

# Athens Regional

MEDICAL CENTER



## MEDICAL STAFF SERVICES

1199 PRINCE AVENUE  
ATHENS, GEORGIA 30606-2793  
706-475-6971

March 29, 2005

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

To Whom It May Concern:

Re Proposed Rule for Authentication of Verbal Orders, Section 482.24 (c)(1)(iii).

The proposed rule states: "If there were no State law that designates a specific timeframe for the authentication of verbal orders, then verbal orders would need to be authenticated within 48 hours".

If there is a State law providing for a 30 day timeframe for verbal order authentication when the verbal order is "repeated and verified" and 48 hours for authentication if the order is not "repeated and verified", is the 30 day timeframe acceptable under terms of the proposed rule?

Sincerely,

A handwritten signature in black ink, appearing to read "C. Hudson".

Cecil C. Hudson, M.D.  
Chief Medical Officer



# AMERICAN PODIATRIC MEDICAL ASSOCIATION, INC.

April 7, 2005

Mark B. McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

**RE: CMS-3122-P**

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations; Proposed Rule (70 Fed. Reg. 15266, March, 25, 2005)

Dear Dr. McClellan:

The American Podiatric Medical Association (APMA), the national organization representing more than 11,000 podiatric physicians and surgeons, is pleased to provide comments on the proposed rule that would revise four of the current hospital conditions of participation (CoPs) for approval or continued participation in the Medicare and Medicaid programs. We offer the following comments:

**History and Physical Examination**

In particular, the CoP requirements related to the completion of a history and physical (H&P) examination are of significance to APMA. We support the proposed revision to the medical staff requirement at § 482.22(c)(5) to specify that a medical history and physical examination must be completed for each patient by a physician (as defined in section 1861(r) of the Act) or other qualified individual who has been granted these privileges by the medical staff in accordance with State law.

The APMA has met with the Centers for Medicare & Medicaid Services (CMS) on numerous occasions to discuss the education and training of podiatric physicians and surgeons. We have provided evidence that demonstrates that training in the performance of H&Ps is an inherent part of the educational process for doctors of podiatric medicine (DPM). As a result, we believe that the proposed change is appropriate and should be finalized without delay.

The APMA has requested that the colleges of podiatric medicine, as well as the American Association of Colleges of Podiatric Medicine (AACPM) and the Council of Teaching Hospitals (COH), offer additional evidence in support of the instruction and training in the performance of H&Ps that is provided to podiatric medical students and residents.

# AMERICAN PODIATRIC MEDICAL ASSOCIATION, INC.

Dr. McClellan  
April 7, 2005  
Page 2

We believe that this additional evidence reinforces that current training is sufficient for DPMs to perform their own H&Ps. Through time and a great deal of effort, the educational process for DPMs has evolved to its current state. For podiatric physicians and surgeons to continue to be denied the ability to perform their own H&Ps is inconsistent with their education and training, as well as inconsistent with current practice and the standards established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Thus, we urge CMS to immediately finalize this revised section of the CoPs.

Additionally, the APMA supports the expansion of the current requirement for completion of a medical H&P examination from no more than 7 days before admission to within 30 days before admission. We agree that this change supports safe patient care as long as the hospital ensures documentation of the patient's current condition in the medical record within 24 hours after admission. We believe that this proposed revision better reflects current medical practice and that the change from 7 to 30 days provides greater flexibility for the patient while allowing the physician to fulfill the necessary requirement in a more reasonable period of time.

### **Authentication of Verbal Orders**

The APMA supports CMS's proposal to retain and revise the current requirement for authentication of medical record entries at § 482.24(c)(1). According to CMS, the proposed revision states that all patient record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by whomever is responsible for providing or evaluating a service provided. The agency intends to retain the current requirement that all orders, including verbal orders, must be dated, timed, and authenticated promptly by the prescribing practitioner, with the exception being that from the effective date of the final rule, to 5 years following the effective date of the final rule, all orders, including verbal orders, must be dated, timed and authenticated promptly by the prescribing practitioner or another practitioner who is responsible for the care of the patient as specified under § 482.12(c) and authorized to write orders by hospital policy in accordance with state law, even if the order did not originate with him or her.

We believe that this temporary provision will provide greater flexibility to hospitals and physicians in the short-term while health information technology continues to evolve to the point where the originating physician may authenticate his or her own orders in an efficient manner. Until that time arrives, we believe it is reasonable to permit another physician who is responsible for the patient's care to authenticate verbal orders, especially given the time constraints to complete this task. Currently, some state laws require that verbal orders are authenticated within 24 to 48 hours. In the absence of a

AMERICAN PODIATRIC MEDICAL ASSOCIATION, INC.

Dr. McClellan  
April 7, 2005  
Page 3

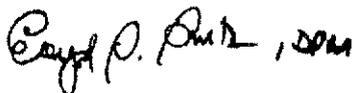
defined time period, CMS is proposing that verbal orders must be authenticated within 48 hours. We believe that in the best interest of patient care, this is a reasonable requirement, especially in light of the greater flexibility provided in terms of who may authenticate those orders.

**Conclusion**

The APMA is pleased with the proposed revisions to the hospital CoPs involving H&Ps and authentication of verbal orders. We believe that the H&P changes are long overdue and look forward to them being finalized immediately.

If you have questions concerning our comments, please contact Dr. Nancy L. Parsley, Director of Health Policy and Practice, at (301) 581-9233.

Sincerely,

A handwritten signature in black ink that reads "Lloyd S. Smith, DPM". The signature is written in a cursive style with a large initial "L".

Lloyd S. Smith, DPM  
President

3300 Gallows Road  
Falls Church, Virginia 22042-3300  
Tel 703 698-1110

April 5, 2005

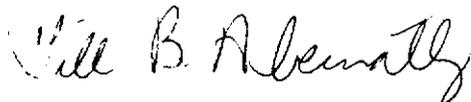
Centers for Medicare and Medicaid Services  
Office of Strategic Operations and Regulatory Affairs  
Regulations Development and Issuances Group  
Attn: Jim Wickliffe  
CMS-3122-P Room C5-14-03  
7500 Security Blvd.  
Baltimore, MD 21244-1850

**Re: Medicare Conditions of Participation, Pharmacy Services, Securing Medications  
Proposed Rule Change**

Mr. Wickliffe:

This is to voice hearty support for the proposed rule change for securing medications from an all drugs must be locked at all times rule to all drugs must be secured and locked when appropriate or for controlled substances rule. As the commentary suggests, this is in fact consistent with current practice and allows appropriate flexibility in assuring necessary security of medications with appropriate consideration of clinical needs. This is an excellent update to these 25 year old rules.

