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A letter from our President

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Teachers of medicine take pride preparing the next generation of physicians for their future, training those who will be our leaders of healthcare. Many have started programs, following well-accepted standards, while many have been stewards of more established programs, graduating hundreds of residents over the years.

Then, seemingly overnight and without reason, these teachers are considered unqualified to lead their programs, without rational thought, and their lifelong work is taken away because they are judged to have inferior credentials. This is the struggle that has resulted for many osteopathic internal medicine physicians as an unintended consequence of single accreditation.

For some background, in 2014, the American Osteopathic Association (AOA), Accreditation Council for Graduate Medical Education (ACGME), and American Association of Colleges of Osteopathic Medicine (AACOM) entered into an agreement that consolidated all graduate medical education into a single accreditation system.

Central to the agreement was that AOA-certified program directors retained the ability to certify candidates who met the requirements for each subspecialty. All specialty and subspecialty boards agreed to have osteopathic certified program directors certify eligibility for allopathic boards; except one, the ABIM.

For AOBIM-certified program directors, this has been devastating. Through the transition to the single accreditation system, program directors have assisted their hospitals in making the change from AOA to ACGME accreditation requirements, and at the conclusion of training, have certified that residents have met these requirements.

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As with every other certifying board, it was expected that the ABIM would recognize the significance of this historic merger and grant equivalency to AOBIM-certified program directors. Yet, in March 2020, the ABIM affirmed no such equivalent authority would be granted.

While internal medicine residents have the option to select ABIM or AOBIM certification at the culmination of their training, program directors who are AOBIM-certified will not be allowed to certify the training of their residents and fellows for ABIM eligibility. To provide residents this choice, these program directors are forced to obtain ABIM certification or risk losing their jobs.

It is clear that AOBIM-certified program directors are equally qualified as ABIM-certified program directors to attest to the training status of their trainees to sit for either the AOBIM or the ABIM certification exams.

The ACOI has been working with the AOA on a response to this unfair and discriminatory ruling by the ABIM.

Continued
For the past several years, ACOI has been working closely with AOA staff and outside counsel to prevent the damaging impact of this requirement by the ABIM. These actions led to the AOA and seven osteopathic internists and subspecialists filing a lawsuit against the ABIM on December 30, 2020. The AOBIM-certified program directors who initially joined the lawsuit are Joanne Baker, DO; Jody Bentley, DO; Erica Kuhn, DO; Judith Lightfoot, DO; Katrina Platt, DO; Troy Randle, DO; and Keith Reich, DO. In addition, I have spoken to many others who have been affected, although have not yet joined the suit. All were put in the same position and are forced to either take the ABIM exam or lose their jobs.

The ACOI strongly supports the AOA’s efforts to move this discussion to the courts, as there has been no explanation given why the ABIM stands alone amongst credentialing boards in their decision. We thank Kevin Klauer, DO, EJD and the AOA Leadership for their steadfast support to correct this affront to our profession. In this newsletter, you will find the details of this lawsuit outlined by Deputy Executive Director, Tim McNichol, JD.

We are proud of the ACOI collaboration with the AOA and are equally proud to support our members and help bring this lawsuit to fruition. It is our greatest honor to all of us as an organization to protect our profession and advocate for our osteopathic internists, and we are hopeful for a reasonable outcome in this matter.

Michael A. Adornetto, DO, MBA, FACOI
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Residents:
March AOBIM exam registration closes 2/12/21!

Everything You Need to Know to Register for the Early Entry Pathway AOBIM March Exam!

As osteopathic internists know, the AOBIM exam is the GOLD STANDARD for up-and-coming osteopathic internists. Here are some quick facts to help see if you are qualified to take the exam and how to register before the deadline of February 12.

- **Who is eligible to take the Early Entry Exam?** 3rd year internal medicine residents.

- **Why take the early entry exam?** Provide yourself some much-needed stress relief by getting your certification exam done this Spring! It’s one big thing to mark off your to-do list. The AOBIM offers this special opportunity to take the exam in the Spring, sooner than the typical fall date, to allow Residents who are juggling many demands to complete this requirement sooner. Plus, it is a great way to see where you stand without the stress of waiting until the Fall!

- **Can I take the AOBIM again in the fall if I take it in the Spring?** Absolutely! And, you’ll be even better prepared and more confident having taken it in the Spring.

