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Welcome to the UMA House of Delegates, 2020. This is our first ever virtual House of Delegates (HOD), and like so many innovations brought about by Covid-19, I predict it will be a positive feature of the future. The virtual HOD makes it possible this year to meet safely, and enables many to attend and participate who might not otherwise be able to travel.

First, to all those who are new, I would like to extend a special welcome. Your job as physician is already a busy one and the time you are committing is sincerely appreciated. First time delegates are often a little uncomfortable in the normal HOD, as Robert’s Rules of parliamentary procedure are not in the everyday vernacular of most physicians. We welcome you, and hope you will not be shy to speak up and participate. Your voice is welcome here, whatever you have to say.

There are many things I love about the Utah Medical Association. I love the incredibly intelligent company and community. Everyone here has a passion for medicine, and service, in the name of physicians, and our patients, and the enterprises that support us in patient care. I love the intelligent and civilized debates. The HOD and the Board are forums for exchanging ideas, and you need not agree with a colleague to listen to them respectfully, perhaps learn something you didn’t know, maybe even change your mind, or represent your own point of view with articulate passion.

I love the gestalt. If you look around this virtual room, you will see physicians representing nearly every specialty, primary care and surgery, urban tertiary care and rural underserved, academic, large medical group practice, government agencies, small private practices, and students at every stage. We are young and old, ladies and gentleman, and we all belong here, together. We are greater together than the sum of our parts, or specialties, or mode of practice. What unites us is in the service of our community and in our experience and needs as physicians, and these are far more important than the details of our day-to-day work that sometimes divide us. The gestalt is built on respect and civil discourse, and you will find it here.

I want to emphasize that the Utah Medical Association is an organization of physicians, for physicians, and an extension of our service in the community. Just as we take pains to care for the caretakers of our patients, we as physicians must take pains to care for one another. The profession is a noble one, and many of us chose it because we “wanted to help someone,” and we are fascinated with the applied sciences.

The profession is also freighted with expenses and revenue opportunities, whose consideration does not come naturally to some physicians. We ourselves are both expenses and revenue opportunities within the larger healthcare systems. Learning to navigate the larger healthcare systems while preserving the integrity of the profession, of evidence-based medicine, and the physician-patient relationship and covenants, is perhaps more difficult than any other challenge.

The majority of physicians don’t relish politics. And yet, Covid-19 has made it more painfully obvious than ever that we are immersed up to our eyeballs in political considerations (and the eyeball reference comes from an ophthalmologist who happens to be a swimmer & SCUBA diver, comfortable under water). If you were one of the anesthesiologists or ER docs who could not access an N95 mask, you might have wondered where your advocates were with regard to your basic needs. The majority of physicians never thought they would join a union, and yet the majority of us are now employed,
rather than self-employed. Most of us studied smallpox, polio, and dengue fever, but did not expect to practice through a pandemic of Covid-19, or an epidemic of opioid overdose. Merging the basic and applied sciences, evidence-based medicine, with the politics and economics of delivering care in the community, is the challenge physicians face collectively, the *raison d’être* of the Utah Medical Association.

The intellectual integrity of evidence-based medicine is the core of our profession. It doesn’t come easily, requiring years of education, statistics, and peer review. It isn’t always welcome news. It requires translation to the general public and press.

The compassionate delivery of evidence-based medicine is the sweet satisfaction, the visceral pleasure, that drew most of us into medical school. It requires sacrifice of time and treasure. It can be incredibly taxing, and our taxes help pay for it. And yet you come back for more, and you come here, to the Utah Medical Association House of Delegates, on your own time. Thank you.

The Utah Medical Association is here to help you enjoy the gestalt, to preserve both the intellectual integrity and compassionate delivery of evidence-based medicine, even in unforeseen circumstances. The Utah Medical Association is here to help you meet your own needs as a professional provider, as well as the needs of your patients. Welcome! Please don’t be shy.

All this requires both grassroots lobbying by physicians, and professional sophistication in lobbying of legislatures and government agencies, healthcare finance, and in the process for innovation and regulation of new drugs and devices. This is where we as physicians depend heavily on the expert staff of the UMA. We owe them a huge debt of gratitude. If you give them a half a chance, they will teach you how to lobby and advocate effectively for yourself and your patients. They will be at the legislature while you are in clinic or surgery.

The Utah Medical Association, the staff, and all those physicians who have been here once before, are here to help you with your concerns for yourself, the profession, and your patients.

Welcome!

Thank you for joining us.
The UMA House of Delegates may have been a bit quieter than usual due to the COVID-19 induced format change to a virtual meeting, but it was anything but sedate. The House tackled big issues such as abortion policy, racial discrimination, mask mandates and more. Debates were spirited while maintaining the courtesy and respect for opposing views that has been the hallmark of the House of Delegates since it was instituted in 1895.

UMA also unveiled its new logo and tagline (“Better Health, Better Life for Utahns”) to delegates at the House meeting. In addition to UMA policy changes, delegates also approved the creation of a Minority Affairs Committee for the Association.

UMA President Matt Wilson, MD, reviewed his year as UMA President, suggesting that future presidents avoid being elected to serve during a pandemic, but said UMA had still been successful in influencing public policy and assisting Utah physicians weather the global health crisis.

Using a Zoom webinar format, UMA Staff created virtual backdrops and pre-recorded videos to maintain a graphic consistency and break up the potential for sleep-inducing fatigue that can come with long virtual meetings. The UMA Speaker of the House and Vice-Speaker were able to facilitate debate by asking delegates who wished to comment on proposals to raise an “electronic hand,” and make motions using a chat box function. Voting was accomplished using the Zoom polling functions for both officer elections and votes on resolutions and amendments.

Although delegates missed the normal networking and face-to-face interaction of previous House of Delegates meetings, debate and voting using the online format were deemed even more efficient than usual. As in past years’ live meetings, prize drawings were held for those who stayed to the end of the meeting. Sponsoring vendors also provided prize drawings for those who visited their virtual exhibit booths.

St. George ophthalmologist Sharon R.M. Richens, MD, was installed as UMA’s new President for the coming year. Delegates also elected Davis County
Final Actions of the 2020 UMA House of Delegates
September 12, 2020

pediatrician Noel C. Nye, DO, as the new President-elect, the first osteopath to ever win the position.

The following is a complete rundown of actions taken by the House of Delegates along with election results:

RESOLUTIONS ADOPTED

RESOLUTION A1 – Protection Against Legislation Mandating Medical Procedures or Testing
RESOLVED 1, that UMA oppose mandates on medical procedures or testing that is not medically indicated, standard of care, required for legal proceedings, or health department recommendations.

RESOLUTION A2 – Return Title X Funding to Utah
RESOLVED 1, that UMA support the state of Utah applying to receive our Title X funding to provide confidential family planning services to low income individuals without age restriction; and be it further
RESOLVED 2, that UMA encourage the state of Utah to agree to follow the same requirements when providing care using Title X funding as all Utah clinics already follow when providing care to Medicaid clients in cases in which medical care is sought when parental consent is absent.