Sincerely,



Gill B. Abernathy, MS, RPh



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ROSALIND FRANKLIN UNIVERSITY  
OF MEDICINE AND SCIENCE

Chicago, Illinois 60612  
College of Health Professions  
Dr. William M. Scholl College of Podiatric Medicine  
School of Graduate and Postdoctoral Studies



Terence B. Albright, D.P.M.  
Dean

1775 Green Bay Road  
North Chicago, IL 60064  
Telephone: 847-578-8401  
Facsimile: 847-775-6516  
terence.albright@rosalindfranklin.edu  
www.rosalindfranklin.edu

May 04, 2005

Mark B. McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

**RE: CMS-3122-P**

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Proposed Rule (70 Fed. Reg. 15266, March 25, 2005)

Dear Dr. McClellan:

As the Dean and Chief Academic Officer of the Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University, I am writing to comment on the proposed rule that would revise four of the current hospital conditions of participation (CoPs) for approval or continued participation in the Medicare and Medicaid programs.

Our institution supports the proposed revision to the medical staff requirement § 482.22(c)(5) to specify that a medical history and physical examination must be completed for each patient by a physician (as defined in section 186(r) of the Act) or other qualified individual who has been granted these privileges by the medical staff in accordance with state law.

The Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University offers a four-year podiatric medical degree program. The College is accredited by the Council on Podiatric Medical Education (CPME) approved by the United States Department of Education (USDE). Of the seven standards and requirements for accreditation, Standard 3, Educational Program, states in part "The Institution offers an educational program that ensures graduation of competent and ethical doctors of podiatric medicine". Further, the Standard states the College is to "Ensure the attainment of knowledge, skills and attitudes for the diagnosis, and evaluation of the overall health status of children and adults, leading to a determination

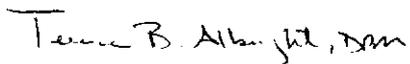
about the relationship of the patient's health to pathology in the lower extremity". To this end our curriculum which is competency driven and assessment validated, produces a graduate who is capable of performing a comprehensive history and physical.

Specifically, our students undergo extensive classroom and laboratory training in physical diagnostic techniques. These skills are assisted through an advanced, state-of-the-art Education and Evaluation Center. The Center enables the student to acquire professional interviewing and physical examination experience through the use of standardization patients. Finally, their skills are put to practical use through direct interaction with patients during hospital and clinical clerkships. The aforementioned curricular synopsis indicates our students receive both didactic and clinical exposure to enable the graduate to perform a comprehensive history and physical examination for any patient.

In summary, I feel confident that through allopathic education in a health science center setting and clinical training, our students are capable of performing history and physical examinations as they enter residency training. The conditions of participation should be revised to allow podiatric physicians the ability to practice their skills in the appropriate hospital settings.

If you have any questions, please do not hesitate to contact my office.

Sincerely,

A handwritten signature in black ink that reads "Terence B. Albright, DPM". The signature is written in a cursive style with a horizontal line above the first few letters.

Terence B. Albright, D.P.M.  
Dean

May 4, 2005

Mark B. McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

**RE: CMS-3122-P**

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations; Proposed Rule (70 Fed. Reg. 15266, March, 25, 2005)

Dear Dr. McClellan:

I have been asked to provide you information regarding the participation of podiatric students and residents in performing complete history and physical examinations.

Council on Podiatric Medical Education (CPME) publication 120, *Standards and Requirements for Accrediting Colleges of Podiatric Medicine*, requires that the clinical sciences curriculum ensures the attainment of knowledge, skills, and attitudes for the diagnosis and evaluation of the overall health status of children and adults, leading to a determination about the relationship of the patient's health to pathology in the lower extremity.

The Council's residency requirements have been revised; in the transition, two separate documents are in place. CPME publication 320, *Standards, Requirements and Guidelines for Approval of Residencies in Podiatric Medicine* (April 2000), requires that the internal medicine rotation afford residents training opportunities in performing complete history and physical examinations. Specific to podiatric surgical residencies, expectations established by the American Board of Podiatric Surgery for the core clinical rotation in podiatric clinic/office require resident participation in complete preoperative evaluation including history and physical examination, differential diagnosis, and rationale for proposed surgical intervention

The competencies identified in CPME publication 320, *Standards and Requirements for Approval of Residencies in Podiatric Medicine and Surgery* (July 2003), require that podiatric residents perform and interpret the findings of a thorough problem-focused history and physical

Dr. Mark B. McClellan  
May 4, 2005  
Page 2

examination, including problem focused history, neurological examination, vascular examination, dermatologic examination, and musculoskeletal examination. Furthermore, participation in the medicine and medical subspecialty training resources requires that residents perform a minimum of 25 comprehensive medical histories and physical examinations.

College and residency on-site evaluators are asked to verify that these training experiences are provided.

I hope that this information is of assistance to you. If I may answer any other questions, please let me know.

Sincerely yours,



Alan Trinkleman  
Director

ART/



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# California Medical Association

*Physicians dedicated to the health of Californians*

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April 27, 2005

Mark McClellan, MD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
PO Box 8010  
Baltimore, MD 21244-8010

RE: CMS-3122-P

Dear Dr McClellan,

I am writing on behalf of the California Medical Association (CMA) and its member physicians. Thank you for the opportunity to provide comments on your proposed regulations addressing a number of Conditions of Participation for Medicare. Specifically, these regulations propose changes to existing requirements for history and physical examinations (H&Ps); on the authentication of verbal orders; on securing of medications; and on Postanesthesia Evaluations.

The CMA is very pleased with your proposed regulations – many of the proposed changes directly reflect comments and recommendations previously submitted to CMS by the CMA. As noted in the preamble to the proposed regulations, the existing regulations are contrary to current practice and are unduly burdensome. In particular, we welcome your new rule that would allow verbal orders to be dated, timed and authenticated by the prescribing practitioner or another practitioner responsible for the care of the patient. **However, as described below, CMA believes the timeframe on the proposed exception must be more flexible.**

We are very pleased that the CMS has addressed longstanding concerns/frustrations of physicians with regards to the following:

### **I. Completion of the Medical History and Physical Examination (H&P)**

The existing required 7-day timeframe within which an H&P must be completed is not consistent with the current practice of medicine. In fact, even the JCAHO has revised its standard to allow a history and physical examination to take place within 30-days before admission, provided any changes are documented in the patient's medical record. This conflict between the JCAHO's standard and the existing COP that requires an H&P within 7-days is one that has often been brought to the CMA's attention by member physicians as a source of confusion and frustration. Changing the COP requirement to require a 30-day window with a requirement that an update of the person's condition must be documented in the medical record within 24 hours after admission will be a welcome change.

