The Michigan Society of Pathologists again sponsored the Annual Residents Research Competition open to both residents and fellows. This year’s competition was an unqualified success with 27 poster entries - 12 from Wayne State University, 8 from Henry Ford Health System, 4 from University of Michigan and 3 from St. John/Providence Health System. Included were mother and daughter submissions: Seema and Aisha Sethi representing respectively WSU and HFHS. Six of the entrants submitting two abstracts each. Entries were judged by a newly established review committee chaired by Rouba Ali-Fehmi. We are indebted to the following committee members for their blinded review of the abstracts- Kedar Inamdar, Mitual Amin, Raja Rabath-Hammad, Lamia Fathallah, Martin Bluth and Vinod Shidham.

Congratulations to the 2011 winners: First Place: Oleksander Kryvenko (Henry Ford), Two Second Place winners: Seema Sethi (Wayne State) and Juan Camilo Gomez-Gelvez (Henry Ford). Third place: Stephen Christopher Smith (Michigan). A big thanks to all who participated in making the competition both educational and successful.

SPRING CONFERENCE FEATURING DR. BRUCE SMOLLER EXAMINES DERMATOPATHOLOGY

Dr. Bruce Smoller trained in anatomic and clinical pathology at Harvard’s Beth Israel Hospital followed by a dermatopathology fellowship at Cornell New York Hospital under the tutelage of Dr. Scott McNutt. He remained on faculty for several years before moving to Stanford University to direct the dermatopathology section. While at Stanford, he served as Director of Dermatopathology and attained the title of Professor of Pathology and Dermatology. From there, he moved to the University of Arkansas for Medical Sciences where he was named the Chair of Pathology and held the Aubrey J. Hough Jr. Endowed Chair in pathology. Recently, he was named the Executive Vice President of the United States and Canadian Academy of Pathology and relocated to Augusta, GA to serve in this full-time position. He is also maintaining his connections to University of Arkansas as a dermatopathology consultant and is performing a similar role for Georgia Health Sciences University. Bruce has served as the President of the American Society of Dermatopathology, the Editor in Chief of the Journal of Cutaneous Pathology and as a member of the Education Committee and Council of the USCAP, he sits on numerous editorial boards of both pathology and dermatology journals. Bruce has authored or coauthored 9 textbooks of dermatopathology and over 40 chapters on the subject and has published in excess of 250 original articles in the field.

Also presenting at the spring conference are Adrian Ormsby, MD and Lee Min, MD speaking on Non-Melanocytic Lesion Case Studies Commonly Encountered in Community Practice

Dr. Ormsby is the Division Head of Surgical Pathology at the Henry Ford Hospital and a fellowship trained dermatopathologist. He is a graduate of Auckland Medical School, New Zealand and completed his residency in Anatomic Pathology and Dermatopathology Fellowship at The Cleveland Clinic, Cleveland, OH. He has a broad professional skill set and publishes and lectures in the fields of dermatopathology, gastrointestinal and breast pathology. Adrian has been recognized as one of Hour Detroit magazines Top Docs.

Dr. Lee is a Senior Staff Dermatopathologist at Henry Ford Hospital and a graduate of Seoul National University College of Medicine, Seoul, Korea. He completed his residency in Anatomic & Clinical Pathology and Dermatopathology Fellowship as well at Henry Ford Hospital. His extensive professional activities include nearly 200 publications and numerous workshops and courses. He has been named to America’s Top Physicians four times and is a popular pathology educator being named twice as Henry Ford Teacher of the Year.
LOOKING AHEAD
2012 SPRING CONFERENCE
Saturday May 5
at The Inn at St. John’s
featuring
DERMATOPATHOLOGY
presented by
BRUCE SMOLLER, MD
Executive Vice President,
U.S. & Canadian
Academy of Pathology

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PRESIDENT’S PERSPECTIVE
Richard Zarbo, MD

Changing the Status Quo in Michigan - Role of the Pathologist

“We cannot solve our problems with the same thinking we used when we created them.”  -Albert Einstein

I am wrapping my remarks in superior company to address the quality challenge we have before us as Pathology leaders. We are beginning a new phase in American medicine where the net reimbursement for services will eventually challenge our ability to deliver the customer demand for even higher levels of quality. If that isn’t enough, we will also now face non-payment for poor healthcare quality, some of which we may have no direct control over. But there is much we can do as pathologists.

As Einstein intimated above, a new systematic approach to work is called for. In 1926, Henry Ford,(10) reflecting on the extremely efficient auto manufacturing business he created, noted that: “Our system of management is not a system at all; it consists of planning the methods of doing the work as well as the work.” To translate to our business, the old way of doing business was to manage outcomes such as labeling defects and misidentifications by detecting defects after the fact. But inspection is a countermeasure when you cannot trust what you just produced, ordered, or received to be defect-free. Inspection itself is rework. It is far better to eliminate the need for inspection on a mass basis by building quality into the product (or service) in the first place.