RESOLUTION A4 - Health Care Quality

RESOLUTION A5 - Utah Physician-Supported State Mask Mandate
RESOLVED 1, that UMA recommend and support a statewide mask mandate, as supported by medical and epidemiological evidence, until the pandemic is sufficiently under control as defined by state public health and epidemiology experts, and be it further
RESOLVED 2, that UMA continue its efforts and support of public education on the public health benefits of mask wearing.

RESOLUTION A3 - Health Care Quality Improvement Care Act by Peer Review Protection at the Physician Practice Level
RESOLVED 1, that the UMA medical malpractice committee evaluate the current peer review statute as it relates to discoverability to see if further language needs to be added to cover physicians, physician practices and medical malpractice carriers under the protections of the peer review statute so that quality review and peer review discussions are protected; and be it further
RESOLVED 2, that UMA propose legislation to fix the peer review physician issues if needed and recommended by the UMA medical malpractice committee and continue to work with physician practices on the issue of immunity in peer review.

RESOLUTION B1 - Non-discrimination Against Osteopathic Physicians and Osteopathic Medical Students
RESOLVED 1, that UMA denounce discriminatory acts or behavior against physicians or medical students solely based on osteopathic or allopathic training; and be it further
RESOLVED 2, that UMA adopt a non-discrimination position statement or policy that denounces discrimination, harassment, or retaliation against any physician or medical student based solely on their osteopathic or allopathic training.

RESOLUTION B2 - Support for a Utah Advance Directive and POLST Registry
RESOLVED 1, that UMA support the ongoing development and maintenance of an electronic registry for Utah advance directives and Utah POLST forms in order that hospitals, treating physicians, emergency medical providers, home health and hospice agencies can have access through a Utah POLST Registry so the patient’s wishes can be followed; and be it further
RESOLVED 2, that UMA help educate physicians on how to properly fill out and update the POLST forms and Advance Directives with appropriate patients so the forms can be uploaded to the Utah POLST Registry and patients’ wishes may be followed.

RESOLUTION B3 - Racial Inequalities and Healthcare Disparities
RESOLVED 1, that UMA and its members denounce all forms of racism; and be it further
RESOLVED 2, that UMA and its members
increase their awareness of racial and ethnic disparities in healthcare and work toward eliminating these; and be it further.

RESOLVED 3, that UMA and its members commit to understanding their own biases and to adopt the principles of inclusion, non-discrimination, consistency, and equitable access to healthcare services for all members of our communities; and be it further.

RESOLVED 4, that the UMA offer educational opportunities to encourage better understanding and awareness of racial inequalities and healthcare disparities among its members and in the UMA.

RESOLUTION B4 – Electronic Health Record and Health Information Exchange Interoperability with Utah’s Controlled Substance Database

RESOLVED 1, that UMA collaborate with the Utah Division of Occupational and Professional Licensing and Controlled Substance Database (CSD) administrators to adopt rules that allow for electronic health records systems used by Utah physicians and other controlled substance prescribers to interface with the CSD to ensure that all providers have access to patient CSD records during the treatment of their patients; and be it further.

RESOLVED 2, that UMA collaborate with the Utah Division of Occupational and Professional Licensing and the Controlled Substance Database (CSD) to adopt rules that allow for the Utah Clinical Health Information Exchange to interface with the CSD; and be it further.

RESOLVED 3, that UMA request that the Utah Division of Occupational and Professional Licensing:

- report on the status of the Controlled Substance Database (CSD) interoperability with electronic health records and the Utah Clinical Health Information Exchange (cHIE) and describe current gaps in CSD interoperability, and
- collaborate with UMA to establish a plan to increase the number of prescribing clinicians that have an electronic health record interoperable with the CSD.

RESOLUTION B5 – Optional COVID-19 Testing for Physicians

RESOLVED 1, that UMA advocate with state and local government, hospital systems, and other pertinent stakeholders for optional asymptomatic testing of healthcare workers for SARS-CoV-2 at low or no cost; and be it further.

RESOLVED 2, that UMA encourage employers to follow current CDC and CMS recommended strategies and guidelines for testing and quarantine of healthcare workers for SARS-CoV-2.

RESOLUTION REFERRED TO THE BOARD FOR REPORT BACK TO THE HOD

RESOLUTION A3 – Early Abortion Access in Utah

RESOLVED 1, that UMA oppose on a case by case basis legislation that directly or indirectly seeks to deprive people of the right to obtain an abortion prior to fetal viability, with viability considered as the capacity of the fetus for sustained survival outside the uterus, which is a medical determination, may vary with each pregnancy, and is a matter for the judgment of the responsible health care providers; and be it further.

RESOLVED 2, that UMA support legislation that seeks to reverse previous limitations placed by legislative bodies on that right.

OFFICERS & ELECTIONS

Sharon R.M. Richens, MD, was installed as UMA’s new President.

Noel C. Nye, DO, was elected as President-elect.

Other officers elected were the following:

At-Large Director:
Jason R. Hoagland, MD FAAP

AMA Delegate:
Patricia F. Hirning, MD FACP

AMA Alternate:
Richard F. Labasky, MD MBA

Speaker of the House:
Paul N. Clayton, MD

Vice Speaker of the House:
Sarah L. Woolsey, MD MPH FAAFP

Nominating Committee:
Mark K. Milligan, MD
Scott D. Peterson, MD
William K. Sheffield, MD FACEP
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Learning all the skills necessary to take care of a broad range of patients, whether it be infant or grandparent, to needing the skills to cover emergency departments, ICUs and labor and delivery decks, can be quite daunting at times. Luckily, there are plenty of resources available. As an intern, I felt like I was drowning in this sea of knowledge but gradually identified a tried and true set of resources that provided me with a life vest for my ongoing upstream paddle. So, for all you interns out there feeling overwhelmed, you are not alone! There are so many things out there to help you! The internet! Your program! Apps and apps galore!

My favorite resources to review key topics, facilitate on-the-fly learning and hit home those basics are:

**AAFP MONTHLY JOURNALS**

Each issue covers three major topics pertinent to clinic and hospital rotations. The articles are concise, easy to read, up to date and evidence based. You can get them mailed to you and/or emailed through the AAFP website. When I have down-time on lighter rotations, I will read a few and even reference them for specific topic review (I have collected over a year’s worth now. My bookshelf is nerdy.)

**DYNAMED**

This overlooked cousin to UpToDate is easier and faster to skim (in my opinion). The information is delivered in bullet-point format and is more concise and more updated (reviewed and updated weekly). If you are looking for more detailed information, then you only need to scroll down. It keeps things short at the top and then expands on topics below.
Proactive risk management programs can reduce the risk of a claim or suit. We offer many specialty-specific programs, as well as those that can be used by all medical practitioners. Our policyholders have access to MICA’s extensive selection of risk management tools, such as: office audits, online CME, monthly webinars, podcasts and weekly Hot Topic emails. Our dedicated risk management hotline is staffed during business hours by Risk Management Consultants who are available to answer any questions you may have about risk mitigation in your own practice.

