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Ohio Podiatric Medical Association
Journal

OHIO PODIATRIC MEDICAL ASSOCIATION

INSIDE THIS ISSUE

President's Message

Where We Stand in 2012

by David Hintz, DPM, MPH, CPH

2012 OPMA PRESIDENT

As I begin my presidency, 2012 has several positive developments for our profession. One of the most important initiatives will be podiatry's continued inclusion in optional services. Despite the ongoing budget crisis in the State of Ohio, podiatry now has substantive data that proves podiatric cost savings to healthcare with two studies—Thompson Reuters and the Duke University study. We must be ever-vigilant legislatively and continue to educate legislators as we network.

OPMA experienced a setback with our legal battle; however, we have filed a selective appeal as our strategy to exhaust a legal remedy. We will see how this progresses through the appellate process. Another consideration is approaching the issue of reimbursement equivalency through other fronts during the coming year and confidently laying the ground work for resolution of this complex issue.

A further concern is the Affordable Care Act and our inclusion as podiatric physicians. Currently we are not included in this very important federal legislation. OPMA is actively advancing our position to the APMA by providing our assistance at every opportunity. As Ohio podiatric physicians, we want to help move our inclusion forward in a favorable and resolute fashion.

My goal as your president is to make noise about our profession and the importance of the services we offer, the full scope of our services and how these services can be leveraged to reduce health care costs in the state of Ohio and in the Nation.

Dr. Petrolla and OPMA President Dr. David Hintz.

FAQ FOR YOU

OARRS: The Ohio Automated Rx Reporting System

Background and Purpose

The Ohio Automated Rx Reporting System (OARRS) was established in 2006 as a tool to assist healthcare professionals in providing improved and safer treatment for patients. House Bill 93 of the 129th General Assembly authorized the Board to adopt Ohio Administrative Code (OAC) Rule 4731-11-11, Standards and Procedures for Accessing OARRS, in an effort to encourage prescribers to access OARRS.

The OARRS Prescription History Report

An OARRS Prescription History Report can assist in assuring that a patient is getting the appropriate drug therapy, is taking their medication as prescribed, and may alert prescribers to signs of possible misuse or diversion of controlled substances. The system serves a secondary purpose to enhance the monitoring of the misuse and diversion of controlled substances.

Requesting an OARRS Prescription History Report

A prescriber is authorized to request an OARRS Prescription History Report on an individual only if:

1. the request is for the purpose of providing medical treatment and
2. the prescriber has a current prescriber-patient relationship with the individual named in the request. Please note that unauthorized accessing of an OARRS Report may be in violation of Board of Pharmacy laws.

Some frequently asked questions are discussed below.

OARRS: Frequently Asked Questions

QUESTION 1: ***How do I register for OARRS?***

A: The Ohio Board of Pharmacy maintains and operates the OARRS system. Information on registering with OARRS, acceptable use policies, and assigning delegates can be obtained by contacting the Ohio Board of Pharmacy.

QUESTION 2: ***Can I have my office staff access OARRS on my behalf?***

A: Yes. Licensed individuals, such as nurses and physician assistants may obtain an account from the Board of Pharmacy to access OARRS on your behalf. Under House Bill 93, a physician may also name non-licensed staff such as medical assistants or other office personnel, as delegates to access OARRS on the physician's behalf. The Board of Pharmacy limits the number of non-licensed delegates to three per physician. For more information please contact the Ohio Board of Pharmacy.

QUESTION 3: ***What types of drugs are reported to OARRS?***

A: Currently controlled substances in schedules II, III, IV, V, and all dangerous drug products containing carisoprodol or tramadol are required to be reported to OARRS. These drugs are referred to as "reported drugs" in Rule 4731-11-11.

QUESTION 4: ***Does the OARRS rule apply to drugs administered in an in-patient or office based setting?***

A: No. Rule 4731-11-11 only applies to instances when you either prescribe or personally furnish controlled substances, carisoprodol, or tramadol to a patient and does not apply to the administration of drugs in an in-patient or office based setting.

