WESTCHESTER PHYSICIAN

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PRESIDENT'S MESSAGE

INSURANCE COMPANIES PROFIT BY INCREASING BURNOUT

Every week of every year I am on the phone with a medical director from one of the insurance carriers trying to get a test or a surgery approved. Why do I have to jump through hoops when I almost always get the approval? Why am I talking with a pediatrician about an orthopedic or spine patient? Why do they never have all the notes and reports we sent in for their review? Why do they automatically deny tests or surgeries when specific words are not written in my notes? Why do they trust the radiologist report and disregard the surgeon's interpretation?

The first story I will tell readers is about a young healthy physician who had a herniated disc in his spine and suffered with severe leg pain. He went through weeks of physical therapy and 2 epidural injections. A recent MRI showed a herniated disc and surgery was decided upon and approved. The patient underwent a successful microdiscectomy and 2 months later lifted something heavy which led to a recurrence of the same pain. After no improvement with rest and anti-inflammatories, a new MRI was ordered and denied. The denial stated that the patient did not have an X-ray or 6 weeks of conservative treatment and an MRI was just done 3 months ago. Clearly the "screener" did not read the patient's notes or realize that the patient just had surgery for the same complaint. So instead of seeing patients at my normal pace during the day, I had to waste time talking to a medical director. When calling a medical director, the majority of the time is spent talking to a screener and waiting on hold. Once the medical director takes the call, in most cases like this, it takes 90 seconds to obtain the approval.

The first thing we have to realize is that the job of the "screener" is to find a reason to deny the request. The second thing we have to realize is that many physicians will not take the time to get on the phone and therefore the test will not be performed and the company saves money. Even if the test is delayed for a few weeks, the company saves money. The third thing we have to realize is that this situation is so common but so aggravating and is a major contributor to physician burnout.

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MARSHAL PERIS, MD
President, WCMS

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UPCOMING EVENTS

Networking Event
Thursday, May 3, 2018
Captain Lawrence Brewery
Elmsford, NY

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FROM THE EDITOR…
PETER J. ACKER, MD
PEDIATRIC ECONOMICS 101

Note: This is a column from January 2009

My pediatric office has been relatively quiet of late. The usual notion of medicine being recession proof has been shattered by this unusually anxious period. Certainly, a worried parent will always bring their child in, but there were clearly many visits of yore that in a strictly medical sense were optional. Parents would troop in with a barely ill child, "just to be sure" with a casualness that mimicked the use of credit cards during boom economic times. I recall years ago when we first signed on to an HMO, being amazed at how often a parent would appear with their child if payment in full was a $10 co pay, sometimes three or more visits for one cold. Today, parents are being much more circumspect about making appointments. My daily pace has slowed and in general the patients I do see are a bit sicker.

Certainly, these are anxious times, but curiously and a bit strangely, I find my mood not echoing the gyrations of the Dow Jones Index. Am I happy that my savings and retirement port folios have been decimated? Of course not. But I have to confess that I don't feel as bad about it as I would predicted if someone had laid out this scenario for me two years ago. Part of it is that I appreciate just how bad it can be as I hear of friends losing jobs. My business may be shrinking, but as long as there are leaky noses and pipes, pediatricians and plumbers will still be employed. Now, lest the reader feel that I am wandering into some sort of Pollyannaish netherland, let me assure everyone that I do have times of angst as I go over bills, contemplate what I will have to cut out, in order to pay next month's college tuition bill. Yet, improbably, I am finding little nuggets of pleasure and satisfaction. I remember my father years ago telling me that he found it pleasurable to muster the discipline to cut out certain bad habits, like an after dinner chocolate. I didn't quite get it at the time, figuring that it was a remnant of his depression era boyhood. But today, I find myself feeling a sense of satisfaction as I limit some of the admittedly frivolous consumerism I used to indulge in. Take eating out at restaurants. In times past, my wife and I went out frequently, using any excuse or whim (did you know that today is the anniversary of the constitution? – let's celebrate) Now, we carefully plan our next outing, lingering over a copy of Zagat's, anticipating mightily the gustatory pleasures to come.