To learn more about the risk management tools that MICA provides, how you can become a member, or to get a quote, visit our website mica-insurance.com or contact us at 800.352.0402.
**UPTODATE**

Of course. Best part is that it is linked to Lexicomp so you can type in a topic or drug and get a good set of results. I find UpToDate not specific enough for quick review though and can get wordy so is hard to skim in a pinch.

**EPOCRATES**

It is very helpful for pharmacology like Lexicomp but easier to look up pharmacokinetic info on the application and faster to search side effects, interactions, etc. But as far as dosing for specific conditions, Lexicomp is still my go-to. All the pharmacists use Lexicomp so you can rest assured what you look up on Lexicomp will earn you rounds points and be accurate.

**MDCALC**

Let’s be honest, we cannot possibly remember formulas and calculators for everything. This application is gold. Sometimes if I cannot remember if there is a calculator for a specific condition, I will just type random related words in and always find something helpful for patient care. Great for inpatient, outpatient rotations and clinic.

**DOXIMITY APP**

In the new world of virtual visits, having an easy VV backup on your phone and phone dialer is crucial. I find the app helpful for the dialer component. You can set it to show the clinic phone number when you call patients, so you don’t have to worry about patients getting your personal number when you are answering patient messages. The dialer also has an option for video chat which can help if your virtual visit experiences glitches and you need a quick backup. Patients get a text message with a link they click, and no download needed on their end.

**USPSTF AND SHOTS APPLICATIONS**

Helpful for clinic well child checks and other healthcare related questions.

**PROGRAM-DIRECTED DIDACTICS**

These occur weekly at the program I am in and offer lectures on topics relevant to family medicine specifically. They are well rounded and cover aspects of patient care the applications do not. Even if you cannot attend, the lectures are provided to all and can be read at another date.

**FIRST AID, STEP UP TO MEDICINE BOOKS, BOARD PREP BOOKS**

Yes, that’s right. I still reference my old medical schoolbooks at times (call me a hoarder or masochist). The information in them becomes a lot more relevant as you go through residency and sticks in a different way when reading it again.

**LIBRARY RESOURCES PROVIDED THROUGH INSTITUTION**

You can look up literally anything via the library.

This is a lot of information. Seems familiar doesn’t it? I found that what worked best for me was reading my AAFP monthly journals, taking notes of helpful information during didactics and using DynaMed/UpToDate (easier access on computers sometimes) / Epocrates if needed while on inpatient rotations, or if I had a quick question I needed to research on the fly. It is easier to retain information if it is tied to a patient encounter so make the most of your shifts. This also allows for less studying during your free time so you can unwind and have fun. All in all, good luck, you got this.

**WINTER, THE DYING SEASON**

I heard a colleague refer to the winter months as the dying season and yes, as a resident covering the inpatient service at a local hospital during late November and December, that name seemed to encompass my time on the service well. It was overwhelming in its accuracy.

Performing clinical rotations in a small, rural town in Pennsylvania during medical school has made me no stranger to this terminology. But as a resident, with more responsibility, this phrase meant more to me than ever before.

On service, one ICU patient after another was dying. How could this be happening? What was I doing wrong? I felt sad, incompetent and beaten from my job. I was not sure how to cope.

I found myself recovering well during the workday, or so I thought, because I was required to maintain focus for the care of my other patients. But when my day off came around, I was suddenly and harshly thrust back into those events the minute I had the chance to relax. I was haunted by the faces of the patients I had lost and the voices of their distraught family members. I remember hearing one phone call I had with a patient’s daughter over and over any time I fell asleep, her distinct cries piercing and distinct even in a dream. Her cries brought back the faces of so many others—others from residency and others from medical school.

How do we cope with death as residents? We are overworked, over-stressed, and constantly doubting our decisions, choices, and expertise. We have limited time to process patient deaths and, I
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admit, in the moment my thoughts kept circling back to: *this is my fault*. I missed something. I made a mistake. This is because of me. Me. ME.

But this was never the case. The guilt creeps in so easily because we take this job to help patients, make them feel better and improve quality of life, relieve their fears, their family’s fears—make everything okay. But this is not always possible. Death is inevitable.

My experiences in medical school dealing with patient death ultimately drove me to pursue a career in family medicine so I could provide preventive care to reduce comorbidities for patients and hopefully, untimely deaths. They also helped me develop skills that made me more comfortable having end of life discussions with patient families while in residency. Despite all of this, the feelings of guilt and self-doubt surrounding patient death persisted.

This alludes to the importance of support and education surrounding managing patient death provided by residency programs and medical schools to address those unavoidable feelings and reduce burnout. Many articles also exist on how to deal with death and dying in medicine and how preparing students in medical school can help in the long term because this topic is so difficult for many. Ultimately, articles cannot prepare us for the emotional complexity associated with these events, but they do open up a dialogue that is also important on processing emotions. Ultimately, the experiences themselves prepare you.

Below are some methods I have experienced in medical school and residency that have been effective for my own experiences:

1. Support group: open dialogue about managing emotions, wellness strategies
2. Debriefing after events: what happened, how it happened, what can be learned
3. Co-resident reach out

It wasn’t until this winter inpatient rotation, during my intern year in residency, that I realized what I was doing wrong. I was not focusing on the exceptional care I was able to provide thanks to a wonderful team. Nor did I focus on the connections I was able to make with patients and their families. I kept making every situation about myself—but in healthcare, we work as a team. We work together to provide the best care we can to patients and I never utilized the team support that was available to me to help me process these events. Thankfully, I am lucky to be in a program where I get to work with my friends every day and it took support from my fellow residents, family and time during days off to reflect and face what I was feeling. It also took a thank you card from a patient’s family, to remind me that even if death can’t be avoided, there are still ways to help patients and their families.

Tory Toles, MD, is from Las Vegas, Nevada, and chose the University of Utah because it is an institution known for innovation and provides a diversity of educational opportunities, community involvement and strong commitment to care, all while located in an area with amazing natural beauty and outdoor recreation. Her medical areas of interest include medical education, office-based procedures, and reproductive and women’s health.
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As our nation struggles to overcome the most severe threat to public health in our lifetime, we must rely on evidence-based science and data. Doing so is key to formulating an effective response that protects our patients while earning their trust in the guidance we provide.

The AMA strongly opposes fear-driven rhetoric and political intimidation aimed at the apolitical search for objective science and data. There is no room in our nation’s emergency response to COVID-19 for a disdain of facts, science, and public health.

Solutions and policies grounded in the best science and evidence build societal trust and a common understanding in combating COVID-19. It is vital that our government’s scientific institutions can pursue and openly share objective data and information free from political filters and outside influence.