- **What are the important dates to know?**
  - Register for the early pathway exam by **February 1, 2021** to avoid late fees. The final deadline is **February 12, 2021**.
  - Early entry exam will be held remotely **March 1-6, 2021**.
  - Register for the fall exam by **August 6, 2021** to avoid late fees. The final deadline is **September 5, 2021**.
  - The fall exam will be held remotely in **September, 2021**. Additional information coming soon!

- **How can I prepare for the exam?** The ACOI 2019 Board Review Course is an excellent resource to prepare for the exam and can be purchased on the ACOI Online Learning Center. As a special bonus, anyone who purchases the 2019 Board Review will receive access to the 2021 Virtual Board Review Course for free! Both courses are available to everyone, even residents who are not yet eligible for the Early Entry Exam but what to get a head start on preparing.

- **Should I take the ABIM or the AOBIM?** The AOBIM is clinically equivalent to the ABIM and offers more options for recertification than does the ABIM, removing the high stakes pressure of the ABIM. Residents of osteopathic internal medicine are highly encouraged to take the AOBIM boards to help them stay on their path. You’ve made a commitment to the osteopathic world of medicine and statistics show more and more medical students are going in the osteopathic direction. In fact, there are more medical students now attending colleges of osteopathic medicine than ever before! We all know that the DO approach is a special one that considers a holistic viewpoint by creating a partnership with patients that, through a collaborative approach, helps patients live their best lives.
ACOI Heroes: Facing COVID-19

Dr. Walter Mickey Delivers Care Through All Obstacles
by Gina Kilker

Despite being quarantined from his wife and young children for months on end and fatigued by the number of COVID-19 patients in his ICU unit, ACOI member Walter Mickey, DO, FACOI soldiers on. An advocate for changing attitudes about mask-wearing within his community, he’s endured several months of personal and professional challenges. As a board-certified ICU intensivist in St. Louis, Dr. Mickey has been providing care for the most critically ill COVID-19 patients.

One thing is certain—he is not willing to potentially expose his wife of 15 years, Kelsey, to the virus. Kelsey suffers from ulcerative colitis, which is controlled by the use of immunosuppressants. “It’s pretty much one of the worst things you could be on when there’s a viral pandemic,” Dr. Mickey says.

While he takes extreme measures to keep his loved ones safe, he finds it frustrating to see so many others not taking the health crisis seriously. “I work in the ICU with COVID and the virus can be asymptomatic, so I don’t ever know if I have it. I can’t risk being in the same place with my family, so I turned my basement into a negative pressure space and I have been living there away from my wife and my three kids for nine months.”

When he went into self-imposed isolation, his now one-year old daughter could barely sit up. Now, months later, she is walking and running. He hasn’t been able to interact with her during any of those milestone moments. Instead, he has only seen his family either through Facetime or through the filter of a screen door. The one exception he made was when he ventured upstairs in full protective gear for a 15-minute visit with his baby daughter, Fiadh (pronounced Fee-Ah), to wish her a happy birthday.

Though Dr. Mickey has received both doses of the Pfizer vaccine, he notes that the lack of clarity on whether the vaccine can prevent the spread of infection means he could still carry the virus and infect others. He plans to remain in isolation until Kelsey can receive the vaccine. The timeline for her to receive it is currently unknown.

Supply Shortages and Future Uncertainty

At the hospital, Dr. Mickey and his team have had to endure continued shortages of testing kits and PPE. At one point, it was the testing swabs. At another, it was the reagents. The problem he sees is the limited number of companies that manufacture the needed supplies and components.

Dr. Mickey says he is thankful for his hospital’s lab director, who has built up the in-house testing infrastructure as quickly as could be expected given the unexpected appearance of COVID-19. Still, six months into the pandemic his entire ICU was receiving just eight rapid tests a week. Today, he says it is “markedly better” than it was at the beginning.

As for the worry about getting sick himself, prior to getting the vaccine, he says, “I had to get over that a long time ago. We all know going into medicine that there’s infectious diseases and that we’re going to come into contact with them and we have the potential to get sick.”

The difference, he noted, between this pandemic and the normal risk of being infected with an infectious disease in pre-COVID-19 times, is just how unpredictable COVID has been.
COVID-19: DOs in Action
(Continued)

Social media, however, provided the platform to offer him unique insights. “Through social media, we early on established an informal worldwide network of intensivists to be able to exchange information, ideas, and treatments.” The global professional camaraderie the Facebook exchange created was a bright spot at a time when it was needed most.