Similarly, I have been extracting enjoyment out my slower pace at the office. I find myself spending more time with each patient and explaining in detail say the various causes of fever and why I can be reasonably sure that this fever is of a benign nature. I also have more time to read up on conditions in more depth than I have had time for in the past. I appreciate each new patient and have learned not to take anything for granted.

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Health & Fitness: Kullman's Korner

High Intensity Interval Training. HIIT for short. The latest craze in fitness. What is it?
HIIT is a training technique where you give one hundred and ten percent effort for a relatively quick burst of activity followed by a short rest or active recovery. Then repeat for multiple rounds.
It's difficult. It borders on insane. But the benefits are multiple. It increases metabolism for up to 48 hours afterward. The workouts are quick and can be done any where. It combines muscle building, fitness, and calorie burn.

Time to try it:
3 rounds for time.
30 second rest between rounds

15 burpees
15 push ups
15 high knees
15 v ups
15 mountain climbers
15 lunges
60 second plank.

Good luck!

Michael Kullman, MD Anesthesiologist

Northern Westchester Hospital

President's Message
Insurance Companies Profit by Increasing Burnout

(Continued from page 1)

The second story is about a manual laborer with a non-work related condition of his spine called stenosis and spondylolisthesis. Over a five year period of time, the patient underwent physical therapy, injections, acupuncture and tried many medications. He had multiple X-rays and MRIs over the years and continued to work. When he came to see me, he was done dealing with his condition and wanted a surgical fix. He was a candidate for surgery with correct indications, correlating imaging and had failed conservative treatment for over 5 years. His insurance company denied his surgery. When I spoke with the non-surgeon medical director for this patient, he agreed that the patient had the correct symptoms and imaging to justify surgery….but he hadn't had any physical therapy or documented conservative treatment in the last 6 months!

The take home point here is that long term history is not important at all. Even though the problem this patient was diagnosed with was a progressive one that would eventually lead to surgery, the insurance company wanted me to try to make him better again temporarily in order to potentially be "off the hook" for payment of a major surgery. They were willing to pay for unindicated, less expensive treatment now in the hopes that he may not be covered by them in the future when he eventually has the indicated and desired surgery.

I have many more examples of blood pressure-raising frustration. The insurance carriers know how much angst this causes and they are profiting greatly on delaying and denying imaging and procedures. They are banking on many physicians just giving up and going along with the denials and allowing the patients to deal with the denial themselves. The carriers place low level employees on the front line looking through records for key words and denying anything they can in order to save money. For the physicians like me who want to do the right thing for their patients, the process of approval for medically necessary and indicated procedures is one of the biggest contributors to job dissatisfaction and physician burnout.

If you are a physician that works for an insurer, shame on you for allowing these practices to harm our profession and contribute greatly to our work stress. How can anyone justify reviewing a case outside their specialty and rendering an opinion on indications for an imaging study or a procedure? The guidelines created by the carriers for their physician reviewers to follow are put in place to save as much money for the carrier as possible. The insurers like to advertise that they are health promoting organizations, but to the providers, they are obstructive and profit from wasting valuable physician time. Laws must be put in place to change this practice. Physicians must not sit idly by and allow denials and legislators to ignore this major issue. Don't give up on your patients or your happiness and career satisfaction.

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THE BUSINESS OF MEDICINE
YOU GROW OR YOU DIE

Rick Weinstein, MD, MBA
Director of Westchester Sport & Spine @ White Plains Hospital Center

Businesses either grow and flourish or wither and die. When I first started in practice, I knew I had to develop my orthopedic business. I believed it was grow or shrink…it is not. There is no room for shrinkage in business. There is not even a tolerance for staying still. Move forward and do not stand still.

Being in practice for over 20 years, I have seen what others have done and what has worked and what has not. What makes one business succeed and the other fail in the same location and business environment?

The key to growing is anticipating changes that are coming and not only being ready but making strategic moves before you are trapped. As multispecialty groups aggregated more doctors, they consumed the primary care docs who were a significant source of our referrals. This has caused many specialists to join these large groups or join hospitals to help guarantee an inflow of patients. I have tremendous respect for those doctors who have held out and not joined large groups but have still remained busy and financially successful. As your local market continues to change, you must adapt to the changes. Businesses are Darwinian; you either adapt to the changes or become extinct.