How do we do this? By constantly monitoring in-process feedback and customer feedback to understand variation. It is this “scientific” understanding of the workplace that allows work to be redesigned by educated managers and trained, empowered work teams who use defined work rules focused on standardization of work, sound workflow principles, and efficient process improvement tools.

Successful change of the status quo is highly dependent on effective leadership and as a pathologist, you are a leader.

Many of your hospitals participate in the Michigan Hospital Association’s Keystone-Surgery Patient Safety Initiative. You might not know that, but your Operating Room manager probably will. I have had the pleasure of serving as the pathology consultant for this state-wide collaborative and marvel at the innovations that hospital teams from across the State have initiated to drive safety defects to zero.

The hand-offs, communications and safety issues related to specimens from our Michigan operating rooms has been a continuous focus of Keystone-Surgery since 2009. Much improvement has taken place already as measured by each hospital site monthly in the past 2 years. These data for specimen safety issues often come from the pathology laboratory. Did you know that? If not, you are missing an opportunity to become involved in changing the status quo, lending your expertise as a pathologist and improving the health and well being of patients whose care you have control over.

2012 Spring Conference Featuring Dermatopathology – its not just skin-deep!:
Maintaining our relevance in the future
The Health Care Reform Law (PPACA) is steadily rolling out now, and provisions will continue to kick in over the next 8 years, through 2020. Here is a review of select provisions of this act, along with some times of their implementation. This is by no means a complete list. I have not and likely will not read the 1,000 plus page law from start to finish. Good website resources exist with exhaustive lists of the Plan’s provisions. I’ve tried to list issues of more concern to physicians. The first part of the Health Care Plan proposed by President Obama is contained in The Stimulus Bill which he signed into law in February 2009 (http://www.readthe stimulus.org/) The second part of the Plan (a 1000+ page document) was signed into law in March 2010.

Plan Provisions by Year:

**2010:** (26 total; 26 in effect)

- A total of $245 million has been given to states to improve their processes for reviewing health plan premium increases. On July 7, 2011, HHS released a list of states and territories with effective review programs in the private small group and individual markets. On September 1, 2011, states and HHS will begin reviewing proposed premium increases for 2012.

  In September, 2010, The General Accounting Office announced the appointment of 19 members to the Board of Governors for the new Patient-Centered Outcomes Research Institute (PCORI). This group is responsible for Comparative Effectiveness Research. The PCORI website is available at http://www.pcori.org/.

- Provides a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap (“doughnut hole”) in 2010. Currently, when enrollees pass $2,700 in costs, they lose coverage until they reach $6,154. Further subsidies and discounts that ultimately close the coverage gap begin in 2011.

  In June, 2010, the first rebate checks were sent to Medicare beneficiaries who reached the Medicare Part D coverage gap. As of March, 2011, 3.8 million beneficiaries had received a $250 check.

- Provides tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees. Phase I (2010-2013): tax credit up to 35% (25% for non-profits) of employer cost; Phase II (2014 and later): tax credit up to 50% (35% for non-profits) of employer cost if purchased through an insurance Exchange for two years. In December, 2010, the IRS released guidance on the tax credits and the form that small businesses can use to claim the credits.

- Creates a temporary program to provide health coverage to individuals with pre-existing medical conditions who have been uninsured for at least six months. The plan will be operated by the states or the federal government. It expires when exchanges are implemented in 2014.

  The federal government is operating PCIP programs in 23 states and the District of Columbia, while the remaining states are running their own programs. On November 5, 2010, HHS announced new plan options for 2011 that include lower premiums for the federally administered programs.

  *Extended dependent coverage for adult children up to age 26 for all individual and group policies.

  *Prohibited insurers from denying coverage to children because of pre-existing conditions.

  *Prohibits health plans from placing lifetime limits on the dollar value of coverage and from rescinding coverage except in cases of fraud. Restricts annual limits on the dollar value of coverage (and eliminates annual limits in 2014).

**2011:** (20 total; 17 in effect)

- Required pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.

  *Restructured payments to private Medicare Advantage plans by phasing-in payments set at increasingly smaller percentages of Medicare fee-for-service rates; freezes 2011 payments at 2010 levels. The plans would have to spend at least 85 cents of every dollar on medical costs, leaving 15 cents for plan operations (overhead and salaries).
- Provided grants to states to begin planning for the establishment of Health Insurance Exchanges, which facilitate the purchase of insurance by individuals and small employers. Grants awarded starting March 23, 2011; enrollment in Exchanges begins January 1, 2014

  *Employers required to report the value of healthcare benefits on employees’ W-2 tax statements.

**2012:** (11 total; 9 in effect)

- Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.

  In December, 2011, CMS announced 32 health care organizations that will participate in the new Pioneer Accountable Care Organization project.

  *Reduces Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions.

**2013:** (13 total; 2 in effect)

- States indicate to the Secretary of HHS whether they will operate an American Health Benefit Exchange (Insurance Exchange).

