified that “when one of the three key components is used as the substantive portion in 2022, the practitioner who bills the visit must perform that component in its entirety to bill.” For example, if MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner **must perform all portions or aspects of MDM that are required** to select the correct level of service for the visit.

Examining the changes in your practice’s workflow in response to this policy change brings into consideration those services where the physician may previously have had minimal interaction with the patient and allowed the NPP to take the lead.

Continued





CODING CORNER

(Continued)



In many of these care scenarios, documentation by the provider who performed the substantive portion of the patient's care would have been the NPP. In accordance with the above guidelines, the substantive provider (the NPP) would now be the provider to bill the visit. This will result in a payment differential of 15 percent had the same service been billed as physician services. While there will be a loss of reimbursement for the service provided, the provider who performed the substantive portion of the service is appropriately paid.

Although a modifier is required to identify split or shared visits, as of this writing one has not been formally identified. The Final Rule indicates the modifier is important for program integrity and quality considerations. CMS wants to have a way to identify who provides which E/M service, and how often they pay the physician rate for services provided in part by NPPs. As a result, providers will need to implement a policy to ensure that visits billed as split or shared visits use the required modifier. To bill without the modifier would be a misrepresentation of the services billed, regardless of which provider's name is on the submitted claim.

In large institutions with multiple practices, each using nurse practitioners (NPs) and physician assistants (PAs), the submission of multiple claims for patients with providers that are all of one type, (NP or PA) is an issue.

Whether or not one uses split or shared billing, more than one claim submitted to Medicare by different NPs in different practices and specialties, when billed under the same Tax ID, are viewed as one provider, just as they are with physicians in the same specialty. Medicare's policy for multiple claims of this type is to pay one and reject the rest as concurrent care. The same is true whether if it is a NP who submits multiple claims for visits on the same patient or for a PA who submits multiple claims for visits. If the claim is submitted under the same Tax ID, it is an issue. The first one to submit their claim for a specific patient for a specific date of service will receive payment, and the rest will be rejected. This is because NPs and PAs do not have specialty designations from Medicare. My local Medicare Administrative Contractor (MAC) indicated they are aware of this issue but are unable to change it as it is a Medicare policy that would have to be modified by Medicare. On a recent peer to peer group call with our MAC's education group, others indicated they are appealing denied claims. As of this writing, none had been successful in this effort. ●





Hints From **HERMANN**

Incorporating OMM Into Your Practice

Jodie Hermann, DO, FACOI

ACOI Osteopathic Manipulative Medicine Committee



The COVID-19 pandemic has been here for almost two years. As physicians and medical providers, we have been challenged with re-learning how to think things through. We've had to use our observations and try treatments we know with something new we've been seeing and observing. We weren't sure of the cause and mechanism and had no real idea of the possible end points and outcomes. We were jarred out of the world of evidence-based medicine and jammed into the world of the art of medicine.

As patients were being admitted for respiratory problems creating hypoxia and we were just beginning to get an idea of the treatment plans, life expectancy, and new types of oxygen delivery, I was blessed with a patient of my own whose admitting chief complaint was shortness of breath.

By all the data points gathered, he had acute hypoxic respiratory failure. By osteopathic structural exam his thorax was tight, ribs with limited movement, lymph system blocked up, and diaphragm hypertonicity. The arterial and venous system were moving and all the while the patient was a chatty Cathy. A review of risk factors determined he was not a smoker, he did not have COPD, he had no hypertension, and no DM. He had a business of driving people in limos or buses. His most recent trip was to DC with 12 college students for an a capella competition. Two weeks prior, he had a bus load of international people here for a conference, some from Africa.

No one with COVID-19 or otherwise sick. Cervical lymphadenopathy was evident as there was a golf ball sized node at the right thoracic inlet, movable. A chest x-ray showed hilar and mediastinal lymphadenopathy. He was treated for pneumonia, although there was no clear infiltrate. His oxygen saturation kept worsening, and a review of this 63-year-old male's code status and goals of care showed his directive was "Go for it!" It was the weekend with limited hospital resources, and I almost had to intubate. I asked my team and other physicians around me for thoughts, ideas, and insights. I looked at all data, parameters, and possibilities. I checked more outlying second, third, and fourth layered differentials with labs and imaging. I planted a PPD and put him in isolation. His CT thorax looked like polka dots thrown throughout his chest, negative for PE. I kept him off the ventilator, maxed out on an oximixer. I increased his antibiotic coverage, steroids, and nebulizers and looked for reason he could be immune compromised. He was negative for COVID-19.

I was back to the art of medicine. The test of clarity finally presented itself. He was HIV positive. Then more results came—B cell lymphoma. EBV positive. CMV positive. PJP positive. Finally, CD4 count: 12. He trusted me all along. His breathing did ease up, 6L NC. Outside resources were coming in.

He did recall a trip he took during which, at an evening party, he may have had an unprotected sexual encounter. He was hesitant to tell his wife, as the marriage wasn't good. But if he didn't, I would have. It's a reportable disease. The thorax began to move more freely, the CRI more expansive. Treatment adjusted to the information we found. The patient was content under the circumstances.

In the 1980s this was the pandemic, the mystery, the disease taking lives at a rapid rate. Physicians and medicine were running blindly. The parallels did not go by unnoticed. The feeling of ineptitude, the struggle to find the information, the data points, and treatments to help individuals keep their lives and see the gift of life anew. To live for their purpose. To keep the breath of life. I, as a physician, am incredibly blessed and thankful for all who contribute to this field. Even in times of blindness, I know we are all here together. 🌟



2022 Certifying Examination Dates & Deadlines

AOBIM Initial Subspecialty Certification Exams

Remote Online Proctoring
August 18-20, 2022
Application Period: February 21 - July 18, 2022
First Application Deadline: June 18, 2022
Final Application Deadline: July 18, 2022

AOBIM Subspecialty OCC (Recertification) Exams

Remote Online Proctoring
August 18-20, 2022
Application Period: February 21 - July 18, 2022
First Application Deadline: June 18, 2022
Final Application Deadline: July 18, 2022

AOBIM Initial Certification Exam

Remote Online Proctoring
September 20-22, 2022
Application Period: March 18 - August 18, 2022
First Application Deadline: June 18, 2022
Final Application Deadline: August 18, 2022

Application materials are available on the AOBIM's [website](https://www.aobim.org). Contact the AOBIM at aobim@osteopathic.org for additional information.

ACOI National Meetings

2022 Virtual Spring Meetings

Internal Medicine Board Review Course
May 10-14 • Approx. 45 Credits

Hospital Medicine Update
May 11-14 • Approx. 25.75 Credits

Subspecialty Focused Meeting
May 12-14 • Approx. 19.75 Credits

All meetings are certified for AOA Category 1A /
AMA PRA Category 1 Credits™.

[Click here](#) to register for ACOI's 2022 Virtual Spring Meetings!

2022 Annual Convention & Scientific Sessions

October 19-23
Baltimore Marriott Waterfront Hotel, Baltimore, MD

2023 Annual Convention & Scientific Sessions

October 11-15
Tampa Marriott Waterside Hotel, Tampa, FL

2024 Annual Convention & Scientific Sessions

October 9-13
Kierland Resort, Phoenix, AZ

Please note: It is an ACOI membership requirement that Active Members attend an ACOI-sponsored continuing education program at least once every three years.

Information on any meeting listed here may be obtained from ACOI Headquarters at 800 327-5183, or from our website at [acoi.org](https://www.acoi.org).



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