A key to growing is marketing. This can be an expensive campaign, but it can be as simple as making phone calls or sending personal letters to doctors who send you patients. If you want referrals from the ER docs, you better answer their calls and show up in a timely fashion when you need to. Most importantly, be courteous to the referring doctor even if the call is on the Saturday night or at 2 in the morning.

Would you send your family or friends to a doctor who is not nice? I believe almost every doctor is not only competent but smart. There is no room for condescension in contemporary medicine. Don't talk down other doctors, nurses, your staff and especially your patients. It is so simple to listen to your patients and help them. The studies on physician burn-out shows that doctors who spend the right amount of time with their patients and really listen are more satisfied at work and also patients like them better.

The best source of referrals is word of mouth from other patients and other doctors. Since I have started in practice, I always make myself available for same day urgent and emergency visits. This is critical in an orthopedic group where someone cannot wait to be seen for injuries like a fracture. If your 5-year-old daughter broke her wrist, would you tolerate her waiting 2 days to be seen?

There are many ways to grow your practice, but it has to grow. Consider marketing to your community and referring doctors. Be nice to your patients and your staff. Listen to your patients and continue to be a great physician. Make yourself available. Growth is not an option - growth is a necessity.

♦

FROM THE EDITOR…

PETER J. ACKER, MD
PEDIATRIC ECONOMICS 101

(Continued from page 2)

These slower times have also provided time for reflection on my career as a pediatric private practitioner which has spanned a bit more than 21 years. I have formed relationships of long standing and quite often run into former patients or their parents. One of my patients, who I have cared for since his birth is now a senior in college. As he grew up, his mother would often mention how brilliant he was. I, of course, hear this all the time so I must admit, I didn't take it too seriously. As turned out, he went to the university where my older sister is a professor of history. He not only took all her courses, but also did independent study with her. Her verdict – the most brilliant student she's ever had! My sister who visited over Thanksgiving, told me that she had seen him and his parents recently at his induction into Phi Beta Kappa and she told them, paraphrasing that African saying that Hillary Clinton used as a book title, that it takes two parents, a pediatrician and a professor to raise a child.

So life goes on and while the assessments of value in the stock market will continue to gyrate wildly, the value and pleasure of providing good care to patients will continue to accrue steadily as it has these last 21 years.

Westchester County Medical Society

Come join us for our
"REFERRAL ROUNDS"
Networking Event
Thursday May, 3, 2018

Captain Lawrence Brewery
444 Saw Mill River Road
Elmsford, NY
7:00pm

Is your referral pool too shallow? Have you been wanting to meet new referral physicians & Vendors?

Come Join us for our REFERRAL ROUNDS Networking Event

This is a great opportunity to meet physicians in primary care and different specialties to build your referral base...

Referral Rounds Physician Networking Night

Food, Drinks, Fun, Networking!

Food and Beverages will be served

Members are encouraged to bring a non-member physician to this event as their guest!

All members and guests are welcome at no charge.

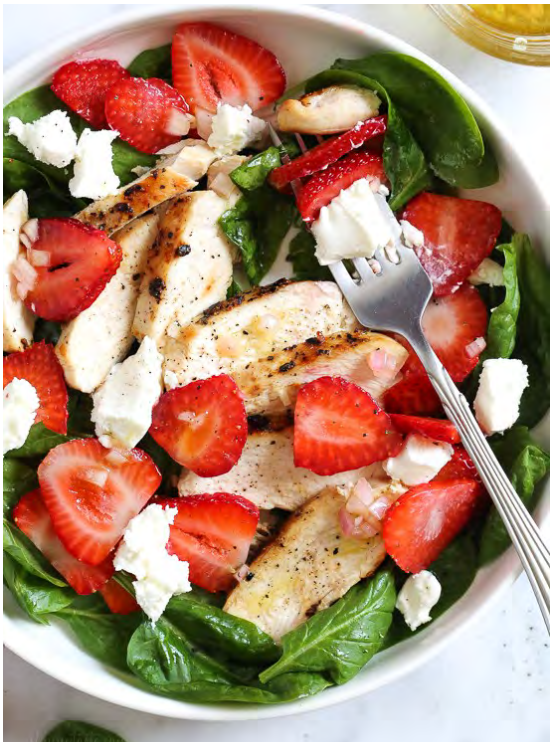
RSVP in advance. Email Janine Miller, Executive Director at jmiller@wcms.org

Please provide Name, address, Email & Telephone number of the attendee/s.