### **II. Authentication of Verbal Orders**

Of all the administration burdens placed upon our member physicians, the current requirement for authentication of verbal orders by the prescribing practitioner is among the most onerous. As currently interpreted, this regulation creates unnecessary burdens for physicians without any

corresponding quality of care benefits - a result we understand CMS is striving to avoid. The CMA welcomes these proposed regulations. Providing an exception to the authentication requirement will definitely provide necessary flexibility.

However, we are concerned that the CMS is only proposing this as a temporary change. We understand that it is CMS' intention to only allow this exception until such time as health information technology "is sufficient to allow the originating physician to authenticate his or her own orders in an efficient manner." We further appreciate that CMA believes this development in technology will occur within 5-years, thereby making the requirement for the prescriber to authenticate a verbal order an easier requirement, without the current burdens. However, the CMA is concerned that the proposed time limited exception to this requirement will expire prior to the technology actually being widely available and used. **Therefore, the CMA recommends that the proposed exception be built into these regulations in a manner that offers some flexibility rather than one that is time-defined, without regards to reality. Specifically, the CMA recommends the following language be adopted:**

§ 482.24 Condition of Participation: Medical Record Services (c)(1)(ii)

For the period from the effective date of the final rule, until such time as health information technology is sufficient to allow the originating physician to authenticate his or her own orders in an efficient and non cost-prohibitive manner, ~~to 5 years following the effective date of the final rule~~, all orders, including verbal orders, must be dated, timed and authenticated by the prescribing practitioner or another practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to write orders by hospital policy in accordance with State law.

### III. Securing Medications

As with the proposed changes to the H&P time frame, the CMA applauds the CMS' proposed rules on securing of medications. We completely agree that the current practice of medicine is in conflict with existing rules that require all drugs and biologicals to be locked. Examples of situations in which this rule is overly burdensome include the practice of patients needing access to drugs in order self-administer medications, the need for quick "handy" availability of resuscitation medications, and the need to set up anesthesia carts in the operative suite in advance of surgery. The proposed new language that would require that all drugs and biologicals be kept in a secure area, and locked when appropriate is appropriate and needed.

### IV. Completion of Post-Anesthesia Evaluation.

The CMA supports the CMS' proposed rules on the completion of post-anesthesia evaluations. Requiring the person who administers the anesthesia to write the follow up report is another example of a bureaucratic requirement that does not add to increased quality patient care. As recommended in these proposed rules, the CMS acknowledges that any individual qualified to administer anesthesia can in fact do the postanesthesia evaluation. CMA applauds this change.

Thank you again for the opportunity to provide comments on these proposed regulations. With one exception we are supportive of the recommended changes. However, as discussed above, we encourage the CMS to amend its time limitation on the exception to requiring the prescriber to authenticate a verbal order. We acknowledge that once health care technology advances, this will

not be a burdensome requirement. However, until such time that the technology both exists and is cost effective and readily available to practicing physicians, the exception should continue.

We look forward to working with you on the implementation of these proposed changes. If you have any questions, please contact Robin Flagg at (415) 882-5110.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael J. Sexton". The signature is fluid and cursive, with the first name being the most prominent.

Michael J. Sexton, MD  
President

Cc: CMA Executive Committee  
CMA OMSS Board  
Jack Lewin, MD  
Robin Flagg, MPH  
Greg Abrams, JD

7  
April 15<sup>th</sup>, 2005

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

RE: CMS-3122-P

Administrator McClellan:

With regard to the medication security portion of the proposed rule change, I fully endorse this change.

I also enthusiastically anticipate that the interpretation of this change is what you have reflected on your web site description: "This regulation requires that all drugs and biologicals be kept in secure areas, or locked when appropriate, to prevent unauthorized persons from obtaining access. This regulation addresses community concerns, provides flexibility for hospitals in determining control of nonscheduled drugs and biologicals, and is more patient-focused and outcome-oriented than the current requirement."

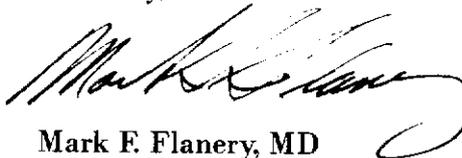
Healthcare facilities should have the latitude to determine who authorized persons are, and what is appropriate security, per State law, and local conditions.

The current rule, as has been interpreted, is too restrictive, leading to unnecessary and redundant security impositions. From an anesthesia care perspective, many patients have had a delay in care, sometimes critical, due to difficulty accessing medications that are secured in accordance to the current rule.

Again, I sincerely support the rule change, please advance the change accordingly.

Thank you for your consideration.

Sincerely,



Mark E. Flanery, MD  
Anesthesiologist

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# The Permanente Medical Group, Inc.

39400 PASEO PADRE PARKWAY  
FREMONT, CALIFORNIA 94538-2398  
(510) 795-3000

ANTIOCH	RANCHO CORDOVA
DAVIS	REDWOOD CITY
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FREMONT	ROSEVILLE
FRESNO	SACRAMENTO
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HAYWARD	SAN JOSE
MARTINEZ	SAN RAFAEL
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MOUNTAIN VIEW	SANTA ROSA
NAPA	S. SACRAMENTO
NOVATO	S. SAN FRANCISCO
OAKLAND	STOCKTON
PARK SHADELANDS	VACAVILLE
PETALUMA	VALLEJO
PLEASANTON	WALNUT CREEK

CALVIN WHEELER, M.D.  
Physician-in-Chief

VICTORIA O'GORMAN  
Medical Group Administrator

April 15, 2005

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

RE: CMS-3122-P, Condition of Participation: Medical Staff (482.22), Section 482.22(c)(5)

Ladies and Gentlemen:

I represent 70 Doctors of Podiatric Medicine, employed by The Permanente Medical Group in Northern California. The Permanente Medical Group employs 5,000 physicians nationwide and is the largest medical group in the United States.

We are very pleased with the proposed revisions to the Conditions of Participation regarding who may perform history and physical examinations. In California, Doctors of Podiatric Medicine have been performing history and physical examinations on our patients for many years. Recent interpretation of the existing COPs by some regulatory agencies in our state has resulted in our inability to perform an independent history and physical examination. This has resulted in an unnecessary and embarrassing situation for the practitioner and has been a waste of patient time. The recent interpretation of the COPs in our situation has not resulted in better outcomes and has, in fact, increased the cost of providing medical care to our patients.