From The Desk of the Executive Director

Learning from the past to create a better future

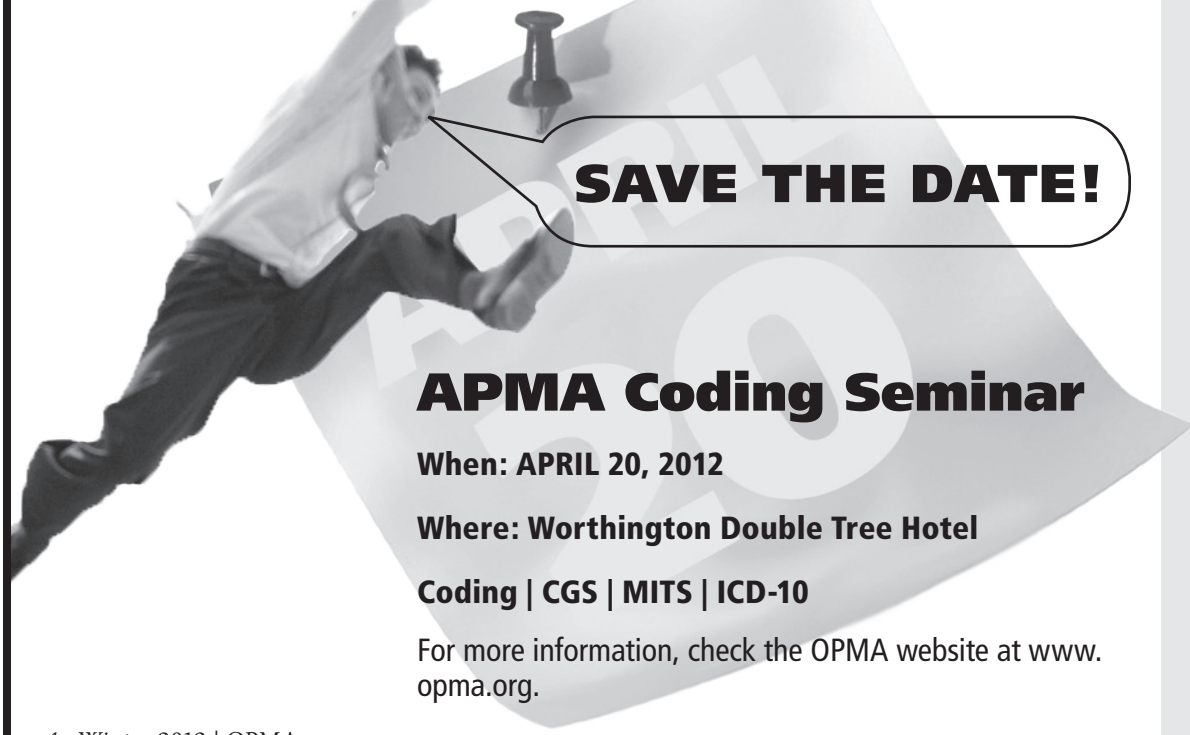
by Jimelle Rumberg, PhD, CAE

Time is flying; and, I must admit, it's overwhelming with each passing year to ponder. It seems that Thanksgiving was literally yesterday and tomorrow will be mid-February. What a whirlwind! In association work, our planning is a continual cycle. The planning never stops for events, meetings or strategies that need development. Once the House of Delegates concludes we begin a full-court press on the Region IV planning. In between there are legislative matters, regulatory meetings, publications to print, and Web development, so the list goes on and on. As you would expect, we try to learn from past deficiencies to improve the cycle and our operational processes to achieve a better association. We are invested in making OPMA a great organization and hope you find value in what we do for you and your professional practices.

There is so much occurring nationally and at a state level with Medicare, Medicaid, and Workers Compensation that it's daunting. Please ensure that you read your blast emails and check our Web site for continual updates. It is the fastest way for us to keep you in the loop. If you have questions, please call OPMA. Likewise, if you should receive something in the mail (typically an offer or incentive program) that sounds too good to be true, please let us know. Chances are we'll get several calls regarding anything of that nature.

With a new year comes new challenges, the 5010, ICD-10 training, CGS and MITS. Know that OPMA will have a stellar APMA Coding workshop on April 20th at the Worthington Double Tree Hotel. Details will be sent soon, so please plan to attend and mark your calendar today! The APMA presenter will be Phill Ward, DPM, who is a member of the APMA Board of Trustees and on the APMA Coding Committee.

So we're all underway in 2012. Plan to attend your local academy meetings this year as your New Year's Resolution particularly when OPMA President David Hintz visits your area. Hope your year is "Toe"riffic and we look forward to seeing you on April 20th for the APMA Coding Seminar and June 7, 8 and 9 for Region IV.



APMA Coding Seminar

When: APRIL 20, 2012

Where: Worthington Double Tree Hotel

Coding | CGS | MITS | ICD-10

For more information, check the OPMA website at www.opma.org.

WITH YOU IN MIND

Workers' Comp Premiums Got You Down?

As an Ohio Podiatric Medical Association member you can save significantly on your workers' compensation premium by joining the OPMA workers' compensation program administered by CareWorks Consultants, Inc. (CCI).

CareWorks Consultants is an Ohio-based company located in Dublin, Ohio. CCI is the largest third party administrator (TPA) in the state. We utilize an approach that integrates safety prevention and risk control with aggressive claims management to deliver a significant return on investment for you as a member.

As you work on your budgets for 2012, we ask that you keep the OPMA workers' compensation program in mind as a cost savings tool. In fact, here are some items to consider when evaluating the program:

- The 66 OPMA members in the 2011 group rating program saved a combined $26,903 in premiums.
- Save up to 53% on your workers' compensation premium.
- Your participation in this program helps the OPMA which is your practice advocate.