In the meantime, while his wife Kelsey carries on parental duties without him, Dr. Mickey is concerned that she hasn’t been able to do many of the things that other mothers can. “Since the pandemic hit, her life has essentially been a self-imposed imprisonment, so to speak. She takes the children on walks and to play outside, but because other people aren’t willing to take this seriously for the most part, she can’t really go anywhere—it’s just not advisable. So she has essentially been stuck in our house with very few exceptions since mid-March.”

Fighting COVID Misinformation

His concerns also extend to what he has personally encountered in the community; the attitudes toward masking troubles him. He attributes the propagation of misinformation and lackadaisical attitudes toward masking to the disjointed pandemic response on both the federal and state level.

“I’ve felt, personally, a distrust of us medical professionals to some extent. There were a lot of conspiracy theories floating around. People started accusing us of inflating the COVID numbers. We went from being the face of trying to help people to the face of some kind of oppression (with mask recommendations). People stopped wearing masks and they started having gatherings.”

As a result, the cases in the St. Louis area skyrocketed and the ICU filled with nothing but COVID patients. Hoping to provide education and context to his community, he turned once again to social media. “I have been extremely vocal, mostly through Facebook, to make people understand why it’s important to wear masks.”

He says these attitudes are baffling to him, especially when his nine-year-old daughter, Kaitlyn, succinctly summed up the problem for him one day: “Why won’t people just wear masks?,” she asked him. “Wouldn’t that make this all go away?”

Support in the Face of Condemnation

Without daily interaction with his family for support, Dr. Mickey says he is grateful for his colleagues who have been there for each other from the beginning. Between texting and phone calls, they find comfort in commiserating with one another. The group was especially valuable to him when he experienced one of the most disturbing episodes of his career thus far.

Dr. Mickey received a phone call from a member of his community accusing him of wanting to control other people’s behaviors and of fear mongering, as well accusations that he is personally profiting from the pandemic. “She was outraged because I was vocal about public health measures as I informed people about why it’s a bad idea to have Halloween parties and why it’s a bad idea to not wear protective masks. I try to educate people that the numbers are going up and, no, this is not because we are doing more testing! It was Neil deGrasse Tyson who said ‘The good thing about science is that it’s true whether or not you believe in it.’”

With misplaced community outrage, rising cases, and continued isolation, what keeps Dr. Mickey motivated to keep going? He says that it comes down to numbers and realizing that his profession comprises a very small group of healthcare providers—there are just over 30,000 ICU intensivists for a population of over 325 million in the U.S. He feels he has a crucial responsibility to use the training and the knowledge that he has. “If I don’t do this, who will? That is what keeps me moving forward.”

Dr. Mickey poses with his daughters Kaitlyn and Molly during a short family visit.
Living Our PRINCIPLES

As many ACOI members are experiencing, the COVID-19 pandemic has brought Principle-Centered living to the forefront. Throughout 2021, we will not only continue to focus on our members’ stories as the pandemic continues, but we will also highlight how Principle-Centered Medicine™ is playing a pivotal role in our members’ lives.

1. Focus on Health and Well-Being

Doctors of osteopathic medicine are trained to think and act in a way that has become an instinctive part of the care they provide. At ACOI, those tenets are the heart of Principle-Centered Medicine™. ACOI member Walter Mickey, DO, FACOI urges members to focus on their own health and well-being (Principle 1) during this challenging time by speaking out if they need support, not only for their own benefit, but to be in the best possible position to provide optimal patient care. He and his associates also created and leveraged meaningful and pervasive relationships (Principle 2) and support each other through the challenges they each continue to face.

In the words of Dr. Walter Mickey:

“If there are other providers who are anything like me, they may feel like they are completely alone during this pandemic. The biggest thing I would want other doctors to know is that we are not alone. We are an entire profession of individuals that are facing the same unknown, the same uncertainty, the same fear, the same common enemy, in this virus, that is causing this suffering on a scale that most of us have never seen before in our careers.”