We urge you to adopt the proposed changes as expeditiously as possible and thank you for addressing this issue.

Sincerely,

  
 Nicholas Daly, DPM  
 Chair, Chiefs of Podiatric Surgery  
 The Permanente Medical Group

/sh





Stockton / Manteca / Modesto

Jack Gilliland, M.D.  
Physician-in-Chief

José R. Rivera, M.P.H.  
Medical Group Administrator

Stockton Medical Offices  
P.O. Box 210005  
Stockton, California 95269-9005

Manteca Medical Offices  
1721 West Yosemite Avenue  
Manteca, California 95337

Modesto Medical Offices  
P.O. Box 577680  
Modesto, California 95357-7680

April 8, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, M.D. District 21244-8010

Dear Ladies and Gentlemen:

RE: CMS-3122-P, CONDITION OF PARTICIPATION FOR MEDICAL STAFF  
REGULATION, 482.22 SECTION 482.22 (C) (OVER) (5) (OVER)

I am a practicing orthopedic surgeon with Kaiser Permanente in Stockton, California. I happen to be working with a very competent group of podiatrists in our group. Apparently, they are yet not allowed to do their own history and physical examinations. They have been managing complex ankle and foot surgical cases and I fail to understand why would not be allowed to do their own history and physical examinations. They go through podiatry school of medicine just like regular medical schools and in my opinion they are very well qualified to do their own history and physical examinations.

This clarification will be very helpful not only to them, but to other medical care providers who end up doing their history and physical examinations.

I therefore am strongly suggesting that a podiatrist practicing in the State of California, in particular, all podiatrists across the national, in general, are allowed to do their own history and physical examinations before carrying out their surgical procedures.

Thank you very much for paying attention to this.

Yours sincerely,

Dhiren Nanavati, M.D.  
Department of Orthopedics  
Kaiser Permanente Stockton  
Exchief of Surgery  
Marion General Hospital  
Marion, OH

DN:yj

# WASHINGTON STATE SOCIETY OF ANESTHESIOLOGISTS

April 20, 2005

RE: CMS-3122-P Medication Security:

The Washington State Society of Anesthesiologists (WSSA) fully endorses the change related to medication security in the proposed rule.

We also fully anticipate that the interpretation of this change will be what is reflected in the CMS web site description: "This regulation requires that all drugs and biologicals be kept in secure areas, or locked when appropriate, to prevent unauthorized persons from obtaining access. This regulation addresses community concerns, provides flexibility for hospitals in determining control of nonscheduled drugs and biologicals, and is more patient-focused and outcome-oriented than the current requirement."

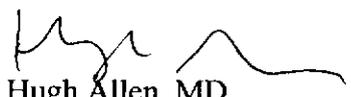
Healthcare facilities should have the latitude to determine who authorized persons are, and what appropriate security is, considering State law and local conditions.

The current rule, as it has been interpreted, is too restrictive and has led to imposition of unnecessary and redundant security requirements on anesthesia personnel. From an anesthesia care perspective many patients have had a delay in care, sometimes critical, due to difficulty accessing medications that are secured in accordance certain agencies' and facilities' interpretations of the current rule.

Again, we strongly support the rule change, and urge its adoption.

Thank you for your consideration.

Sincerely,



Hugh Allen, MD  
President

03/31/05

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
PO Box 8101  
Baltimore, MD 21244-8010

Dear CMS:

Re: 482.24 Paragraph (c) (1) (iii)

Instead of specifying a time frame for verbal order authentication in so many "hours", please consider a "calendar day" time frame. JCAHO has allowed this with restraint order authentication. The reality is that some physicians time very few of any of their entries, and many have never complied with timing the authentication of verbal orders. Hospitals' Medical Record Services end up getting cited with this deficiency on JCAHO reviews, not the offending physicians.

Re: 482.24 Paragraph (c) (2) (A)

Please address specifically the updating requirements for outpatient surgery H&P's. Do you leave it up to the hospital to define how/where this updating should happen, for example, physically on the copy of the H&P that is being updated, or by definition included in the first progress note that is written? Does there need to be some statement such as "I have reviewed the H&P and there are no significant changes.", or "See progress note for H&P update."?

Please address the updating requirements for Obstetrical H&P's, in particular the use of the ACOG standard prenatal form. Would it be correct to assume that an ACOG prenatal record whose last documented visit was over 30 days prior to admission would not be able to be updated? Or is the prenatal record a special case?

Please work with JCAHO on being congruent. Having a difference of interpretation of one word can drain already tapped hospitals resources as we attempt to "do the right thing".

Respectfully,

*Diann Roper*

Diann Roper, RN  
Helen Keller Hospital Medical Records Department  
P.O. Box 610  
Sheffield, Alabama 35660



**DATE:** April 15, 2005

**TO:** Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**ATTENTION: CMS-3122-P**  
P.O. Box 8010  
Baltimore, MD 21244-8010

**FROM:** Mark Washnock, M.D., Chair  
Department of Surgery

**RE: CMS History & Physical Rule Recommendations**

It has been noted that CMS is in the process of revising standards related to history and physical requirements to make them similar to the current JCAHO standards.

The surgeons at Marquette General Health System generally support your revision efforts toward similarity with JCAHO on requirements for history and physical documentation. However, they unanimously recommend that the proposed requirement for an update just prior to a procedure be made **ONLY IF THERE HAVE BEEN ANY CHANGES TO THE PATIENT'S CONDITION SINCE THE HISTORY & PHYSICAL WAS DONE**. This will maintain the update when necessary, but not require additional processing when nothing more is required or of benefit.

If you have any questions regarding the surgeons' support, please contact Mr. William Nemacheck, CEO, Marquette General Health System.

MW:sr

c: William Nemacheck, CEO

A handwritten signature in black ink, appearing to read "William Nemacheck MD".



Roger S. Kingston, D.D.S. Charles C. Phillips III, D.M.D.