To receive a quote, please contact Jason Bainum with CCI at 1-800-837-3200, ext. 7114 or jason.bainum@ccitpa.com. The deadline to receive a quote and file is fast approaching. We appreciate your consideration of this cost-effective program. You can be assured that your involvement also helps the Ohio Podiatric Medical Association.

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SECRETS OF SUCCESS

Bird's Eye View of Territorial Conflict

by Lynn Homisak, SOS Healthcare Management Solutions, LLC | www.sos-hms.com

Hummingbirds are unmistakably identifiable and easily picked out of a crowd because of their miniature size and striking metallic colors. While it is next to impossible to pick a "territorial" employee out by the way he or she looks, their actions give them away; actions which believe it or not are very similar to that of the hummingbird.

At some point during each day, I find myself distracted by what is taking place right outside my office window—a number of hummingbirds are swooping, diving, chirping, and body checking one another—all in an attempt to protect *their* feeding spot. Although these tiny birds visit the feeders every day; they do not exactly demonstrate a "what's mine is yours" sharing mentality. Rarely will two ever sit at the same feeder together and those that do manage to perch for a drink never (even for a second) let their guard down. They *rest* in attack mode; always on the lookout for potential intruders. It appears that getting along with each other is not an option and the best way to prevent them from fighting is to just keep them separated. That's why it is recommended (if hanging more than one hummingbird feeder) that they be placed at least 100 feet apart—or around a bend, out of each other's view. It is territorialism at its best—and for them, probably part of the instinctive way that they protect themselves.

From Outdoor Setting to the Office

As I continue to observe their activity, I can't help but think how many times I've seen similar behavioral patterns in staff—overly-protective of their turf and purposely provoking conflict with anyone who they feel invades it. Why do they do it?

Territorialism is a behavior that seems to develop over time in some (not all) people. Whether due to feelings of insecurity, the inability to be a team player or the need for constant assurance and attention, it is more common than one might realize and if left unattended, ends up negatively affecting productivity, efficiency and overall office morale. Whatever the source, the characteristics are classic.

Consequences for Everyone

On the surface, these individuals appear friendly, cooperative and willing to help and share knowledge with other staff—yet behind the scenes they secretly guard and hide necessary information, see to it that all change is unsuccessful, hold back on orientation processes and micromanage their co-workers (or subordinates) to the point where everyone but them appears to fail. Territorial personalities do not generally emerge when working independently, because there is no threat; but the minute it is suggested that new personnel are being considered to help ease their burden, that's when they go into their defensive mode and the conflict begins.