HARD TO REGAIN TRUST

Trust and credibility are at the heart of ethical, responsible behavior and effective leadership in medicine, in business, and in our daily lives. Once lost, these qualities are exceedingly difficult to regain. To risk the credibility of institutions such as the Centers for Disease Control and Prevention (CDC) or the Department of Health and Human Services for partisan political purposes is beyond unacceptable – it is unconscionable.

Our AMA has and always will vigorously oppose any form of political intimidation or fear-driven rhetoric that interferes with the collection and dissemination of objective science and factual data dealing with COVID-19 or any other aspect of public health. Our response to this pandemic must not allow any type of delay, distortion, misinformation, or deliberate falsehoods to come into play.

Today, our collective commitment to evidence-based science is more important than ever. Consider vaccines. We know that the repetition of disproved theories and false claims through social media and other channels has prompted some individuals to avoid immunizing themselves and their children – leading to outbreaks of mumps, measles, and other vaccine-preventable diseases.

AVOIDING POTENTIAL DISASTER

Once a COVID-19 vaccine is proven safe and effective, our patients need to know that its development was not compromised by political considerations or any factor or procedure that lies outside of evidence-based science. Efforts to undermine the credibility of the CDC also jeopardize the public’s trust in a COVID-19 vaccine, with potentially disastrous consequences.

We must demand the preservation of an environment in which physicians, scientists, academic researchers, and other experts can develop and freely communicate evidence-based information without fear of retribution, reprisal, or any other negative outside influence. Determining the safety and efficacy of a vaccine or course of treatment must be made by scientists and researchers and affirmed by transparent science and evidence.

Physicians know that trust lies at the center of the physician-patient relationship. We must do all we can to ensure trust remains an essential element of our national fight to overcome COVID-19.

Editor’s Note: This commentary was originally published on the American Medical Association website. The opinions expressed do not necessarily represent those of the Utah Medical Association.
Fundamentals like corporate earnings, interest rates, and economic growth are the main concerns of the stock market. But external events may sometimes be correlated to stock returns, for instance, the 4-year election cycle in the United States. Looking back to the 1850s, studies show the election cycle and its potential impact on the stock market. The “Presidential Cycle,” as it is known, shows a consistent pattern in which the first two years of a presidential term have tended to produce below-average returns while the last two years have been well above-average.

Presumably, the reason for this is that during the first half of a term, a president's new agenda could take some time to work its way through the economy. It might even produce some indigestion for the market if it is not considered “market-friendly.”

However, during the last two years, the party in power tends to be more inclined to focus its attention on getting re-elected, or so goes the general thinking. It presumably does this through fiscal stimulus and even monetary stimulus (at least it could have until the Fed became independent in 1951). This gooses the economy and creates a big rally that, presumably, is intended to ensure the re-election of the incumbent party (or at least that is the goal).

The market’s lackluster performance in 2018, followed by strong gains in 2019, certainly fits this pattern. This year, despite the global pandemic and...
early-year recession, bulls continue to hope that 2020 could be more of the same.

**SHORT-TERM DIFFERENCES, LONG-TERM SIMILARITIES**

What’s interesting to note is that whatever the differences are in outcomes over the first two years following a presidential election (and there are many), they have all but disappeared by the time a full 4-year term has taken place.

For instance, on average, as measured by the average growth of a composite index, over the first 2-year period, the market does better following a Republican win (+8.3%) than a Democrat win (+5.8%). Still, over a full 4-year term, the average difference virtually disappears, and we are left with +8.6% vs. +8.8% for Republican presidencies and all presidencies, respectively.

The contrast is even more extreme when there is a sweep. When the Republicans sweep, the 2-year average forward return is +12.2%, and when the Democrats sweep it is a mere +3.4%. But again, after four years, the difference in average returns is almost gone (+8.6% vs. +8.2%). There is also a difference between the various gridlock scenarios. Republican wins without a majority in the House or Senate have produced an average 2-year forward return of only +1.1%. In comparison, Democrat wins with opposition in Congress have produced an average forward return of +14.5%. Again, over the 4-year term, the difference narrows to +8.7% vs. +10.9%.

Part of this difference could just be the result of a small sample size. For instance, there were only six instances of a Democrat winning the White House without taking control of both houses of Congress, including President Obama’s second term in 2012 as well as President Clinton’s second term in 1996. These were very strong periods for the market, producing annualized gains of +22% and +27%, respectively.

There were only nine gridlock cycles on the Republican side, including George W. Bush’s first term in 2000, right at the top of the tech bubble. That produced a 2-year annualized return of −25%. Ronald Reagan’s first term in 1980 produced a 2-year return of −2% as the double-dip recession of 1980 and 1982 was still finding its bottom. But Reagan’s re-election in 1984 produced a +26% annualized gain over the subsequent two years.

Mid-term elections likely play a role in creating a contrast between the 2- and 4-year returns. The political pendulum is always swinging it seems, sometimes quickly and other times slowly. While some mid-term elections reinforce a president’s mandate, others cancel them out, mitigating whatever market momentum (positive or negative) was underway in the first two years.

**IT ALWAYS COMES BACK TO FUNDAMENTALS**

It could also just be that if you wait long enough, the long-term fundamentals of earnings and interest rates, labor growth and productivity, and the mean-reverting nature of an independent monetary policy, take over in driving long-term returns.

Most think that is what ultimately is going on here. The economy—and therefore, the market—is simply bigger than the direction the political winds are blowing. Plus, the mid-term elections tend to equalize any lopsided returns over the first two years.

It is a good reminder that while it is sometimes suggested that a particular president or party is “good” or “bad” for the stock market, ultimately, it is the long wave of economic fundamentals that drives the markets beyond any one election or any one party. ■
As mentioned in the legislative report in the April/May 2020 issue of the *Utah Physician*, the legislature passed one bill on balance billing—a bill to collect information on the issue. This bill, SB 155, requires reports from physicians, hospitals, and other healthcare providers who bill out-of-network Utah patients for certain healthcare services provided from July 1, 2020, through June 30, 2021.

The healthcare services that need to be reported to the Utah Department of Insurance (DOI) include services provided in the emergency department under EMTALA, as well as any follow-on services that stabilize, improve, or resolve the condition of the patient. This includes the work of emergency physicians and physicians on call in the emergency department.

Because the purpose of this reporting is to look at balance billing, physicians will only need to keep track of billing for services provided to patients that have insurance for which the physician is out-of-network, unless the patient is a traveler from out of state but is treated in a Utah facility. Physicians do NOT need to report on out-of-state patients. Physicians providing these services will need to keep track of how many of these episodes of emergency care they bill for and how many of those that they then balance bill for during the 12 months from July 2020 through June 2021. They will need to keep track of these numbers for each insurer where they are not in-network and for whom they see patients. Balance billing means billing the patient for the difference between the physician’s charged amount and the insurer’s allowed amount. It does not include billing the patient for copayments, coinsurance, or deductibles.