A PROFESSIONAL CORPORATION

Diplomates, American Board of Oral and Maxillofacial Surgery  
Fellows, American Association of Oral and Maxillofacial Surgeons

May 13, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P. O. Box 8010  
Baltimore, MD 21244-8010

Re: CMS-3122-P, Completion of the Medical History and Physical Examination (H&P)

Dear Sirs and Madames:

We are oral and maxillofacial surgeons, and have reviewed the proposed changes to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

We are concerned that applying this definition to History and Physicals (H&P's) will cause hospital medical staffs to limit this privilege exclusively to MD/DO's and, as a result, negatively impact patient care and our ability to treat trauma and facial reconstruction cases in the hospital. Already some medical staff organizations are attempting to change hospital bylaws to limit this privilege to MD/DO's, perhaps because of their unfamiliarity with the education and training standards of other health practitioners.

Limitation or withdrawal of oral and maxillofacial surgeons' H&P privileges would restrict access for our patients and limit our ability to treat trauma victims at the local hospitals. It would also have the effect of compromising the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

We oppose this change as proposed, and suggest that the CoP be revised to specifically include MD/DO's, and oral and maxillofacial surgeons for patients admitted for oral and maxillofacial surgery procedures.

Yours truly,

Roger S. Kingston, DDS

Charles C. Phillips III, DMD

Scripps Carmel Valley Medical Office Building  
12395 El Camino Real • Suite 304 • San Diego, CA 92130  
Tel (858) 793-3393 Fax (858) 793-3383

**SOUTHERN ARIZONA  
ORAL & MAXILLOFACIAL SURGERY**  
Ronald C. Quintia, DDS

May 11, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-3122-P  
P.O. Box 8010  
Balitmore, Maryland 21244-8010

Re: CMS-3122-P, Completion of the Medical History and Physical  
Examination.

To Whom It May Concern:

I am a practicing oral maxillofacial surgeon and have been for eighteen years. It has been brought to my attention by the American Association of Oral and Maxillofacial Surgeons, that there is a proposed change to the CMS conditions of participation (CoP) related to H & P's that would allow this service to be performed by a physician, as defined by the Social Security Act.

Apparently, the Social Security Act defines physicians as doctors of medicine or osteopathy; doctors of dental surgery or dental medicine; doctors of podiatric medicine; doctors of optometry and chiropractors. I support the use of this definition in most contexts. However, I am very concerned that applying this definition to the H & P will cause hospital medical staffs to begin to limit this privilege to MD/DO, and as a result, negatively impact my ability to manage my patients.

Apparently, there are some hospitals in the country that are already trying to do this. Fortunately, that has not been the case for me, in Tucson. However, for my colleagues who have not had the open forum of discussion of this particular privilege by other hospitals, anything that would impede their ability to treat their patients, I think, would limit access for care and needlessly discriminate against well-trained oral and maxillofacial surgeons.

We have argued and fought for this privilege for a number of years and, as far as I was concerned, when I started practicing in 1986, the question was no longer one of

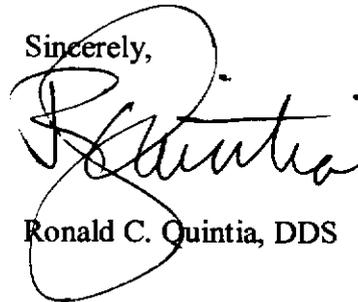


concern, as the hospitals seemed to understand that all oral surgeons were well-trained in the admission of patients. I understand the motivation for using the Social Security Acts definition in the (CoP) as a result of concerns brought to your attention by the podiatrists. Podiatrists, with their advanced training, maybe qualified to perform a H & P just like any other doctor who has gone through a residency that encompasses this important part of patient care into their program.

I oppose the proposed change and suggest that the (CoP) be revised to include a doctor of medicine or osteopathy, oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H & P, a doctor of podiatric medicine who has completed an accredited residency.

It seems too often that in healthcare, we take a giant step forward and two steps backward. I hope that this is not the case in this particular circumstance. I would be happy to comment further, if you desire.

Sincerely,

A handwritten signature in cursive script, appearing to read "R. Quintia". The signature is written in black ink and is positioned above the printed name.

Ronald C. Quintia, DDS

cd



*Rec'd  
5/19/05  
D.W.*

Charles N. Kahn III  
President

May 19, 2005

Dr. Mark McClellan, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Ave. S.W.  
Washington, D.C. 20201

**Re:** CMS Proposed Rule with Comment Period, Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post anesthesia Evaluations, Federal Register, Vol. 70, No. 57, March 25, 2005, pp. 15266-15273.

Dear Administrator McClellan:

*Mark*

The Federation of American Hospitals (FAH) is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members are full-service community hospitals, teaching and non-teaching, urban and rural, who provide critical health care services across the ambulatory, acute, and post-acute spectrum. We appreciate the opportunity to comment on proposed changes to Medicare's Hospital Conditions of Participation (CoPs).

Most of the current CoPs were drafted in 1985 and are woefully out of sync with current medical practice, patient safety and quality advances, and sometimes at odds with the parallel accreditation standards from the Joint Commission on Accreditation of Hospitals (JCAHO). FAH has long advocated that Medicare's CoPs be thoroughly reviewed and revised, and has, over the years, submitted comments to the Centers for Medicare & Medicaid Services (CMS) on several occasions regarding the provisions contained in this proposed rule. We commend CMS for proposing revisions to four CoPs that are not in keeping with today's practice of medicine, and we urge CMS to move swiftly to adopt these changes given the high level of support that has been expressed by a range of stakeholders in the past. Our comments are provided in the order of their presentation in the March 25, 2005 Federal Register's proposed rule.

### **CMS-3122-P: Completion of the Medical History and Physical Examination**

The proposed rule would amend the medical staff and medical record services CoPs. (*See* 42 C.F.R. §§ 482.22, .24.) The change specifies that a medical history and physical examination must be completed no more than 30 days before or 24 hours after a hospital admission; that the medical history and physical exam be completed by a physician or other qualified individual who has been granted these privileges by the medical staff in accordance with state law; and that the medical history and physical exam be placed in the patient's medical record within 24 hours after admission.

We applaud CMS for proposing to codify the medical history and physical CoP requirements with guidance previously issued by CMS in a January 28, 2002 memorandum to Associate Regional Administrators and State Survey Agency Directors. The proposed changes would also align the CoPs with standards used by the JCAHO, which, heretofore, has been an ongoing source of conflict for hospitals creating confusion and needless additional work.

We do seek clarification, however, of one provision contained in the January 28, 2002 CMS memorandum regarding CoP at C.F.R. § 482.24(c) entitled "Content of record." While this standard is included in the January 28, 2002 CMS memorandum, it is not addressed in the proposed rule. We request that CMS clarify that this provision remains a standard within this CoP under the proposed rule, and that the final rule expressly include this standard.