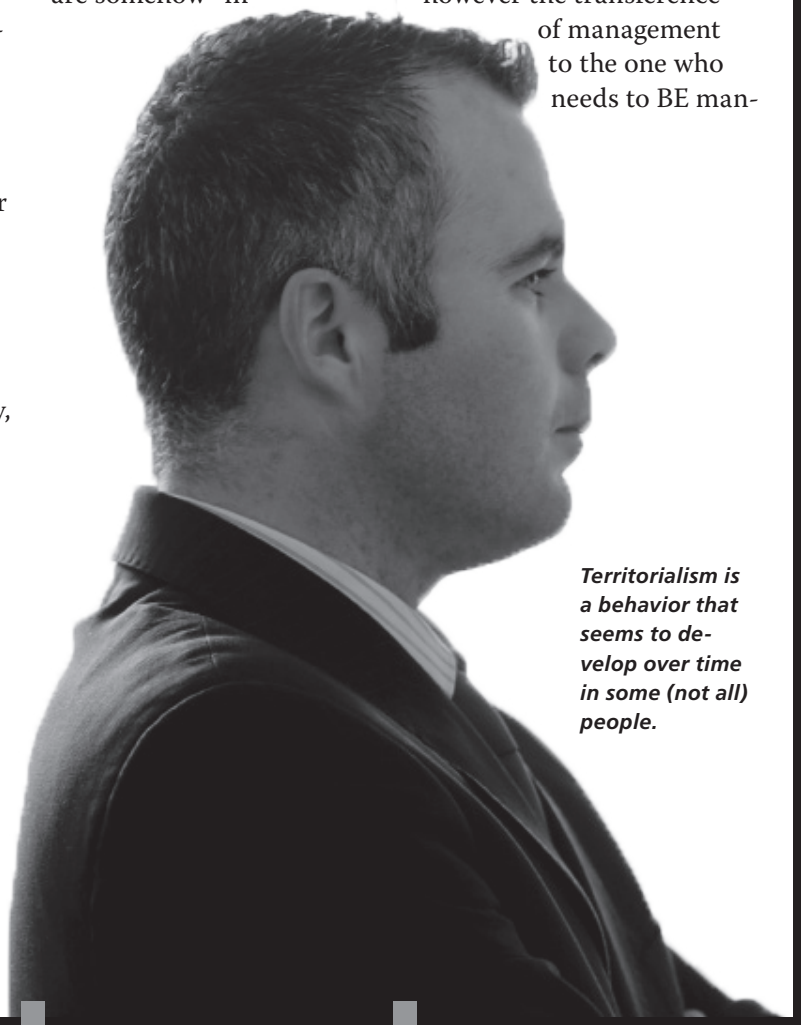
What to Look for

Make no mistake. These individuals may have acquired a great deal of knowledge about their job which not only has them, but also their doctors believing that they are somehow "invaluable" and "indispensable"—thus feeding their egos even more. Knowing they hold this knowledge is also one of the reasons that doctors are reluctant to address it; often for fear that they will lose this individual and with them the magical keys to their success!

To make matters worse, these individuals are unsuitably elevated into a management position (again because of their tenure) for which they are not qualified; giving them the power to control staff and eventually (but more subtly) the doctor and the practice.

What are the Options?

No one wants to dismiss a staff person who they feel is an asset to the practice, least of all this writer; however the transference of management to the one who needs to BE man-



Territorialism is a behavior that seems to develop over time in some (not all) people.

aged is irresponsible—and threatening to the practice. Don't misunderstand; delegating duties and decision making responsibilities to trained staff is necessary; even encouraged.

Taking the Leadership Role

Likewise, having a skilled office manager (key word: *skilled*) is most definitely an advantage; however, knowing when to regain control of the leadership reins and take action is critical. When it is apparent that this individual is the one holding back progress; jeopardizing teamwork, disrupting and manipulating other staff and becoming overly protective of their work, it's time to step in. The first order of business is to have a heart to heart conversation with this person and make them aware that you realize what is happening.

How to Deal with Change

Since change is an intimidating factor to them, use this time to talk candidly about how it will affect them and their job in an effort to remove any (real or perceived) job insecurity issues. Review their written job description; insist that a procedure manual be crafted to get what information is in their head—on paper! Encourage job-share opportunities and schedule regular performance reviews in an effort to communicate in a constructive way what you expect from all members of the team. Finally, explain that there is no room for unacceptable behavior from any team player and involve them by asking for suggestions on resolution with a reasonable date and time (10 days) to re-assess progress.

Take it from the Pros!

Those who have experienced a territorial staffer will affirm that one bad apple ***can*** spoil the whole bunch and I'm sure that kind of uncooperative culture is not one you wish to encourage in your practice! Understand that if territorialism is a problem you face—it won't go away on its own. Don't live with it…do something about it before ***your*** territory is threatened. Reevaluate, regroup and if necessary, take serious measures to remove this particular strain of "staff infection." Oh, if hummingbirds could talk…

Ms. Homisak, President of SOS Healthcare Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and recently inducted into the PM Hall of Fame. Lynn is also an Editorial Advisor for Podiatry Management Magazine and recognized nationwide as a speaker, writer and expert in staff and human resource management.

PHOTO REVIEW

House of Delegates Meeting December 3, 2011

Photos from top right: ***APMA Delegation***

Second from top: ***Board of Trustees for 2012***

Third from top: ***Executive Committee for 2012: Drs. Angelo Petrolla, OPMA Sec/ Trees; Karen Kellogg, OPMA Second Vice President; David Hintz, OPMA President; Marc Greenberg, OPMA First Vice President; Alan Block, OPMA Immediate Past President; and Jimelle Rumberg, Executive Director.***

Second from bottom: ***Dr. Alan Block received the Thomas J. Meyer Award from OPMA President Dr. David Hintz***

Bottom photo: The 2012 APMA Leadership Breakfast

Dr. Rick Weiner and daughter are faithful attendees to the OPMA HOD

Top left to bottom: ***Taking the Oath of Office with Drs. Block and Hintz; OPMA Legal Counsel Nanci Danison addresses the House; Dr. Block presiding over the 2011 OPMA HOD; Rick Whitehouse, Executive Director of the Ohio State Medical Board and OSMB President Dr. Shellee Suppan; OPMA Lobbyist Charlie Solley discusses legislative strategies with the HOD.***

From top to bottom right: ***APMA President Mike King addresses the HOD; Dr. Bruce Blank with APMA President Dr. Mike King and APMA Board of Trustee Member Dr. Seth Rubenstein; Dr. Rumberg and Congressional Candidate Dr. Brad Wenstrup at the APMA Leadership Breakfast; Dr. Larry Osher reviews changes with GXMO testing in Ohio.***

OHIO UPDATES

OSMB Elects Officers

At its December meeting, the State Medical Board elected the following members to serve as officers in 2012.