For each out-of-network insurer, physicians will need to take those two numbers for the 12 month period and calculate the percentage of care episodes they balance billed a patient for emergency, out-of-network services compared with the total number of episodes they billed for those services and report those percentages, not send raw or individual patient information in to the DOI.

By January 4, 2022, physicians and others will need to report to the Utah Insurance Department the percentage of balance billing they did for patients of each insurer. We will give further information on where to report the data as we get closer to the reporting date. In the meantime, make sure you are collecting this data for the one year time period if you are balance billing for services given through an emergency department. The law makes physicians and other healthcare providers immune from civil liability for disclosing this information to the department. The report is also to include the specialty or subspecialty of the physician or other provider.

The insurers will also be submitting a report to the Insurance Department for the same reporting period. The insurers are to report whether they provided reimbursement for out-of-network emergency services directly to the patient and the percentage of emergency department claims received for Utah patients that were provided by out-of-network providers.

The Insurance Department will provide a written report to the legislature on the information received under this bill, however the detailed information providers and insurers submit to the Insurance Department will be protected from disclosure under the state’s GRAMA law. The Insurance Department will also report on the amount charged by air medical transport providers that engage in balance billing.

We hope the information reported will clarify the scope of balance billing in Utah, because most proposals to address the issue so far have been driven by anecdotes rather than a clear picture of the extent of the practice. We then can address the actual problem and find a workable solution rather than trying to find a solution to an issue that is not really known or backed up by any data.
Chances are that by the time you are reading this, you have either provided care by telehealth or have been a recipient of a telehealth visit. Utah and the nation have seen unprecedented advances in the delivery of care virtually. The Utah Department of Health, Office of Health Care Statistics documented significant increases in a recent report from the All Payer Claims Database in both medical and behavioral care delivered by telehealth. Yet even before COVID-19 dawned, UMA was advancing telehealth coverage options for Utah clinicians. Long ago in March, our advocacy team advanced HB 313 sponsored by Representative Melissa Ballard, and it was passed and signed into law. The legislation “requires

Will We Call 2020 the Year of COVID-19 or the Year of Telehealth in Utah?

Local Resources for Utah Physicians
BY SARAH WOOLSEY, MD, MPH
certain health benefit plans to provide coverage parity and commercially reasonable reimbursement for telehealth services and telemedicine services.” Parity for coverage of telehealth services was a great advance for Utah commercial insurers and will add to the opportunities for telehealth payment that Utah Medicaid has provided. The COVID-19 crisis that has followed has even more telehealth coverage available under emergency status at both state and federal levels. Federal CARES Act funding is also being used to support telehealth advancement in the state and Utah providers will benefit.

One important resource for Utah providers is an independent state agency, the Utah Telehealth Network (UTN) a healthcare-focused division of the state Utah Education Network that provides broadband support, secure connectivity, and ensures telehealth “flows” throughout the state. UTN focuses on rural, underserved, and safety-net care settings and they stay up to date on Utah telehealth topics, including policy and billing information that may be in flux during the pandemic. Check their resources page for billing information for Utah payers, state emergency status regulations, and Medicaid updates. The UTN is receiving state CARES Act funds to provide access to an affordable HIPPA-compliant telehealth platform for clinics and hospitals, long term care settings, and dialysis centers. They encourage all providers to have HIPPA-compliant systems in place for patient care and will be providing technical and implementation support through their integrated audio, video, billing and scheduling platform. They are also convening all state entities that have received CARES Act monies directed at telehealth education, delivery, and hardware to ensure needs are met, programs aligned, and that all Utahns benefit from the COVID-19 stimulus.

Utah clinicians can reach out with comments, needs, and UTN will work to connect you to these resources.

The UTN also houses a regional federally funded education and support organization the Northwest Regional Telehealth Resource Center (NRTRC). Utah providers can access their educational programs, technical assistance, and stay apprised of national policy changes at nrtrc.org. The NRTRC has also received CARES Act funding to support telehealth advancement and permanence. Watch for upcoming educational offerings that focus on clinical processes, billing, and sustainable telehealth care delivery.

Another local resource is Comagine Health. They are interested in the delivery of telehealth in long-term care settings, outpatient clinic efficiency, and making sure quality is maintained as we continue using telehealth to reduce spread of COVID-19 and other infections and increase access to health care. Access a patient guide to assist your office to ready patients for their visits and other resources for all types of care through their telehealth resource page.

As UMA members we can continue to advocate for coverage for telehealth and use our voices to ask for maintenance of telehealth as a delivery option for our patients to see us, be paid to deliver continuous, high-quality care, and to allow us adapt as needed to pandemics, patient needs, and expand access to the great care we are known for in our state.

Reference
2  https://home.treasury.gov/policy-issues/cares
3  https://utn.org/covid/utah.shtml
4  https://comagine.org/resource/938
5  https://comagine.org/program/covid19/telemedicine

Sarah Woolsey, MD, MPH is a board-certified physician, telehealth user and consumer, chair of the Utah Telehealth Network Advisory Board, Comagine Health’s medical director for system-wide quality improvement, and was recently elected as UMA’s Vice Speaker of the House of Delegates.
The first major overhaul in more than 25 years to the codes and guidelines for office and other outpatient evaluation and management (E/M) services was included in the recent release of the 2021 Current Procedural Terminology (CPT®) code set published by the American Medical Association (AMA).

These foundational modifications were designed to make E/M office visit coding and documentation simpler and more flexible, freeing physicians and care teams from clinically irrelevant administrative burdens that led to time-wasting note bloat and box checking. The changes to CPT codes ranging from 99201–99215 are proposed for adoption by the Centers for Medicare and Medicaid Services on Jan. 1, 2021.

The E/M office visit modifications include:

- Eliminating history and physical exam as elements for code selection.
- Allowing physicians to choose the best patient care by permitting code level selection based on medical decision-making (MDM) or total time.
- Promoting payer consistency with more detail added to CPT code descriptors and guidelines.

“To get the full benefit of the burden relief from the E/M office visit changes, health care organizations need to understand and be ready to use the revised CPT codes and guidelines by Jan. 1, 2021,” said AMA President Susan R. Bailey, M.D. “The AMA is helping physicians and health care organizations prepare now for the transition and offers authoritative resources to anticipate the operational, infrastructural and administrative workflow adjustments that will result from the pending transition.”

The AMA has developed an extensive online resource library that includes a checklist, videos, modules, guidebooks,
as well as other tools and resources to help transition to the revised E/M office visit codes and guidelines.

The revised E/M office visit codes are among 329 editorial changes in the 2021 CPT code set, including 206 new codes, 54 deletions, 69 revisions. The CPT code set continues to see growth in new and novel areas of medicine, with the majority (63%) of new codes this year involving new technology services described in Category III CPT codes and the continued expansion of the Proprietary Laboratory Analyses (PLA) section of the CPT code set.