### **CMS-3122-P: Authentication of Verbal Orders**

The proposed rule would amend the nursing services and medical record services CoPs. (*See* 42 C.F.R. §§ 482.23, .24.) It would allow for a qualified proxy to authenticate verbal orders for an interim period of 5 years. The proposed rule states that 5 years is believed to be an adequate period of time for the development of widespread technologies that would allow the originating physician to provide an electronic or written authentication in a timely manner. The proposed rule would also permit the authentication of verbal orders to be entered into the patient's medical record within a timeframe specified in state law, or in the absence of state law, within 48 hours.

FAH commends CMS for recognizing the critical importance of minimizing verbal orders -- both oral and telephonic -- and continuing to require documentation of the order in the patient's medical record. We agree that an authentication requirement is necessary to protect hospitalized patients' health and safety.

However, there appears to be an inadvertent policy change to section 482.24 (c) (1) as stated on page 15270 of the March 25, 2005 Federal Register regarding medical record entries, which states,

“This proposed requirement would maintain and reinforce the current regulation for authentication of *all* medical record entries. It would require that *all* patient medical record entries be legible, complete, dated, *timed*, and authenticated in written or electronic form by the person responsible for providing or evaluating a service provided.” (Italics added for emphasis.)

The current language for section 482.24(c)(1) as contained in the January 28, 2002 CMS memorandum to Associate Regional Administrators and State Survey Agency Directors, does *not* include “timed” as a requirement for all entries made in the patient’s medical record. As a result, not all medical record entries are required to be timed. We request clarification of the preamble language on page 15270 in the March 25, 2005 Federal Register and recommend that the word “timed” be deleted from the final rule or that it be clarified to state that the requirement to time the entry applies only to authentication of verbal orders.

We support the proposed rule that would allow another practitioner who is responsible for the care of the patient, and who is authorized to write orders by hospital policy in accordance with state law, to authenticate verbal orders that he/she did not originally order. We believe this approach reflects the needs of medical practice today and does not raise quality of care concerns.

We would like emphasize the need to re-evaluate the 5-year “temporary exception” period in a systematic and timely manner. We recommend that CMS begin planning this evaluation at least 12 months prior to the end of the 5-year period to allow for adequate time to assess the availability and capability of electronic health records and hospital information systems.

We also recommend that the language proposed under this section, 482.24 (c) (1) (iii), be corrected to read:

“All verbal orders must be authenticated based upon Federal *or* (not “and”) State law”.

As currently written, it is not possible for hospitals to comply with both Federal and State law if State law is different than 48 hours.

### **CMS-3122-P: Securing Medications**

The proposed rule amends the CoP on pharmaceutical services related to securing medications. (See 42 C.F.R. § 482.25.) It requires that all drugs and biologicals be kept in a secure area and locked when appropriate. Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be locked within a secure area. The rule also proposes that only authorized individuals have access to locked drugs.

We support the proposed rule that all drugs and biologicals be kept in a secure area and locked when appropriate. We seek clarification, however, on several aspects of the language contained in the proposed rule. First, the preamble language on pages 15269-70 addresses the treatment of Schedule I medications and non-prescription medications at the patient's bedside that are self-administered. The preamble on page 15270 indicates that medications are secure, but not necessarily locked, if "unauthorized persons are prevented from obtaining access" to them. However, the proposed rule does not make clear the definition of "unauthorized person" and whether patients are considered authorized to keep non-controlled drugs at their bedside. We request that the final rule specifically clarify this question, and take into account standard medical practice that allows urgently needed medications to be available at the patient's bedside.

We remain concerned about the definitions of "secure" area and "unauthorized" persons and the ability of hospitals to control the unauthorized use of Schedule I drugs, particularly paralytic agents, when there is no longer a requirement that all drugs be kept in a locked storage area. CMS should make clear to all providers, particularly anesthesiologists, that the draft rule is not intended to be a relaxation of the current CoP in this regard. For the safety of patients and hospital employees, hospitals need the authority granted by the CoPs to enforce limited access to all drugs in all hospital settings.

#### **CMS-3122-P: Completion of the Post anesthesia Evaluation**

The proposed rule would amend the completion of post anesthesia exam CoP. (See 42 C.F.R. § 482.52.) It would allow for the post anesthesia evaluation exam to be conducted and documented by an individual qualified to administer anesthesia, rather than the current requirement that the post anesthesia evaluation report be written by the individual who administered the anesthesia.

We fully support this proposed policy change because it recognizes the changes that have occurred in hospital practice and provides greater flexibility to hospitals to ensure high quality patient care.

#### **Closing Comments**

The Federation welcomes CMS efforts to update the four CoPs contained in this proposed rule. We urge CMS to adopt these changes as soon as possible following the rulemaking process. The Federation hopes that CMS continues its efforts to update its CoPs to ensure they are meaningful standards reflective of today's medical practice.

Also, we believe CMS should consider amending the existing medical staff bylaw at 42 C.F.R. § 482.22 to require medical staff responsibility to provide on-call coverage. The lack of available on-call specialists in our nation's emergency departments is one of the most serious problems community hospitals are encountering today, and a real threat to patient quality and safety. Greater CMS emphasis on the needs and responsibilities of medical staffs to provide on-call coverage under the CoPs would be helpful to hospitals,

which are challenged to stem the tide of ever decreasing on-call specialist availability and the operational dilemmas that presents, particularly regarding compliance with the Emergency Medical Treatment and Active Labor Act.

We also urge CMS to address continuing confusion, on behalf of state surveyors, in assessing compliance with behavioral versus medical/surgical restraint use. (*See* 42 C.F.R. § 482.13 (e) and (f).) Restraints, in general, are used to change behavior, but the distinction expressed in the current CoPs between behavioral and medical/surgical use is confusing and lacks clarity. We recommend that CMS amend this CoP.

We further recommend that CMS consider amending the CoP to include those nursing services that may be administered per physician-approved hospital policy but do not require documentation of orders. Specifically, we suggest that CMS consider allowing PSA screening for prostate cancer to be permitted in a manner similar to mammography screening for the benefit of increased awareness and early detection.

Finally, we offer comments on two issues under the CoP entitled “governing body.” (*See* 42 C.F.R. § 482.12.) This CoP clearly delineates the governing body’s responsibility for determining, in accordance with state law, who is eligible for appointment to the medical staff. FAH supports this CoP as an important leadership accountability standard for ensuring a hospital’s quality of care. However, in deeming hospitals eligible for Medicare payment, JCAHO allows the governing body to delegate this responsibility to a committee which has final authority to grant or renew privileges (*see* MS.4.20.A.5). This is another important example of how CMS and JCAHO standards vary in ways that can affect a hospital’s deemed status and have a potentially harmful effect on patient care.