“We have to support each other! If we don’t, that’s when we’re going to get in trouble as individuals and as a profession. We should not be afraid to speak up and say what we’re feeling. A lot of times doctors are taught to distance—that’s not as true though being a DO! Thankfully, that’s one of the things that attracted me to osteopathic medicine. It is the more holistic approach. But, in general, we’re taught to some degree to distance ourselves—to not feel—because we have to go on to the next patient. But we are human, and we cannot survive by distancing and not feeling.”

“We have to be able to speak up and say what we’re going through, to say how it’s affecting us, to ask for help if we need it, and certainly to not be ashamed of the anxiety, stress, and the fear. We also can’t be afraid to reach out to our colleagues for help or, if they look like they may need help, to ask them how they are doing and really mean it! We need to take the time to listen to each other and make sure that our colleagues are doing okay.”

“Physician suicide is a huge issue in medicine and I am afraid of what is going to happen as this pandemic continues. One of the doctors in our hospital recently committed suicide. While I didn’t know him very well personally, I’ve not yet heard a single person say, ‘Oh, yeah he was going through a lot.’ I think, in our profession, we are reticent to speak to our own mental health and that is the worst thing we can do. We have to recognize our own humanity to be able to serve the patients and to be able to make it through this.”

2. Create Meaningful and Pervasive Relationships

3. Practice Deep Listening

4. Embrace Wholeness

5. Recognize the Health Potential Within Us

6. Address Complexity

7. Find and Maintain Balance
Many of us had blessings in 2020, along with hardships. We can only bring the lessons and insights forward with us into the current moment and the moments that follow. We begin the year with hopes of a better 2021. ACOI has taken a great effort to remind us, as osteopathic physicians, to remain true to and in recognition of the tenets of Osteopathic Medicine and the 7 principles of Principle-Centered Medicine™.

This is a year to take us on a journey of remembering, enacting, and embracing the basic foundation of osteopathic medicine that translates into being a physician in any specialty.

For this column, we will be focusing on incorporating those two components into Osteopathic Manipulative Medicine.

Remember the Osteopathic Tenets as approved by the American Osteopathic Association House of Delegates:

1. The body is a unit; the person is a unit of body, mind, and spirit.
2. The body is capable of self-regulation, self-healing, and health maintenance.
3. Structure and function are reciprocally interrelated.
4. Rational treatment is based upon and understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function.

And the 7 principles of Principle-Centered Medicine™:

1. Focus on Health and Well-Being
2. Create Meaningful and Pervasive Relationships
3. Practice Deep Listening
4. Embrace Wholeness
5. Recognize the Health Potential Within Us
6. Address Complexity
7. Find and Maintain Balance

This year I will take you on a journey each month that helps us all to remember and realign with what drew each of us as individuals to the profession and how we are given the gift and opportunity to translate it to those around us. This includes our patients, our health care team, our friends, and our family.

This column is interactive and inclusive. We want to hear from all of you. Where has your life led you? Where have your hurdles been? What are your challenges? What are your strengths? How are you creating and sustaining balance in your world? Ask questions—share pearls. We embrace all topics that you have: the practice of medicine, the application of medicine, the view of osteopathic principles within the practice, integration of osteopathic manipulation, research, etc.

Take my hand as we venture through this next year learning more about OMM. Build strength and inclusivity for all of those around us. I look forward to our journey together!

Jodie Hermann, DO, FACOI is Chair of the Osteopathic Manipulative Medicine Department and Assistant Professor at the University of New England College of Osteopathic Medicine.

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Washington in Brief

The 117th Congress convened on January 3. With the conclusion of the runoff elections in Georgia, Democrats hold the majority in both the House and the Senate, in addition to the White House. Following President Joseph R. Biden’s inauguration, Congress must now turn its attention to a multitude of pressing issues. First on the agenda will be efforts to advance a COVID-19 relief package to provide direct financial assistance and funds to assist in the distribution of vaccines, among many other things. In addition, the Senate must consider nominations to multiple positions for the new Administration, as well as respond to the articles of impeachment approved by the House on January 13 against former President Donald J. Trump. The ACOI will continue to closely monitor these and many other issues that directly impact you and the patients for whom you provide care.

Suit Filed Against the ABIM

The American Osteopathic Association (AOA) and seven osteopathic internists filed a lawsuit against the American Board of Internal Medicine (ABIM) in the United States District Court for the Eastern District of Pennsylvania on December 30, 2020.