Changes to the CPT code set are considered through an open editorial process managed by the CPT Editorial Panel, an independent body convened by the AMA that collects broad input from the health care community and beyond to ensure CPT content reflects the coding demands of digital health, precision medicine, augmented intelligence, and other aspects of a modern health care system. This rigorous editorial process keeps the CPT code set current with contemporary medical science and technology, so it can fulfill its vital role as the trusted language of medicine today and the code to its future.

Among this year’s important additions to the CPT code set are new medical testing services sparked by the public health response to the COVID-19 pandemic. The CPT code set has been modified with several code additions and revisions that have been approved for immediate use and published for the 2021 CPT code set.

The CPT code set continues to be modified to respond to the fast pace innovation among digital medicine services that can improve access to health care and improved health outcomes for patients across the country. This is illustrated by new codes for retinal imaging and external extended electrocardiogram (ECG) monitoring.

The addition of code 92229 for retinal imaging with automated point-of-care, and revision of codes 92227 and 92228, better support the screening of patients for diabetic retinopathy and increase early detection and incorporation of findings into diabetes care. Innovative solutions like the augmented intelligence technology described by new code 92229 have the potential to improve access for at-risk patient populations by bringing retinal imaging capabilities into the primary care setting.

Technological advances in the field of continuous cardiac monitoring and detection have prompted the addition of codes 93241, 93242, 93243, 93244, 93245, 93246, 93247, 93248, along with associated guideline revisions. These codes will replace Category III codes 0295T, 0296T, 0297T and 0298T, which were deleted. These new codes utilize an innovative algorithmic technology that works in concert with a patch that is much easier to wear for patients and provides more accurate and complete data for physician interpretation.

To assist the health care system in an orderly annual transition to a newly modified CPT code set, the AMA releases each new edition four months ahead of the Jan 1 operational date and develops an insider’s view with detailed information on the new code changes.

The AMA also invites the health care community to stay up-to-date on the significant CPT code changes for 2021 by attending two virtual events this November, the Outpatient CDI Workshop and the CPT and RBRVS 2021 Annual Symposium. Meeting agendas and registration are available on the AMA website.

For more information, a special section for CPT education has been created for the AMA Ed Hub™, an online leaning platform containing CME and education, including a module series covering E/M codes, Clinical Examples of Radiology, as well as an overview of CPT coding basics.

Coding books and products, including the CPT 2021 Professional Codebook, are available from the AMA Store. The 2021 CPT codes and descriptors can be imported straight into existing claims and billing software using the downloadable CPT 2021 Data File. The file contains the updated code set’s complete descriptor package, including official descriptors for consumers and physicians, and the complete official CPT coding guidelines.

Tobacco Smoking Around the Time of Pregnancy, Utah PRAMS 2016–2018
FROM THE UTAH DEPARTMENT OF HEALTH

KEY FINDINGS

Prior to pregnancy, women were more likely to use tobacco if they were single, younger than age 20, did not attend college, on Medicaid or without insurance, living at 100% of the federal poverty level or greater, and whose pregnancy was not intended (Figure 2).

38.1% of women in Utah quit smoking when pregnant while 25.2% cut back, 19.9% quit before pregnancy, 10.9% quit later in the pregnancy, and 6.0% did not quit smoking during pregnancy (Figure 3).

Setting a deadline to quit smoking helped 32.7% percent of women quit smoking during pregnancy in 2016-2018 (Figure 4).

Smoking before pregnancy increases the risk of infertility. Smoking during pregnancy increases the risk of spontaneous abortion, prematurity, low birthweight, and sudden infant death syndrome. Despite known harmful perinatal outcomes from smoking, many women continue to smoke before and during pregnancy.

Studies show women who are most able to quit smoking by themselves during pregnancy quit before their first prenatal visit. Without intervention, women who continue to smoke after their first prenatal visit are more likely to continue smoking during pregnancy. Although quitting early in pregnancy produces the most favorable pregnancy outcomes, quitting at any time can yield benefits.

The Utah Pregnancy Risk Assessment Monitoring System (PRAMS) provides state-specific population data on maternal attitudes and experiences before, during, and after pregnancy. This study highlights the smoking status in women and information collected on quit methods before, during, and after pregnancy during the combined years of 2016–2018.

In the three months before pregnancy, 9% of women smoked tobacco daily, 4% smoked daily during the last trimester, and 5% smoked daily at the time they responded to the survey (2–4 months after delivery) (Figure 1). Disparities in pre-pregnancy smoking rates were identified among some sub-populations of women. When compared to the overall birth population, higher rates of prepregnancy of smoking were seen among women who were single, younger than age 20, unmarried, did not attend college, on Medicaid or without insurance, living at 100% of the federal poverty level or greater, and whose pregnancy was not intended (Figure 2).

Women who Smoked Tobacco Around the Time of Pregnancy

*Figure 1. 9.0% of women reported smoking three months before their pregnancy vs. 3.6% who reported smoking during the last trimester.*

Continued on page 26…
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**Characteristics of Women Who Smoked within Three Months Before Pregnancy**

*Figure 2.* Disparities in smoking rates were seen among sub populations of women younger than age 20, single, did not attend college, on Medicaid or without insurance, living at 100% of the federal poverty level or greater, and whose pregnancy was not intended.

<table>
<thead>
<tr>
<th>Maternal Age (years)</th>
<th>Population Estimate*</th>
<th>% of women who smoked</th>
<th>95% confidence interval</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20</td>
<td>4,902</td>
<td>22.4</td>
<td>16.3 – 28.5</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>20-29</td>
<td>76,343</td>
<td>10.5</td>
<td>9.1 – 11.9</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>56,603</td>
<td>6.4</td>
<td>4.9 – 7.8</td>
<td></td>
</tr>
<tr>
<td>≥ 40</td>
<td>3,306</td>
<td>**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal Race/Ethnicity</th>
<th>Population Estimate*</th>
<th>% of women who smoked</th>
<th>95% confidence interval</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, not Hispanic</td>
<td>109,047</td>
<td>9.0</td>
<td>7.9 – 10.1</td>
<td></td>
</tr>
<tr>
<td>Other race, not Hispanic</td>
<td>8,442</td>
<td>9.9</td>
<td>5.2 – 14.6</td>
<td></td>
</tr>
<tr>
<td>Any race, Hispanic</td>
<td>21,937</td>
<td>7.9</td>
<td>5.7 – 10.2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal Education</th>
<th>Population Estimate*</th>
<th>% of women who smoked</th>
<th>95% confidence interval</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>11,193</td>
<td>23.0</td>
<td>19.4 – 26.7</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>High school /GED</td>
<td>27,562</td>
<td>19.2</td>
<td>16.8 – 21.6</td>
<td></td>
</tr>
<tr>
<td>Some college/Associates</td>
<td>47,461</td>
<td>7.5</td>
<td>5.5 – 9.5</td>
<td></td>
</tr>
<tr>
<td>Bachelor/Master/Doctoral</td>
<td>51,782</td>
<td>2.0</td>
<td>0.9 – 3.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal Race/Ethnicity</th>
<th>Population Estimate*</th>
<th>% of women who smoked</th>
<th>95% confidence interval</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 100%</td>
<td>23,143</td>
<td>21.9</td>
<td>18.6 – 25.1</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>101-138%</td>
<td>40,406</td>
<td>11.7</td>
<td>8.4 – 15.0</td>
<td></td>
</tr>
<tr>
<td>139-185%</td>
<td>17,438</td>
<td>7.2</td>
<td>4.5 – 10.0</td>
<td></td>
</tr>
<tr>
<td>≥ 186%</td>
<td>80,890</td>
<td>5.4</td>
<td>4.3 – 6.5</td>
<td></td>
</tr>
</tbody>
</table>