Secondly, under the governing body CoP we suggest that CMS directly address the issue of allowing hospital governing bodies to amend medical staff bylaws when necessary. The current CoP does not support or require a prohibition on the governing body’s ability to unilaterally amend medical staff bylaws. However, state licensing laws, and federal law through Medicare’s CoPs, generally hold a hospital’s governing body to be ultimately responsible for every aspect of the hospital’s operation. To ensure compliance with federal, state and local laws, there may be times when a governing body must act to amend the medical staff bylaws without medical staff approval or risk significant fines, Medicare or Medicaid funding, or loss of their license. Notably, medical staff members do not face the same consequences if their bylaws fail to comply with these requirements. As CMS is undoubtedly aware, the ability of governing bodies to enforce processes that ensure safe patient care, such as the EMTALA requirement discussed above, has brought this issue to the forefront. We urge CMS to strengthen this CoP by expressly addressing the need for governing bodies to amend medical staff bylaws without medical staff approval when patient safety and quality may be threatened.

We would be happy to discuss our comments further if it would be helpful. Please contact Susan Van Gelder or Jeff Micklos on my staff. Susan may be reached at 202-624-1528 or by email at [svangelder@fah.org](mailto:svangelder@fah.org). Jeff may be reached at 202-624-1521 or by email at [jmicklos@fah.org](mailto:jmicklos@fah.org).

Sincerely,

A handwritten signature in black ink, appearing to be 'L. G.' or similar, written in a cursive style.

May 8, 2005

Mark B. McClellan, MD, Ph D  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMA-3122-P  
PO Box 8010  
Baltimore MD 21244-8041

**RE: CMS-3122-P**

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations; Proposed Rule (70 Fed. Reg. 15266, March, 25, 2005)

Dear Dr. McClellan,

The California Podiatric Medical Association (CPMA), a component society of the American Podiatric Medical Association (APMA) is pleased to provide comments on the proposed rule that would revise four of the current hospital conditions of participation (CoPs) for approval or continued participation in the Medicare and Medicaid programs. We offer the following comments:

**History and Physical Examination:** For California the CoP requirements related to the completion of history and physical examination are of great significance. The California Podiatric Medical Association strongly supports the proposed revision to the medical staff requirement at § 482.22 (c) (5) to specify that a medical history and physical examination must be completed for each patient by a physician (as defined in section 1861 (r) of the Act) or other qualified individual who has been granted these privileges by the medical staff in accordance with State law.

Current California law allows doctors of podiatric medicine (DPMs) to perform their own history and physical, which is also consistent with the current practice and standards established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). However, local hospitals within the state of California have sometimes denied DPMs this privilege due to difficulty with accreditation related to inconsistencies with the Conditions of Participation at the federal level. Therefore, DPMs are denied the privilege to perform their own H&Ps, even though permitted to do so by law.

The APMA has met with the Centers of Medicare and Medicaid services (CMS) on numerous occasions to discuss the education and training of DPMs. We believe that the current training is sufficient for DPMs to perform their own history and physicals.

For podiatric physicians and surgeons to continue to be denied the ability to perform their own H&Ps is inconsistent with their education and training, with State law, as well as inconsistent with the current practice and standards established by the Joint Commission on Accreditation of



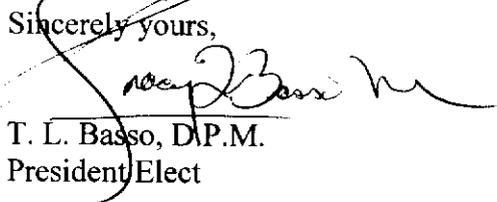
Dr. McClellan  
May 8, 2005  
Page 2

Healthcare Organizations (JCAHO).

Thus, we urge CMS to finalize the revised section of the CoPs dealing with history and physical examinations, which will greatly clarify the predicament that doctors of podiatric medicine (DPMs) face in the state of California. The CPMA is pleased with the proposed revisions to the hospital CoPs involving history and physicals. We look forward to the revisions being finalized and appreciate the clarity that they will bring to all DPMs.

If you have any questions concerning our comments, please contact Dr. John Hultman, Executive Director of Health and Policy at 916-448-0248.

Sincerely yours,



T. L. Basso, D.P.M.  
President Elect

DIPLOMATES, AMERICAN BOARD OF  
ORAL AND MAXILLOFACIAL SURGERY\*

R. Dale Lentz, D.D.S.\*  
Thomas H. Lapp, D.D.S., M.S.\*  
David A. Bussard, D.D.S., M.S.\*  
Joseph F. Heidelman, D.D.S.\*  
Jeffrey D. Buttrum, D.D.S.\*  
Dan E. Faulk, D.D.S.\*  
John E. Moenning, D.D.S., M.S.D.\*  
J. Jeffrey Hockema, D.D.S.\*  
Philip M. Montefalco, D.D.S.\*  
Michael G. Kapp, D.D.S.\*  
John W. Pruitt, D.D.S., M.D.\*  
Kyle A. Wood, D.D.S.\*  
John W. Adelsperger, D.D.S.\*  
Tyler J. Potter, D.D.S.

May 12, 2005

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8140 Knue Road  
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Indianapolis, IN 46250  
317-849-4914  
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Fishers, IN 46038  
317-845-7878  
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Greenwood, IN 46142  
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317-887-0844 FAX

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317-297-7069 FAX

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317-846-3446  
317-574-5151 FAX

IOMSA.com

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

RE: CMS-3122-P  
Completion of Medical History and Physical Examination

To Whom It May Concern:

I am an oral and maxillofacial surgeon and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps and allowing these services to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or general medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

Although I support the use of this definition in most contexts, I am concerned that applying this definition to H&Ps will cause hospital medical staff to limit this privilege exclusively to MDs/DOs, and as a result, negatively impact patient care. Some medical staffs are already attempting to change their By Laws to permit this privilege only to MDs/DOs often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners.

Limitations or withdrawing of oral and maxillofacial surgeon's H&P privileges would limit access for my patients as well as for maxillofacial trauma patients who need my services on a regular basis and severely threaten the accreditation status of 100 accredited oral and maxillofacial surgery residency programs throughout the United States.