The transition to the Single Graduate Medical Education (GME) Accreditation System has had a significant impact on the training of future osteopathic interns and subspecialists. One potential impact is on American Osteopathic Board of Internal Medicine (AOBIM) diplomates who serve as program directors. The ABIM indicated that beginning in 2022 it will require that the attestation of trainee competence for initial ABIM board eligibility may be made only by a program director who is ABIM-certified. Upon learning of this intent several years ago and recognizing the negative impact on osteopathic interns and subspecialists, ACOI immediately began collaborating with the AOA to prevent implementation of this blatantly discriminatory policy. This was met with intermediate success, as the policy was postponed until 2018. However, despite ongoing efforts by AOA and ACOI, the policy was implemented in 2020 and AOA decided that legal action was necessary.

The tortious interference lawsuit challenges the ABIM policy requiring that program directors be ABIM-certified in order to attest to trainee competence for initial ABIM certification. This unjust and indefensible policy ignores the qualifications of program directors certified by the AOBIM and is a direct affront to highly trained and skilled osteopathic physicians certified by the AOBIM. The ABIM stands alone as the only specialty board that does not recognize osteopathic board certification as equivalent.

The direct impact of this policy is that program directors who are certified by the AOBIM must either become certified by the ABIM or lose the ability to attest to the training of their residents who wish to sit for initial ABIM certification. Absent either a change in the ABIM policy, or the attainment and maintenance of ABIM certification, AOBIM-certified program directors will be at risk of losing their jobs or making their programs less competitive by only being able to certify trainee competence for AOBIM certification.

The ABIM’s rule pushes training programs to seek ABIM-certified physicians to serve as program directors, thereby disenfranchising physicians who are certified by the AOBIM. Further, AOBIM-certified program directors will be forced to seek ABIM certification to fulfill the crucial role of qualifying their graduates, DOs and MDs alike, for board certification.

Residents will effectively be directed toward ABIM rather than AOBIM certification because of the competitive disadvantages for AOBIM diplomates created by this rule.

Continued
The lawsuit requests the court issue an injunction against the ABIM to bar it from implementation of its requirement for ABIM certification to attest to trainee competence for initial ABIM board eligibility and asks the court to award damages in response to injuries caused by the ABIM’s actions.

The ACOI continues to actively support this action and offers our gratitude to the AOA and the seven individual physicians who currently serve as either program directors in internal medicine or an internal medicine subspecialty who brought this important lawsuit. Contact Deputy Executive Director Timothy W. McNichol, Esq, with any questions or comments. The ACOI will continue to update you on any developments in this important matter.

Omnibus Funding and COVID Relief Package Signed into Law

President Trump signed into law the “Consolidated Appropriations Act of 2021” on December 22. The comprehensive package funds the federal government for fiscal year 2021, provides additional COVID-19 relief and economic stimulus funds, and addresses surprise medical billing, among other things. The legislation also eases the impact of the Medicare fee schedule budget neutrality adjustments in calendar year 2021 due to improved evaluation and management (E/M) office visit payment and coding rules, as well as extends the 2 percent Medicare sequester moratorium through March 2021. The legislation includes an across-the-board increase of 3.75 percent to the Medicare physician fee schedule for calendar year 2021. The Act also delays implementation of the inherent complexity add-on code for Evaluation/Management services (G2211) until 2024. The American Medical Association estimates the impact of these changes as follows:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>CY 2021 MFS Final Rule</th>
<th>Combined Impact</th>
<th>Legislative Impact of Consolidated Appropriations Act</th>
<th>Specialty</th>
<th>CY 2021 MFS Final Rule</th>
<th>Combined Impact</th>
<th>Legislative Impact of Consolidated Appropriations Act</th>
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<tr>
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Source: Adapted from AMA CY2021 Combined Specialty Impact with New Medicare Physician Payment Schedule & Anesthesia Conversion Factors, Updated RVUs and without G2211.
Additional provisions of note include: additional funding for the Provider Relief Fund and continuation of the Paycheck Protection Program (PPP); the addition of 1,000 Medicare-funded GME slots; the creation of an evidence-based national vaccine awareness campaign to combat misinformation; reinstatement of the 1.0 floor on the work Geographic Practice Cost Index through calendar year 2023; and provisions designated to strengthen parity of mental health and substance use disorder benefits, among other things.