| Maternal Age (years)    |                      |                       |                         |         |
| Intended                | 91,443               | 4.8                   | 3.9 – 5.7               | <.0001  |
| Not Intended            | 29,488               | 16.3                  | 13.4 – 19.2             |         |
| Ambivalent              | 17,402               | 18.4                  | 14.9 – 21.9             |         |


* p-values indicate differences within sub-populations

NS = not statistically significant

*The population estimate reflects an estimate of the number of women in each category, percentages for women whose categorical data is not known are excluded from the table. These numbers were weighted to represent the birth population for the years 2016, 2017, and 2018 combined.

**Insufficient data to report.

Shaded cells show significantly higher percentages of smokers compared with the overall birth population.
Quit Status of Women Who Smoked Around the Time of Pregnancy

*Figure 3.* 38.1% of women quit smoking when they became pregnant, while 6.0% of women did not quit smoking during pregnancy in 2016–2018.

![Chart showing quit status](chart.png)

Methods Used by Women to Quit Smoking During Pregnancy

*Figure 4.* Setting a specific date to quit smoking during pregnancy was the method most used in 2016–2018.

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set a specific date to stop smoking</td>
<td>32.7%</td>
</tr>
<tr>
<td>Booklets/Videos/Other Materials</td>
<td>15.7%</td>
</tr>
<tr>
<td>Other</td>
<td>14.9%</td>
</tr>
<tr>
<td>Nicotine Replacement Therapies</td>
<td>13.9%</td>
</tr>
<tr>
<td>Quit line/Counseling/Class</td>
<td>8.6%</td>
</tr>
<tr>
<td>Prescription Medications</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

CME Calendar

OCTOBER 2020
22–24  Working2Walk Symposium, Online, UUCME (10.5)
22/27  2nd Annual BHCP Clinical Learning Day,
       Murray, IHC (4.0)
26–27  Critical Issues Facing Children & Adolescents 2020,
       Online, ESI (up to 99.75)
30    2020 Update in Medical Specialties and Primary
      Care, Online, IHC (6.0)
30    11th Practical Dermatology for Primary Care,
      Online, UUCME (6.5)
30    Buprenorphine Waiver Training - Half & Half,
      Online, UUCME (4.0)

NOVEMBER 2020
 7    Women’s Health – Virtual CME, Online, UAFP
      (TBD)
13   Medication Assisted Treatment, Online, UUCME
     (3.0)
16   MOCA – Anesthesiology Simulation 2020, SLC,
     UUCME (7.25)

DECEMBER 2020
 7    MOCA - Anesthesiology Simulation 2020
      SLC, UUCME (7.5)

FEBRUARY 2021
 7–11  66th Annual Update in Anesthesiology, Canyons
       Resort, UUCME (26.0)
 26   Utah Ophthalmology Society 42nd Annual
      Conference, Online via Zoom, UOS (7.25)

MAY 2021
 4–7   Ogden Surgical–Medical Society’s Hybrid CME
      Conference, Ogden, OSMS (TBD)

Links to each of these and other events are available on the UMA website at https://www.utahmed.org/wcm/_PhysicianSupport/CME_Calendar.aspx

CME Spotlight

Title:  Controlled Substances: Education for the Prescriber
When:  On-demand Webinar
Where:  Online at cme.utahmed.org
Provider:  UMA Foundation
CME:  3.5 AMA PRA Category 1 Credits™

Following this activity, learners should be able to:

• Know existing laws and rules pertaining to prescribing controlled substances;
• Provide patients the care they need to restore and maintain their health;
• Mitigate the burdens of illness, injury and aging, including appropriate prescriptions for controlled substances when indicated;
• Minimize adverse effects of controlled substance use and reduce risks to the public health.

The following sites allow you to search databases to locate medical meetings throughout the country

ama-assn.org  eMedEvents.com
# CME Calendar

## Recurring Activities
Recurring activities are scheduled at St. Mark's Hospital, IHC Hospitals, Primary Children's Medical Center, and the University of Utah School of Medicine. Contact the sponsor for specific information. For more information on the above listings, please call the provider at the phone number listed below.

## List of Sponsors

### ACOG
**American College of Obstetrics and Gynecology**  
UT Chapter, SLC, 801-747-3500

### ACP
**American College of Physicians, UT Chapter**  
SLC, 801-582-1565 x2441

### ACS
**American College of Surgeons**  
Email UtahATLS@gmail.com for info about ATLS

### ALT
**Alternative CME**  
SLC, 801-200-4321

### AMA
**American Medical Association**  
Chicago 312-464-4761

### AUCH
**Association for Utah Community Health**  
SLC, 801-924-2848

### CA
**Collegium Aesculapium**  
Orem, 801-802-0449

### CM
**CoMagine**  
SLC, 801-892-6645

### ESI
**ESI Management Group**  
SLC, 801-501-9446

### IHC
**Intermountain Healthcare CME**  
SLC, 800-842-5498

### LVH
**Lakeview Hospital**  
Bountiful, 801-299-2546

### OSMS
**Ogden Surgical-Medical Society**  
Ogden, 801-564-5585

### PCH
**Primary Children's Hospital**  
SLC, 800-910-7262

### PRKA
**Program of Addiction Research, Clinical Care, Knowledge, Advocacy**  
SLC, 801-585-6667

### SHC
**Steward Health Care**  
South Jordan, 801-984-2384

### TRH
**Timpanogos Regional Hospital**  
Orem, 801-714-6505

### UAFP
**Utah Academy of Family Physicians**  
SLC, 801-587-3285

### UHLF
**Utah Healthy Living Foundation**  
SLC, 801-993-1800 or 801-712-8831

### UDS
**Utah Dermatology Society**  
SLC, 801-266-8841

### UMAF
**Utah Medical Association Foundation**  
SLC, 801-747-3500

### UMIA
**Utah Medical Insurance Association**  
SLC, 801-531-0375

### UOS
**Utah Ophthalmology Society**  
SLC, 801-747-3500

### USH
**Utah State Hospital**  
Provo, 801-344-4265

### UUCME
**University of Utah Continuing Medical Education**  
SLC, 801-581-8664

### VA
**VA Center for Learning**  
SLC, 801-584-2586

## The following websites offer online continuing medical education:

cme.utahmed.org  
psnet.ahrq.gov/cme  
thedoctormsnchannel.com/cme/  
freecme.com  
pri-med.com/pmo/OnlineCME.aspx  
music.utah.edu/cme  
cmelist.com