Darshan Mahajan, MD—*President.* Dr. Mahajan is a neurologist from Elyria, Ohio.

Anita Steinbergh, DO—*Vice President.* Dr. Steinbergh is a family practitioner from Westerville, Ohio.

J. Craig Strafford, MD—*Secretary.* Dr. Strafford is an OB/GYN from Gallipolis, Ohio.

Dr. Lance Talmage will become Chair of the Federation of State Medical Boards Board of Directors in April 2012. Dr. Talmage will continue as a member of the Board.

Jack Amato, MD—*Supervising Member.* Dr. Amato continues in this position. He is an OB/GYN from Irondale, Ohio.

SADLY MISSED

Passages

JAMES LEE JOHNSON, DPM, 88, of Homosassa, Florida, died Wednesday, April 20, 2011, at Life Care Center of Citrus County in Lecanto, Florida.

He was born in Lima, Ohio, where he was a practicing Podiatrist for over 40 years. He was a veteran. Dr. Johnson was a resident of Homosassa for the past six years. He is survived by his daughter, Mary Lee Johnson of Homosassa. Dr. Johnson will be missed by all who knew him and benefitted from his care.

JAMES REVELAS, DPM, died Friday, October 7, 2011. Dr. Revelas is survived by his wife of 26 years, Angel (Panopoulos) and by his daughter, Celeste A. Revelas of Columbus, Ohio and by his son, Jordan D. Revelas of Norwalk, Ohio.

He was a virtuoso violinist and was a former member of the Youngstown Symphony, the Bellevue Symphony and the Heidelberg Orchestra. Dr. Revelas practiced in Norwalk, Sandusky and Bellevue, Ohio. Dr. Revelas was a respected podiatrist and will be missed by all his patients and friends.

OHIO PODIATRIC MEDICAL ASSOCIATION

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The *OPMA Journal* is provided to Association members and Industry Affiliates of the profession as a part of our communications to inform/ update our members on podiatric issues and events. The contents of *OPMA Journal* are intended for general information purposes only and should not be read as specific legal, financial, or business advice regarding specific issues or factual events. We urge you to consult your legal, financial, and professional advisors with any specific questions you may have.

VERSION 5010 | ICD-10
Compliance, Everyone!

Everyone affected by the Version 5010 and ICD-10 transitions—health care providers, payers, software vendors, and clearinghouses/third-party billers—needs to prepare to meet the following timetable to ensure compliance.

Date	Compliance Step
January 1, 2011	• Payers and providers should have begun external testing of Version 5010 for electronic claims • CMS has begun accepting Version 5010 claims • Version 4010 claims continue to be accepted • External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance
December 31, 2011	• External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance
January 1, 2012	• All electronic claims must use Version 5010 • Version 4010 claims are no longer accepted
October 1, 2013	• Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures • CPT codes will continue to be used for outpatient services

Cutaneous Biopsy Techniques in the Management of Chronic Wounds

by Bradley Bakotic, DPM, DO | Bako Pathology

Many clinicians rely exclusively on clinical acumen when determining how to manage chronic wounds. Though an ulcer's clinical features may be fairly indicative of its etiology, in some instances, such is not the case. Even among the most characteristic-appearing ulcerations, masqueraders do exist. Ruling out the possibility of an unsuspected neoplastic or inflammatory condition could be necessary for the successful management of chronic wounds. In this context, cutaneous biopsy techniques may be invaluable; however, their utility does not necessarily end here.

There are three common clinical settings in which a biopsy may be used in the management of a chronic wound. Clinicians may use histopathology to 1) confirm a clinically suspected diagnosis at the outset of care; to 2) rule out a mimic in cases where a wound is showing recalcitrance or unusual progression; to 3) assess for an underlying predisposing condition independent of the ulceration; or to 4) assess for compounding feature, such as an excessive bacterial burden. Because the clinical presentation of cutaneous ulcerations may be virtually pathognomonic of a particular etiology, the first of these scenarios should not always give rise to a biopsy; however, in some instances, confirmation is warranted. In a minority of cases, the clinical manifestations that surround an ulceration are entirely nonspecific and a biopsy is indicated prior to the initiation of medical care.

For wounds that appear characteristic of a particular etiology, biopsies are usually not initially necessary; however, as a rule of thumb, biopsies should be considered for all ulcers that cannot be readily explained or fail to show improvement after 2 months of treatment. In instances such as this, biopsies are being used to verify that the implemented therapeutic regimen is appropriate. Delays in the diagnosis of some mimics may be medicolegally treacherous. For instance, malignant melanoma, particularly amelanotic variants, may create ulcers that are virtually identical to non-neoplastic ulcers. Delays in this diagnosis may have serious implications with regard to the affected patient's outcome. Simply stated, the failure to reassess ones differential diagnosis in cases where ulcerations show unusual clinical behavior, or recalcitrance, may be a direct cause of increased morbidity.