ACOI Joins in Opposition to Most Favored Nation Model Interim Final Rule

The ACOI joined with other osteopathic organizations in opposition to the “Most Favored Nation Model Interim Final Rule” issued by the Centers for Medicare and Medicaid. The rule requires reimbursement for 50 of the most expensive separately billable Part-B drugs at the lowest price of the drug in any non-US member country of the Organization for Economic Co-operation and Development (OECD) with a GDP per capita that is at least 60 percent of the US GDP per capita. The model is mandatory and applies nationally. Additional drugs would be phased-in at a later time. Prior to the rule’s effective date of January 1, 2021, a federal court issued an injunction that blocked implementation. With legal proceedings ongoing, the fate of the rule is uncertain. The ACOI will continue to monitor this matter closely. You can review the letter sent by the ACOI and others here.

ACOI Joins to Protecting Quality Healthcare for Veterans

The ACOI joined with physician organizations in opposition to the Department of Veteran Affairs’ (VA) Authority of VA Professionals to Practice Health Care Interim Final Rule. The rule permits virtually all non-physician providers (NPPs) employed by the VA to practice without the clinical supervision of physicians, and without regard to state scope of practice laws. Concern was raised that removing scope of practice safeguards by the VA will allow non-physician providers that have not been adequately trained to perform procedures that are outside the scope of their license, undoubtedly leading to a lower standard of care for veterans. In addition to policy concerns, the letter addresses violations in which the rule was implemented by not providing proper notice or the opportunity for public comment.

The letter calls on the VA to rescind the interim final rule and consider policy alternatives that prioritize physician-led, team-based care.

You can review the letter sent by the ACOI and others by visiting our website.

President Unveils COVID-19 Response Plan

Prior to taking office, President Biden announced a $1.9 trillion dollar COVID-19 relief plan on January 14. Included in the plan is: $350 billion to help state and local governments support essential workers and reopen schools; $170 billion for education and $156 billion for health initiatives that include expanded testing and vaccinations; and $1,400 in additional direct payments to individuals, among other things. To date, there have been five separate laws enacted in direct response to the COVID-19 pandemic, the most recent signed into law in December 2020. The ACOI will be certain to closely monitor this and other proposals advanced to respond to the economic and health impacts of the COVID-19 pandemic. Additional information will be provided as it becomes available.

Washington Tidbits

A Resilient Republic

Article II, Section 1 of the US Constitution provides for the position and election of the President of the United States. It outlines the electoral process and provides the way electoral votes are to be tabulated and processed. It reads in part, “The President of the Senate shall in the presence of the Senate and House of Representatives, open all of the certificates, and the votes shall then be counted.” As this constitutionally required activity was attacked on January 6, so was the very fabric of our government. Senators and Representatives were sent into hiding as the Capitol was cleared and security restored. Amazingly, within hours Congress regrouped, and the work of the people was completed. In the coming weeks and months, we will learn more about the specifics of what happened. While the cuts may be deep and the scars significant, the Nation will emerge from this stronger than before!
Greetings colleagues, and welcome to the January issue of Talking Science and Education. I hope the new year will bring health, peace, and renewal to our country and our world.

In last month’s population health quiz, we asked by what percent chlamydia has increased per 100,000 population in the United States between 2018-2019.

Chlamydia increased 5% between 2018-2019 from 497.3 to 524.6 new cases per 100,000, 15% in the past five years (from 456.7) and 43% in the past 10 years (from 367.5). According to the CDC, chlamydia is the most reported sexually transmitted infection. More than 1.7 million chlamydia cases were reported in 2017, though many more cases go undiagnosed and unreported, since infections are usually asymptomatic. Among women, untreated chlamydia can lead to pelvic inflammatory disease, inability to get pregnant, ectopic pregnancy, and chronic pelvic pain. In men, untreated chlamydia rarely causes life-threatening damage but can lead to epididymitis.

Talking Education

ACGME Annual Educational Conference to be Held February 24-26, 2021

The ACGME Annual Educational Conference will be held virtually for the first time on February 24-26, 2021. The conference theme, Meaning in Medicine: Mastering the Moment, highlights how the GME community is rising to meet the challenge of a truly unprecedented time for the health of the world. Frontline workers, including residents and fellows, have demonstrated strength and courage, to serve with compassion, empathy, and love for strangers in their time of need. The community must continue to work together in this historical moment and adapt to a new reality for medicine, learning, leading, and teaching.