February's Healthy Recipe:

Grilled Chicken Salad with Strawberries and Spinach

Skinnytaste.com



Ingredients:

For the dressing:

- 3 tbsp golden balsamic vinegar
- 3 tbsp extra virgin olive oil
- 1 tbsp chopped shallots
- 1 teaspoon honey
- 1 teaspoon water
- 1/8 teaspoon kosher salt
- fresh black pepper, to taste

For the chicken:

- 16 oz boneless skinless chicken breast
- 1 clove garlic, crushed
- 1 teaspoon seasoned salt, to taste (I used Montreal Steak Grill Mates)

For the Salad:

- 6 cups baby spinach
- 3 cups sliced strawberries
- 2 ounces soft goat cheese

Read more at: https://www.skinnytaste.com/grilled-chicken-salad-with-strawberries-and-spinach/

Preparation:

1. In a small bowl whisk together the dressing ingredients.
2. For the chicken: Season chicken with seasoned salt, then mix in crushed garlic.
3. Light the grill or indoor grill pan on medium heat, when hot spray the grates with oil and grill the chicken about 10 to 11 minutes on each side until charred on the outside and cooked through in the center. Set aside on a cutting board and slice on an angle.
4. In a large bowl toss the spinach with the dressing. Divide between 4 plates and top with strawberries, goat cheese and
   grilled chicken.

NUTRITION INFORMATION

Yield: 4 Servings, Serving Size: 1 salad with 3 oz chicken

Amount Per Serving: Calories: 331 calories - Total Fat: 17g - Saturated Fat: g - Cholesterol: 89.5mg - Sodium: 345mg - Carbohydrates: 4g - Fiber: 4g - Sugar: 10.5g - Protein: 31g

WCMS is proud to announce that our administrative office will be moving to the campus of New York Medical College as of April 1, 2018

Our new address will be:
40 Sunshine Cottage Road
Valhalla, NY 10595

MYALGIC ENCEPHALOMYELITIS/CHRONIC FATIGUE SYNDROME: WHAT EVERY PHYSICIAN NEEDS TO KNOW

By Mary Dimmock, Susan Levine, MD, and Terri L. Wilder, MSW

Introduction
Myalgic encephalomyelitis (ME), also known as chronic fatigue syndrome (CFS) or ME/CFS remains an elusive diagnosis to most physicians. There are currently no Federal Drug Administration (FDA) approved treatments specific to this disease. Clinical guidance has often recommended cognitive behavioral (CBT) and graded exercise therapy (GET), but these therapies are inappropriate and potentially harmful for patients with ME/CFS. In 2015, the Institute of Medicine (IOM, now called the National Academy of Medicine) issued new clinical diagnostic criteria for ME/CFS and summarized the growing evidence of biological impairment. Since then, the National Institutes of Health (NIH) has funded three Centers of Excellence to study ME/CFS, a pediatric ME/CFS primer has been published, and the Centers for Disease Control (CDC) has updated the diagnostic and treatment information on its website. Physicians have a critical role to play in providing early diagnosis and effective treatment of this disabling disease.

History
ME/CFS has existed throughout the twentieth century but has been both maligned and misunderstood as a result of a lack of research, a paucity of diagnostic tests and FDA approved treatments, and because of non-specific diagnostic criteria that included patients with other diseases. As a result, patients with ME/CFS have remained unidentified or have been misdiagnosed and thus have struggled to get proper clinical care.

Further complicating our understanding of ME/CFS, a significant number of ME/CFS research studies have focused on the role of psychogenic factors in the development and perpetuation of the disease. These studies were based on the unproven theory that the severity and poor prognosis of ME/CFS was due to the patients' harboring a fear of activity and thus becoming deconditioned and that these could be reversed with CBT and GET. Unfortunately, the most commonly recommended treatments in ME/CFS clinical guidance have been CBT and GET, based on these false presumptions.