ama-assn.org/education-center  
baylorcmce.org  
medscape.org  
vlh.com  nejm.org/continuing-medical-education  
reachmd.com/programs/

cms.gov/Outreach—and—Education/Learn/Earn—Credit/Earn—credit—page.html  
primarycarenetwork.org/  
emedeveents.com/
The nationwide boom in both medical and recreational cannabis has resulted in the opening of new product markets and a growing trend in pharmaceutical treatment, drawing many from the medical fields into a hot new market with ever-changing legislation and a lack of best practices guidelines. In its current state, the conflict between state and federal law has created a level of uncertainty for many.

In the November 2018 election, Utah voters approved Ballot Proposition No. 2, legalizing medical marijuana. On December 3, 2018, the Utah legislature passed a compromise bill known as the Utah Medical Cannabis Act (the “Act”) which revised and superseded Proposition No. 2. The Act directs the Utah Department of Health (“UDOH”) to issue medical cannabis cards to patients, register medical providers who wish to recommend medical cannabis treatment for their patients, and license medical cannabis pharmacies. The UDOH was to complete these activities by March 1, 2020. However, because only some of its guidelines and procedures were in place by then, there are relaxed rules that are in effect until January 1, 2021 including allowing physicians not registered to provide letters of recommendation for cannabis for their patients. After 2020, a medical provider must be registered with the UDOH and have received four hours of department approved continuing education.

The law places a host of additional obligations and restrictions on physicians prescribing cannabis including, limiting the number of patients for whom a provider can recommend cannabis treatment, establishing a patient relationship prior to the prescribing, advertising, and compensation. It is interesting to note that Utah law specifically provides that the designation in the statute of conditions that qualify for the use of medical cannabis does not mean that there is current scientific evidence that clearly supports the efficacy of a medical cannabis treatment for the condition. Therefore, the provider is still subject to applicable standards of the medical profession and the potential for a malpractice action.

Notwithstanding the adoption of the Act in Utah, federal law continues to be in conflict. Because of the supremacy clause of the United States Constitution, federal law is the supreme law of the land and any state law which conflicts with the federal law is preempted. Therefore, notwithstanding Utah and many other states have legalized medical marijuana, it remains illegal federally. The effect of the federal law has far reaching effects beyond the medical use, including the following:

- Some workers’ compensation insurers are unwilling to issue policies for workplaces that allow usage of marijuana.
- Medicare, VA and private insurers will not pay for cannabis products or services.
- The U.S. Food and Drug Administration (“FDA”) has not approved the drugs, foods, and dietary supplements containing cannabis. Therefore, there is a lack of safety and security with respect to marijuana products.
- Investing, proceeds from marijuana-related businesses could lead to criminal prosecution for money laundering.
- Prescribing marijuana remains illegal under federal law since it has not been approved by the FDA. It is classified as a Schedule 1 substance under the Controlled Substances Act.
- Federal law prohibits knowingly or intentionally distributing, dispensing, or possessing marijuana. A person who aids and abets another in violating federal law or engages in a conspiracy to purchase, cultivate, or possess marijuana may be punished to the same extent as the individual who commits the crime.
- Challenges may be made to any business that engages in distributing, dispensing or possessing marijuana due to requirements in their governing documents that they can only engage in activities that are lawful.

Physician Prescribing under the Act

Shortly after the Act was passed, some health care providers told their physicians that that they were not to give patients letters of recommendation for cannabis until they have worked out guidelines. They cited the fact that there are too many unknown details for these letters to be provided. The U.S. Department of Veterans Affairs took the position that as long as marijuana is illegal under federal law, V.A. doctors are not able to prescribe it.

More recently, some employers have cleared their physicians to provide patients with letters of recommendation if they (1) have an established relationship with a patient who has a qualifying condition; (2) feel that they could benefit from treatment with medical cannabis; and (3) are comfortable providing a letter. Others remain hesitant to engage in prescribing or providing letters of recommendation for cannabis for their patients.

Notwithstanding the federal prohibition of marijuana, the U.S. Department of Justice (the “DOJ”) has advised states and local governments that authorize marijuana-related conduct to implement strong and effective regulatory and enforcement systems to address any threat state laws could pose to public safety, public health, and other interests. This hands-off approach has left states in a quandary as to what they must do to avoid a challenge by the DOJ and individual enforcement actions. In response to this, the Federation of State Medical Boards has adopted Model Guidelines for the Recommendation of Marijuana in Patient Care, which can be found at https://www.fsbmb.org/sitesassets/advocacy/policies/model-guidelines-for-the-recommendation-of-marijuana-in-patient-care.pdf.

These guidelines set forth a number of issues that physicians must address in prescribing cannabis for their patients, including dosage, dosing schedule and recommended delivery method. Dispensaries may be in a position to help the patient. However, they vary substantially in their product quality, testing, labeling and employee knowledge. Physicians must also consider other factors that may alter the physiological effects of cannabis in any given patient, such as age, prior experience with cannabis, health history, other medications, method of administration, and the product’s cannabinoid concentration.

Physicians who see Medicare patients must also be aware of Medicare’s treatment of medical cannabis. The federal regulations provide: “In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with federal and state law.” 42 CFR 482.25(b). The Medicare Annual Cost Report (CMS Form 2552) requires an officer to certify that he or she is “familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.” If a physician writes a letter of recommendation or prescription for treatment with medical cannabis for a Medicare patient, the physician may not be able to certify the Annual Cost Report. Similar concerns apply with certifications that physicians must make in obtaining or renewing DEA licenses.

A physician must also consider how to bill for a Medicare patient that has a qualifying medical condition. Will it be billed under the CPT code for a new or established patient visit or will the physician need to present the patient with an Advance Beneficiary Notice of Non-coverage (“ABN”) and charge the patient for the cannabis evaluation?

In addition to Medicare concerns, some private healthcare insurance companies only cover FDA-approved drugs. Since cannabis is not an FDA-approved drug, insurance companies may not cover the cost to the patient.

The cannabis issue is evolving and changing rapidly as federal law and practice standards struggle to catch up with the growth of the industry.

Skye Lazaro is an experienced corporate and criminal defense attorney and Chair of the Firm’s Cannabis Law Group. She assists business and health care clients in navigating the complexity of current Cannabis laws and advises “start-up” and growing companies in a wide range of matters such as risk management, investment, funding and organizational structure.

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