Talking Science and Education: Diabetes Dialogues

SGLT2 inhibitors ‘best choice’ for reducing AKI risk vs other glucose-lowering drugs

For patients with type 2 diabetes, SGLT2 inhibitors conferred a lower risk of developing acute kidney injury (AKI) than use of GLP-1 receptor agonists or dipeptidyl peptidase-4 inhibitors (DPP4i), according to a network meta-analysis of clinical trials.

Min Zhao, MD, of the school of public health at Guangxi Medical University in China, and colleagues contended that it is “critically important” clinicians gain a solid understanding of the differences in AKI risk between the three drugs to improve prescribing practices. However, knowledge of the comparative effects of these three classes of glucose-lowering drugs on risk of AKI is limited because few head-to-head trials have been performed. Unlike standard pairwise meta-analysis (comparing two treatments directly), a network meta-analysis allowed the investigators to compare multiple interventions simultaneously in a single analysis by combining both direct head-to-head trials and indirect comparison between the interventions across a network of studies.

Become a Talking Science and Education winner but remember: no Googling!

Send your answer to don@acoi.org and win valuable prizes!
This enabled them to estimate the comparative effects of DPP4 inhibitors, GLP-1RAs, and SGLT2 inhibitors on the risk for AKI, in absence of head-to-head trials, and rank the safest intervention. The analysis included 18 trials comprising a total of 2,051 AKI events among 156,690 patients.

Results showed SGLT2 inhibitors were associated with a lower risk for AKI compared with placebo (OR = 0.76). The researchers concluded that SGLT2 inhibitors showed a protective effect on the risk of AKI, whereas both DPP-4 inhibitors and GLP-1RAs had neutral effects.

SGLT2 inhibitors were also associated with a lower risk for AKI than GLP-1RAs (OR = 0.79) and DPP-4 inhibitors (OR = 0.68).

Further findings indicated SGLT2 inhibitors had the highest probability of being the safest intervention at 84% (for comparison, GLP-1RAs and DPP-4 inhibitors had a 1% and 0% probability, respectively).

Based on this study, it appears the data supporting the use of SGLT2 inhibitors beyond glucose lowering continues to expand. SGLT2 inhibitors appear to be the best choice for reducing AKI risk.

ACOI Online Learning Center

The COVID-19 pandemic has impacted almost every aspect of your daily life. Your desire to obtain needed continuing medical education and staying abreast of the latest updates in internal medicine does not have to be one of them. We have added new content and improved navigation tools to help you quickly find the educational materials you want and need. You can access a multitude of lectures that span the many areas of internal medicine and earn CME credit when and where it is most convenient for you. We understand the many hurdles you face as a busy practicing physician, resident, or student and want to help simplify things so you can focus on what is important to you and help you stay true to why you pursued medicine. The ACOI Online Learning Center is your one-stop-shop for osteopathic online education.

Coming Soon: ACOI’s Spring Meetings!

Dates have been announced for ACOI’s 2021 Internal Medicine Board Review Course, Clinical Challenges in Hospital Medicine, and a new Integrated Subspecialty Review (focusing on Cardiology, Pulmonology, and Infectious Diseases). The Board Review Course will be held May 11-15 and will help you prepare for both the AOBIM and ABIM exams. Clinical Challenges in Hospital Medicine will be held May 12-15. The new Integrated Subspecialty Review will be held May 13-15. Each meeting will be held virtually for the continued safety of all attendees and our staff. Preliminary agendas will be out soon, so keep an eye on our website and social media platforms!
The new Evaluation and Management (E&M) Guidelines for Office and Other Outpatient Services published in the 2021 CPT book by the American Medical Association (AMA) have caused confusion and consternation. For this reason, I will spend the next several columns exploring definitions and concepts of the document that are now used to choose the appropriate level for codes 99202-99215 office visits.

Although it looks like the Table of Risk you are accustomed to seeing, make no mistake, it is very different in some key areas.

<table>
<thead>
<tr>
<th>Medical Decision Making Before 2021</th>
<th>Medical Decision Making Effective 1/2/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diagnoses or management options</td>
<td>Number and complexity of problems addressed at the encounter</td>
</tr>
<tr>
<td>Amount and/or complexity of date to be reviewed</td>
<td>Amount and/or complexity of data to be reviewed and analyzed</td>
</tr>
<tr>
<td>Risk of complication and/or morbidity or mortality</td>
<td>Risk of complication and/or morbidity or mortality of patient management</td>
</tr>
</tbody>
</table>

The additional words in bold above make clear there are problems that are to be addressed, data to be analyzed, and risk of complications to be considered as they relate to the patient’s management.