Other researchers have focused on evidence of biological pathology across multiple systems, including the characteristic abnormal response to exertion. In 2015, IOM reviewed the published evidence for the biological underpinning of ME/CFS and concluded that the disease is not psychological or due to deconditioning. Based on the findings of more than ten thousand peer-reviewed articles published worldwide, it is clear that ME/CFS is a chronic, multi-system disease associated with neurological, neurocognitive, immunological, autonomic, and aerobic energy metabolism impairment. The IOM report called attention to the disease's hallmark symptoms, such as post-exertional malaise (PEM), a delayed exacerbation of symptoms and a loss of stamina following even trivial cognitive or physical exertion. To address the problem of under- and misdiagnosis, the IOM report also established new clinical diagnostic criteria, which require the presence of the following core symptoms: substantial impairment in activity accompanied by exhaustion; post exertional malaise; unrefreshing sleep and neurocognitive or autonomic dysfunction, all of which must have been present for at least 6 months.

Supporting the conclusions of the IOM report, the Agency for Healthcare Research and Quality (AHRQ, part of Health and Human Services) published a 2016 addendum to a 2014 evidence review that downgraded the 2014 recommendations for CBT and GET, because the supporting studies had included patients with other `fatiguing' illnesses. AHRQ also reported that harms were generally underreported but that GET trials were "associated with higher numbers of reported adverse events." Patient surveys have also reported a worsening of symptoms following both GET.

Since the IOM report, the NIH has undertaken an intensive intramural study to better characterize the pathophysiology of the disease and in September 2017 awarded a 5-year, $35 Million grant to three centers to spur research and effective collaboration among researchers, clinicians and the ME/CFS patient community. Two of these centers are in New York, at Columbia's Mailman School of Public Health and at Cornell University. Also in 2017, a pediatric ME/CFS primer was published providing specific guidelines for the diagnosis and treatment of this disease in children and adolescents and the CDC updated its ME/CFS website, adopting the IOM's clinical diagnostic criteria and removing CDC's earlier recommendations for CBT and GET.

Demographics and Presentation
ME/CFS is believed to affect approximately one million Americans, but quality epidemiological studies are limited and the actual disease prevalence could be higher. The IOM reported an estimated prevalence of 1 to 2.5 Million Americans, which amounts to 62,000 to 125,000 in New York State. ME/CFS affects more women than men and affects people of all socioeconomic backgrounds, age range and ethnic and racial diversity. There are no simple diagnostic tests or biomarkers, and there are no FDA approved treatments specific to this disease. The IOM report estimated that as many as 84-91% of patients are not diagnosed.

The onset of ME/CFS is often sudden, typically following a viral or other type of infection but may occur following other types of physical trauma. In other cases the disease may develop gradually, over a period of weeks or , months

(Continued on page 15)

Classified Ad

Mt. Kisco, 666 Lexington Ave, Newly renovated Prime Location crossroads routes 128 & 117. For Lease: 875sf, 995sf, 1,718sf, 2750sf cjrockett@dpmgt.com

MYALGIC ENCEPHALOMYELITIS/CHRONIC FATIGUE SYNDROME: WHAT EVERY PHYSICIAN NEEDS TO KNOW

(Continued from page 11)

By Mary Dimmock, Susan Levine, MD, and Terri L. Wilder, MSW

Patients describe feeling `flu-like' symptoms chronically. In addition to the characteristic post-exertional malaise (PEM) , patients may also experience cognitive impairment, unrefreshing sleep, autonomic manifestations, such as heart rate variability and excessive sweating, and also experience muscle and joint pain and sound, light, and chemical sensitivity. Elevated antibody titers to viruses may be present, in addition to low levels of autoimmune serology.