An additional clinical setting where a biopsy might prove useful in the management of chronic wounds, involves patients with suspected neuropathy as a predisposing condition. With a 3mm punch biopsy of skin, taken for 10 cm above the lateral malleolus, physicians may qualify and quantify the presence of small fiber neuropathy. Degenerative changes among the intra-epidermal nerves, further may be predictive of the future onset of small fiber neuropathy. Though this examination uses a simple 3mm punch of skin, there are differences in the handling of biopsies taken for this purpose. Most important among these differences are that punches taken for epidermal nerve fiber density testing require a specialized fixative that must be requested from the lab, and care must be taken to avoid crushing the surface epithelium when removing the tissue from the biopsy site. Formalin fixative renders the biopsies useless for small fiber analysis.

In most instances, the biopsy technique of choice for verifying the cause of an ulceration, assessing for neoplastic and non-neoplastic mimics, and characterizing predisposing conditions, is a punch biopsy. In the initial two settings, a central and peripheral 3mm punch is usually sufficient; however, the identification of vasculitis may require additional random punches in hopes of sampling an effected vessel. As aforementioned, epidermal nerve fiber density analysis requires the same 3mm punch taken at 10cm above the lateral malleolus. To document length dependence, (as would be expected in bona-fide cases of small fiber neuropathy), clinicians may also perform a punch biopsy on the ipsilateral side, 10cm distal to the greater trochanter of the femur.

Biopsies are not a silver bullet in the management of ulcerations; however, clinicians should keep them in mind when the indications present themselves. Not uncommonly, these techniques make all the difference!

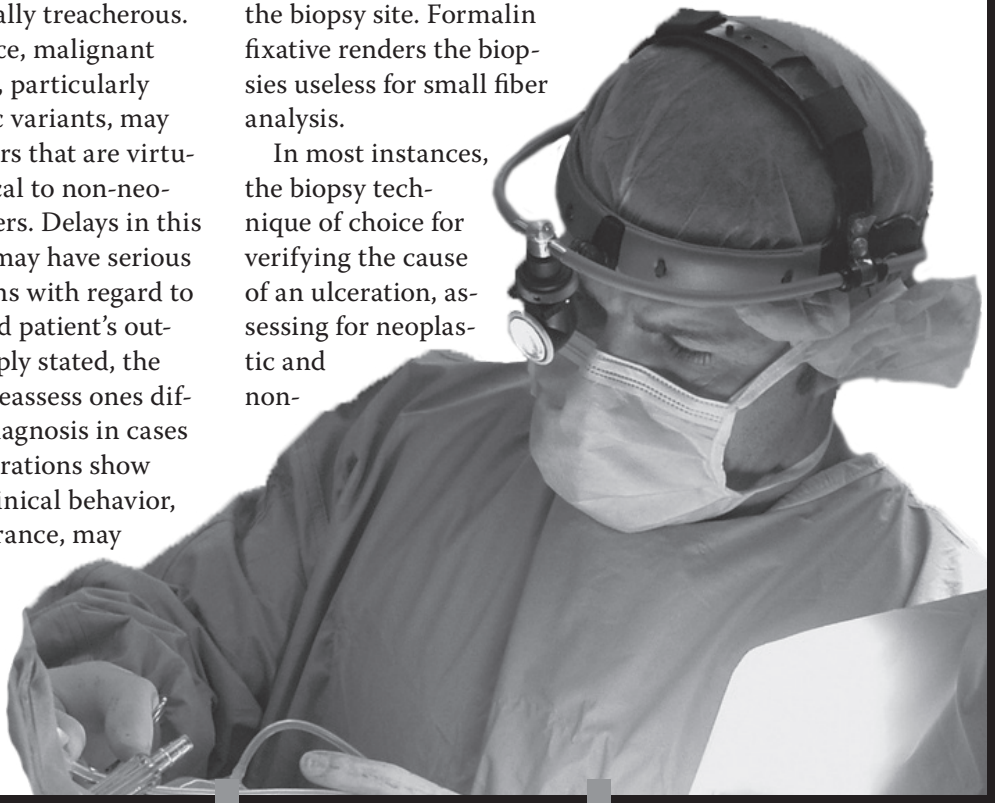

Photo by Chris Kasson, Ohio Department of Development.

FROM CAPITOL SQUARE

Legislative Updates

The arrival of a new year marks the half way point of the Ohio 129th General Assembly. The first year was one of unprecedented change and activity.
The year began with the swearing in of Governor John Kasich and new legislative leaders in both the House and Senate and progressed rapidly with state budget diliberations and the legislative activity. In 2011 the members of the Ohio General Assembly introduced over 650 bills for consideration and passed 47 into law. By all metrics, 2011 was a busy year in the Ohio General Assembly.