The AMA’s 2021 Guidelines for this section of Office Service codes define a PROBLEM as a “disease, condition, illness, injury, symptom, sign, finding, complaint or matter noted at the encounter without a diagnosis being established at the time of the encounter.” A problem is considered managed or addressed only when it is evaluated or treated at the encounter by the provider (physician or qualified health professional) who reports the service. A notation needs to be made that references testing or treatment that is considered but not carried out. Be sure to document all considered treatments that were not utilized because as it may reflect a MDM at a more advantageous level.

In defining terms for this section, the AMA states that noting another professional’s management of a problem “without additional assessment or coordinating care documented, does not qualify as being ‘addressed’ or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam or diagnostic study[ies]) or consideration of treatment does not qualify as being ‘addressed’ or managed by the physician or other qualified health care professional reporting the service.”
For the purpose of MDM, the term “stable” refers to the specific treatment goals set for that particular patient. In defining the term, AMA states that a patient who is not at their treatment goal is not stable. Even if the condition has not changed, if the patient is not at their treatment goal, the condition is not considered to be stable. To this end, I recommend you document goals for a patient’s chronic illnesses so they can be referenced, especially if they are not met. The result is a default definition that an illness is not stable and allows credit for the complexity of the problem.

I am often asked what a “unique test” means on the table. Simply put, if the test has its own CPT code, it is unique. Clinical Laboratory Panel tests have a unique code so they are considered one test, like a Basic Metabolic Panel. Note that a Urinalysis with Culture and Sensitivity is considered two tests because of the two CPT codes required to capture the service. The additional change in counting tests with this methodology is that if your practice is billing for the test, then you cannot count it in your MDM data column. The rationale for this from the AMA is they did not want to incentivize physicians for ordering tests. In the above example, if you did the urinalysis in your office, the ordering of that test does not count in your MDM. If the urine is then sent to a lab for culture and sensitivity, you get one credit for that order.

It is important to note that credit is no longer given for “reviewing” a test you have ordered. The AMA states that when the order is included in the category of test result(s) for MDM, the review of the test result is part of the encounter and not a subsequent encounter. This is a significant change. You still get credit for review of tests from an outside source that are brought to an appointment and for the rare occasion when a test is ordered between appointments. As an example, you order an x-ray at the patient’s appointment. The result comes back a few days later and you decide the patient needs an additional x-ray or even a lab test. Without seeing that patient at an appointment, you do not get credit for the ordered tests. At the next appointment with the patient, you get credit for review of the test. My suggestion when this happens is to make it crystal clear in your documentation that this is an unusual circumstance. For example, document “x-rays reviewed today were ordered outside of the last appointment.” You could also state “labs reviewed today were ordered in consideration of results received in-between appointments.”

I have been asked that if the test results were abnormal, should not credit be given for reviewing and dealing with the abnormal result? Yes, credit should be given, but not for reviewing the results in the data column of the Medical Decision Making Table. It would most likely fall under one of the other two columns in the Elements of MDM table, such as either the patient’s illness being unstable or uncontrolled, or addressed in the risk area of the patient’s management, or perhaps both.

I will examine coding for medical decision making further in next month’s column. Following are some additional resources for your review:

Level of Medical Decision Making Table
Full Guidelines
The ACOI Board of Director wishes to thank all ACOI members for their annual support for the College. The generous support from 75th Anniversary Circle members is of the utmost importance as we seek to maintain an osteopathic approach to internal medicine for future generations of patients.

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Thank You!
American College of Osteopathic Internists

MISSION
The mission of ACOI is to promote high quality, distinctive osteopathic care of the adult.

VISION
ACOI seeks to be the organization that osteopathic internists think of first for education, information, representation and service to the profession.

VALUES
To accomplish its vision and mission, ACOI will base its decisions and actions on the following core values:

LEADERSHIP for the advancement of osteopathic medicine
EXCELLENCE in programs and services
INTEGRITY in decision-making and actions
PROFESSIONALISM in all interactions
SERVICE to meet member needs