ME/CFS can present with a wide range of severity. Even in the same patient, the level of severity can change over time and from day to day as symptoms wax and wane. People with ME/CFS are unable to go about their daily activities in a predictable or consistent manner. The IOM report stated that up to 70% of patients are unable to work and one quarter remain bed- or housebound (the latter however may be an underestimate). The IOM report stated that patients with ME/CFS are more functionally impaired than those with "type 2 diabetes mellitus, congestive heart failure, hypertension, depression, multiple sclerosis, and end-stage renal disease." Caring for severely disabled patients can put an enormous fiscal and emotional strain on family members and other caretakers.

Recovery is rare and as a result, patients can remain ill for decades. The IOM report estimated burden on the American economy is $17-24 billion annually in lost productivity and in direct medical costs.

Clinical Diagnosis

Previously, ME/CFS was considered a diagnosis of exclusion but the IOM criteria provide for the presence of certain "core" criteria in order to make the diagnosis of this disease. The IOM clinical diagnostic criteria for ME/CFS require:

- A substantial impairment in ability to engage in activity that lasts six months or more, is accompanied by fatigue, is not lifelong, is not the result of ongoing exertion and is not alleviated by rest
- Post-exertional malaise
- Unrefreshing sleep
- At least one of cognitive impairment or orthostatic intolerance

Sleep studies may identify co-morbid sleep apnea whereas the results of a tilt table test can confirm the presence of Postural Orthostatic Tachycardia Syndrome (POTS). Neuropsychiatric testing typically shows impaired working memory and slowed information processing. Querying the patient's response the day after activities that were previously tolerated can help determine the presence of post-exertional malaise (PEM). The 2-day cardiopulmonary test (CPET) is used to measure anaerobic threshold, which is reduced in this disease and confirms the seminal finding of PEM.

A number of co-morbidities can be seen in ME/CFS, the most common of which include fibromyalgia, POTS, mast cell disturbances, and certain autoimmune disorders. These will need to be managed as appropriate for each condition.

Treatment

A noted above, there are no FDA approved treatments for ME/CFS. However, there are interventions that the physician can provide to help patients with this disease. First and foremost, the physician can explain post-exertional malaise and the associated aerobic metabolism impairment. For some people, exertion as minor as tooth brushing or eating can trigger PEM and a crash. People with ME/CFS should not exceed their "energy envelope" and they should use an activity management approach called "pacing" to not exceed their limits. Physicians can also prescribe therapies that relieve symptoms, including those for sleep, pain, and orthostatic intolerance, including IV saline and Florinef. For patients with elevated viral titers, antiviral medications can help reduce symptoms. Patients often use earphones, earplugs, sunglasses, and eye masks to relieve the sensitivities to light and sound.

Physicians can also support patients by explaining the disease to the family and supporting applications for disability. Social security accepts the 2-day CPET as objective evidence to support a disability claim. If this test is not easily available, a thorough explanation from the clinician caring for a patient with ME/CFS that describes the patients' daily activities may suffice.

Conclusions

Physicians have an important role to play in the diagnosis and care of people with ME/CFS. In May 2017, New York State Commissioner of Health Dr. Howard Zucker sent a letter to NYS physicians encouraging them to include ME/CFS as part of the differential diagnosis when evaluating patients with these symptoms. The clinical diagnostic criteria published by the Institute of Medicine (IOM) are an important tool in this differential diagnosis that can result in faster and more accurate diagnosis. They can also provide the basis for treatment recommendations that can relieve symptoms and minimize post-exertional crashes. Most importantly, the physician can validate the patient's experience and ensure that the patient is not harmed by inappropriate treatment recommendations for exercise or talk therapy intended to convince the patient they are not ill. *(Endnotes can be found on pages 16 & 17)*

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Endnotes

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Mary Dimmock is the parent of a son with ME/CFS. She is a biochemist by training and retired from the pharmaceutical industry. She is on the board of Solve ME/CFS Initiative.

Susan Levine, MD has been seeing ME/CFS patients in her clinical practice for over 30 years. She is Board Certified in Internal Medicine and Infectious Diseases and has served as past Chairperson of the Chronic Fatigue Syndrome Advisory Committee (CFSAC).

Terri L. Wilder, MSW is a volunteer with #MEAction (www.meaction.net) and was diagnosed with myalgic encephalomyelitis in March 2016. She received a Master's in Social Work from the University of Georgia.