  *Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income; waives the increase for individuals age 65 and older for tax years 2013 through 2016.

  *Medical expense contributions to tax sheltered flexible spending accounts (FSAs) are limited to $2,500/yr – indexed for inflation.

  *Thresholds for claiming itemized tax deduction for medical expenses rise from 7.5% to 10% of income. People age 65 or older can still deduct medical expenses above 7.5% of income through 2016.

  *Individuals making $200,000/yr or couples making $250,000/yr would have a higher Medicare payroll tax of 2.35%, up from the current 1.45%. A new tax of 3.8% on unearned income (dividends and interest) is also added.

**2014:** (19 total; 1 in effect)

- THE MANDATE - Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions). Individual penalty starts at $95 in 2014, rising to $695 in 2016. Family penalty is capped at $2,250.  ****THE MANDATE IS BEING LEGALLY CHALLENGED. TO BE HEARD BEFORE THE US SUPREME COURT IN SPRING 2012 ****

- Insurers prohibited from denying coverage to people with pre existing conditions, or charging higher rates to those with poor or chronic health conditions. Premiums can only vary by age, place of residence, family size, and tobacco use.

- New State Health Insurance Exchanges created. Income based tax credits available for many consumers in the exchange.

**2018:** (1 total; 0 in effect)

- High-cost employer-provided policies ($27,500 for family or $10,200 for single coverage) are subject to a 40% excise tax.

**2020:** (1 total; 0 in effect)

- Coverage gap in Medicare prescription benefit (“doughnut hole”) is phased out. Seniors continue to pay the standard 25% of their drug costs until they reach the threshold for Medicare catastrophic coverage.

2012 and beyond: Important to keep in mind that a few parts of this law are currently under legal challenge. Stay tuned to see if the legal outcomes will change parts of the PPACA, the whole law, or eradicate it altogether.

The compiler wishes to thank Sallie and Sue Schiel and Lora Wright for their patience and kindness. 2-21-2012
2012 CODING CHANGES HIT IMMUNOPEROXIDASE COCKTAILS

BY KIRK WOJNO, MD

According to the NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES Released on 12/29/11 Multiple stains performed on the same slide cannot be billed individually. In effect this policy renders multi-color cocktail immunoperoxidase staining, to be a non-profitable test in most laboratories. This policy leaves the pathologist in a dilemma; either lose money for their laboratory or perform substandard of care staining to make the test profitable.

The new policy manual states that the unit of service for immunohistochemistry (CPT codes 88342, 88360, 88361) is each antibody(s) stain (procedure) per specimen. If a single immunohistochemical stain (procedure) for one or more antibodies is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen. Physicians should not report more than one unit of service per specimen for an immunohistochemical antibody(s) stain (procedure) even if it contains multiple separately interpretable antibodies.

According to doctor Niles Rosen, the medical director of the National Correct Coding Initiative “Thus the coding rules create a moral and ethical dilemma for providers and manufacturers. … If a manufacturer replaces a three antibody multiplex stain with three separate single antibody stains the provider can report three units of service as has always been the case. However, multiplex stains have been developed and promoted as an improvement in technology and quality of care. … If one is concerned about making health care more affordable then they will seek a new code from the AMA CPT panel describing multiplex stain procedures so that a fair and appropriate payment can be set”

One of the most commonly used multiplex stains is the cocktail of p63, 34BE12 and p504s for the diagnosis of prostate cancer. Polling of laboratories across the country including Dr. Jonathan Epstein at the Johns Hopkins Hospital, we find that multiplex immunoperoxidase staining is appropriately utilized in about 5% of prostate cancer cases and sometimes more frequently for less experienced pathologists. So this is not so much of a huge hit to the finances of the laboratory as it is a disturbing trend where the pathologist and the laboratory take the brunt of government imposed cost reductions. The burden then lies with pathologists and organized pathology to advocate for appropriate vendor pricing and correct CPT coding, a process that will take years. In the meantime this is yet another hit to the finances of the laboratory and has the potential to slow the development of more multiplex stains for other diagnostic workups. So in the end, the quality of patient care suffers by this government imposed attempt at cost reduction and the development of advanced laboratory testing is hindered.

Let your voice be heard by contacting CAP and your politicians on this and other matters that affect the quality of patient care.

TWO NEW TRUSTEES JOIN MSP BOARD OF DIRECTORS

December marked the completion of Dr. Sherwin Imlay’s second term as a member of MSP’s Board of Trustees. He was also a member of the Judges Panel for the annual Residents Research Competition. A heartfelt thanks to Dr. Imlay for being an active, productive and loyal Trustee.

At the December Membership meeting Veena Shah, MD was elected by acclimation. Also, announced at the December Board of Directors meeting was the Board appointment of Wael Sakr, MD to fill the remainder of Dr. McKenna’s term. Thank you Barbara for your time as a Board Trustee.