During 2011, OPMA was actively lobbying the General Assembly and state agencies on policies and legislation important to the OPMA membership. Policies including the continued coverage of podiatry as an optional Medicaid service, threats to the quality of health care services provided in Ohio and regulations proposing increased reporting to the State Pharmacy Board.

Last year was a successful year for OPMA advocacy efforts, with the state continuing coverage of podiatric issues as a Medicaid optional service and the State Pharmacy Board amending the proposed regulation, following written testimony by OPMA, to eliminate unnecessary weekly reporting by podiatrists who administer certain medications in the office setting. Despite our many successes, we must be vigilant, there are a number of bills up for consideration in 2012 that are important to the OPMA membership, these bills include.

Alternative and Complementary Medicine: HB 259

House Bill 259 would allow for the unlicensed practice of complimentary and alternative medicine with few restrictions in Ohio. Similar legislation has been introduced in the past only to see the stall due to insufficient support. The OPMA Board has reaffirmed the opposed position taken in the past, due to the great potential for harm that unqualified providers could pose to patients. House Bill 259 is currently pending in the House Health Committee.

Mid-Biennium Budget Review (MBR)

Shortly after taking office Governor Kasich indicated to both legislative leaders and the media his preference for conducting an annual budget process. Historically Ohio's state government operates on a two year budget, with legislators passing a budget every other year. Senior staff within the administration has indicated that the MBR will contain revenue and appropriations updates where necessary, along with policy changes in a number of potential areas including, casino regulation, education funding formula reform, pension reform, and structural reform for the Medicaid agencies.

Physician Designation: SB 121

Senate Bill 121 would establish certain requirements of any physician designation system. Such systems have become popular in recent years, providing patients with ratings of a physicians "quality" or patient's experience. The bill attempts to create a structure that will prohibit insurance companies or others from creating physician designation systems that provide higher ratings for physicians based primarily on the low cost treatment patterns of a physician. The OPMA board has taken a position of support for SB 121. SB 121 is currently pending in the Senate Insurance, Commerce and Labor Committee.

Payment for Health Care Services: SB 136

Senate Bill 136, sponsored by Senators Scott Oelslager (North Canton-R) and Capri Cafaro (Hubbard-D), would require health insurance companies to pay providers for services which the health insurer has provided written prior authorization. Further the bill would shorten the look-back period of time from 2 years to 180 days, during which the health insurer can adjust the payment for services. The OPMA Board has taken a position of support for this legislation. Senate Bill 136 is currently pending in the Senate Insurance, Commerce and Labor Committee.

These are just a handful of the bills important to OPMA that our elected official will be considering in 2012. Watch for the next OPMA *Journal* for additional updates.

ARE YOU AWARE?

Reportable Diseases to the Ohio Department of Health

The diseases listed in this rule and classified as class "A," class "B" and class "C" are declared to be dangerous to the public health and are reportable.

Due to the severity of disease or the potential for epidemic spread, diseases of major pubic health concerns are classified as class "A."

Class A Diseases

The following diseases are classified as class "A" and shall be reported *immediately* via telephone in accordance with rules 3701-3-03, 3701-3-04, and 3701-3-05 of the Administrative Code:

1. Anthrax;
2. Botulism, foodborne;
3. Cholera;
4. Diphtheria;
5. Influenza "A" - novel virus infection;
6. Measles;
7. Meningococcal disease;
8. Plague;
9. Rabies, human;
10. Rubella (not congenital);
11. Severe acute respiratory syndrome ("SARS")
12. Smallpox;
13. Tularemia;
14. Viral hemorrhagic fever ("VHF");
15. Yellow fever; and
16. Any unexpected pattern of cases, suspected cases, deaths or increased incidence of any other disease of major public health concern, because of the severity of disease or potential for epidemic spread, which may indicate a newly recognized infectious agent, outbreak, epidemic, related public health hazard or act of bioterrorism.

Class B Diseases

The following diseases are classified as class "B" and shall be reported in accordance with this rule and rules 3701-3-03, 3701-3-04, and 3701-3-05 of the Administrative Code. Case and suspect case reports and reports of positive laboratory results for diseases specified as class "B"in paragraph (B) of rule 3701-3-02 of the Administrative Code shall be provided by the end of the next business day:

1. Arboviral neuroinvasive and non-neuroinvasive diseases: (a) Eastern equine encephalitis virus disease; (b) LaCrosse virus disease (other California serogroup virus disease); (c) Powassan virus disease; (d) St. Louis encephalitis virus disease; (e) West Nile virus infection; (f) Western equine encephalitis virus disease; (g) Other arthropod-borne disease;
2. Babesiosis;
3. Botulism: (a) Infant; (b) Wound;
4. Brucellosis;
5. Campylobacteriosis;
6. Chancroid;
7. Chlamydia trachomatis infections;
8. Coccidioidomycosis;
9. Creutzfeldt-Jakob disease (CJD);
10. Cryptosporidiosis;
11. Cyclosporiasis;
12. Cytomegalovirus (CMV) (congenital);
13. Dengue;
14. E. coli O157:H7 and Shiga toxin-producing E. coli (STEC);
15. Ehrlichiosis/anaplasmosis;
16. Giardiasis;
17. Gonorrhea (Neisseria gonorrrhoreae);
18. Haemophilus influenzae (invasive disease);
19. Hantavirus;
20. Hemolytic uremic syndrome (HUS);
21. Hepatitis A;
22. Hepatitis B (non-perinatal);
23. Hepatitis B (perinatal);

24. Hepatitis D (delta hepatitis);
25. Hepatitis E;
26. Influenza-associated hospitalization;
27. Influenza-associated pediatric mortality;
28. Legionnaires' disease;
29. Leprosy (Hansen disease);
30. Listeriosis;
31. Lyme disease;
32. Malaria;
33. Meningitis: (a) Aseptic (viral); (b) Bacterial;
34. Mumps;
35. Mycobacterial disease, other than tuberculosis (MOTT);
36. Pertussis;
37. Poliomyelitis (including vaccine-associated cases);
38. Psittacosis;
39. Q fever;
40. Rubella (congenital);
41. Salmonellosis;
42. Shigellosis;
43. Spotted Fever Rickettsiosis, including Rocky Mountain spotted fever (RMSF);
44. Staphylococcus aureus, with resistance or intermediate resistance to vancomycin (VRSA, VISA);
45. Streptococcal disease, group A, invasive (IGAS);
46. Streptococcal disease, group B, in newborn;
47. Streptococcal toxic shock syndrome (STSS);
48. Streptococcus pneumoniae, invasive disease (ISP);
49. Syphilis;
50. Tetanus;
51. Toxic shock syndrome (TSS);
52. Trichinellosis;
53. Tuberculosis (TB), including multi-drug resistant tuberculosis (MDRTB);
54. Typhoid fever;
55. Varicella;
56. Vibriosis;
57. Yersiniosis.

Class C Diseases

The following are classified as class "C" and shall be reported by the end of the next business day in accordance with this rule and rules 3701-3-03, 3701-3-04, and 3701-3-05 of the Administrative Code unless paragraph (C)(7) of this rule applies—outbreak, unusual incidence, or epidemic of other infectious diseases from the following sources:

1. Community;
2. Foodborne;
3. Healthcare-associated;
4. Institutional;
5. Waterborne; and
6. Zoonotic;
7. If the outbreak, unusual incidence, or epidemic, including but not limited to, histoplasmosis, pediculosis, scabies, and staphylococcal infections, has an unexpected pattern of cases, suspected cases, deaths, or increased incidence of disease that is of a major public health concern pursuant to paragraph (A)(16) of this rule, then such outbreak, unusual incidence, or epidemic shall be reported in accordance with paragraph (A) of rule 3701-3-05 of the Administrative Code.

BY LEAPS AND BOUNDS

Baby Steps

Stage 2 of meaningful use moved to 2014

The U.S. Department of Health and Human Services has moved the start date for Stage 2 of the electronic health records meaningful use program from 2013 to 2014. It is anticipated that the final rule regarding Stage 2 of meaningful use will come out in June 2012. This would have given those providers that successfully attested to Stage 1 in 2011 and 2012, a very short window of time to be able to implement Stage 2 in 2013. The good news for those who were successful with attestation in 2011 is that HHS has clarified that those that attested for the first time in 2011 will be able to attest to the Stage 1 requirements in both 2012 and 2013.

This means the first three incentive payments ($18,000; $12,000; $8,000) totaling $38,000 will be based on Stage 1 requirements. Those attesting for the first time in 2012 will stay on the original schedule of Stage 1 for 2012 and 2013 and will have to attest to Stage 2 in 2014 for their third payment. The total incentive payment available over five years, if beginning in either 2011 or 2012, is $44,000.

CMS Develops New Electronic Health Record Guide for Physicians and Health Care Professionals

The Centers for Medicare & Medicaid Services has developed a "comprehensive tool" to help guide physicians and other eligible professionals through all phases of the Medicare electronic health-record incentive payment program. The web-based interactive resource includes chapters on program basics, eligibility and registration. It also has a description of all of the Stage 1 meaningful-use criteria and advises practitioners on how to choose the optional measures they will use as part of the attestation phase of the program. Physicians and other eligible professionals have until December 31 to complete 90 consecutive days of meaningful use of a certified EHR and until February 28, 2012, to report their data and attest that they have met the criteria to be deemed meaningful users in the Medicare portion of the program. The guide can be found here.

| *From the article of the same title Modern Physician (12/11) Conn, Joseph* |

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