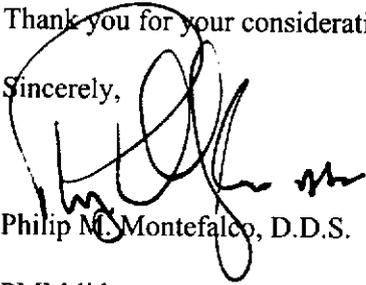
I understand the motivation for using the Social Security Act's definition in the CoP as a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P.

I oppose this proposed change and suggest that a CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Page 2  
May 12, 2005

Thank you for your consideration and these comments.

Sincerely,

A handwritten signature in black ink, appearing to read 'Philip M. Montefalco', written over the word 'Sincerely,'.

Philip M. Montefalco, D.D.S.

PMM:ljd

8

April 10, 2005

Mark B. McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
PO Box 8012  
Baltimore, MD 21244-8012

Dear Dr. McClellan:

I would like to comment on the proposed Conditions for Coverage for End Stage Renal Disease Facilities. Specifically I would like to comment on § 494.140 and the role of a pharmacist within the dialysis facility.

As an inpatient pharmacist, I routinely review the medication regimens of dialysis patients who are admitted to the hospital. These regimens usually contain large numbers of medications with the potential for interactions with other medications or disease states. The regimens are complex and adherence is difficult. In addition, renal dialysis patients have their own set of problems, many of which create conflicts in medication use. As a result, these patients experience a disproportionate share of drug related problems and adverse events. In some cases, adverse drug events are the reason for hospitalization.

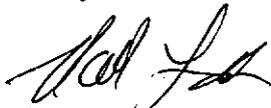
In my role, I frequently intervene with nephrologists and other physicians caring for these patients. These interventions take the form of assisting with dosing of medications, removing contraindicated medications, managing drug interactions, patient counseling, and making therapy cost effective. Many of the problems I detect could be prevented by routine review of medications by a pharmacist trained in renal pharmacotherapy.

Many pharmacists are well trained to serve in a consultant role for dialysis patients. Pharmacists' expertise usually includes knowledge of pharmacokinetics, expertise in patient counseling, knowledge of potential toxicities and of the cost effective use of drugs. Some of us have additional training the specific problems faced by dialysis patients.

I would like to suggest that pharmacists with expertise in nephrology be considered as consultants on the dialysis team. These pharmacists should routinely review medication regimens of dialysis patients. Additionally, these pharmacists should be involved in development of policies that involve medication use within a facility.

I hope that you will consider including pharmacists in the routine care of dialysis patients.

Sincerely,



Paul Lata, PharmD  
Clinical Pharmacist, Case Management Services  
Bay Area Medical Center, Marinette, WI

**Crayton R. Walker, D.D.S., M.D.**  
**Oral and Maxillofacial Surgery**

Diplomate American Board of Oral and Maxillofacial Surgery

May 17, 2005

**Centers for Medicare and Medicaid Services**  
**Department of Health and Human Services**  
**Attention: CMS – 3122 – p**  
**P.O. Box 8010**  
**Baltimore, Maryland 21244-8010**

**RE: CMS-3122-P Completion of Medical**  
**History & Physical Examination**

Dear Sirs:

I am writing this letter with regards to the CMS Conditions of Participation (COP) related to History and Physical Examinations.

Oral and Maxillofacial Surgeons are well trained in their advanced surgical programs of four to six years beyond dental school, to provide their patients History and Physical Examinations. This has been well established through recognized University Surgical Residency Programs over the last thirty year's time.

To now limit this procedure to strictly M.D.'s and D.O.'s for hospitalized patients is unsatisfactory. Not only will this cause delay in the hospitalized patient's treatment by having the patient see another doctor, it will also prevent the patient receiving the best examination and diagnosis of their oral surgical condition, by trained Oral and Maxillofacial Surgeon.

This is the standard of care practiced in the United States over the last thirty year's time. As both a licensed physician and dentist, I believe I have unique qualifications to review and discuss this matter. The History and Physical Examination should continue to be performed by the Oral and Maxillofacial Surgeons.

Your further review of this matter would be most appreciated.

Sincerely,



**Crayton R. Walker D.D.S., M.D.**  
**Oral and Maxillofacial Surgeon**



Michael J. Trepal, D.P.M., F.A.C.F.A.S.  
Vice President For Academic Affairs  
and Dean

1800 Park Avenue  
New York, N.Y. 10035

Phone: (212) 410-8067  
FAX: (212) 369-4608  
mtrepal@nycpm.edu

May 13, 2005

Mark B. McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

**RE: CMS-3122-P**

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Proposed Rule (70 Fed. Reg. 15266, March, 25, 2005)

Dear Dr. McClellan:

I write on behalf of the New York College of Podiatric Medicine (NYCPM), an independent institution located in New York City since 1911. NYCPM is chartered by the State of New York to offer the Doctor of Podiatric Medicine degree and receives its professional accreditation from The Council on Podiatric Medical Education. NYCPM provides both undergraduate and graduate podiatric medical education. We are pleased to provide comments on the proposed rule that would revise four of the current hospital conditions of participation (CoPs) for approval or continued participation in the Medicare and Medicaid programs

NYCPM supports the proposed revision to the medical staff requirement at § 482.22(c)(5) to specify that a medical history and physical examination must be completed for each patient by a physician (as defined in section 1861(r) of the Act) or other qualified individual who has been granted these privileges by the medical staff in accordance with State law. We offer the following comments in support of our belief that a Doctor of Podiatric Medicine is qualified by virtue of training to competently perform a general history and physical examination:

Students at the New York College of Podiatric Medicine (NYCPM) receive comprehensive training in the performance of history and physical examinations throughout their formal medical education.



Our training in these clinical skills starts in the first year of the pre-clinical sciences in our **Physiology Course (DMETS1218)**. It is continued in the second year in the **Physical Assessment Course (DPMED218)** and carried throughout the clinical rotations in all departments in the Third and Fourth Years. We have developed a detailed **Competency Evaluation** process that ensures students attain the necessary and required clinical competencies prior to graduation. Each student must have the clinical competency verified by a faculty member who has observed the student performing that skill. Clinical skills are reinforced also at the graduate level during the residency training years as well as in courses by the Post-Graduate Medical Education Department at NYCPM.

For more than ten years, our **Physical Assessment Course** has been taught by Mark H. Swartz, M.D. Dr. Swartz is an internationally known expert in clinical skills and is the sole author of *Textbook of Physical Diagnosis: History and Examination* which is now in preparation for its Fifth Edition to be published in October 2005. This book has been considered the standard textbook for teaching clinical skills in the United States and has been translated into six foreign languages. It is used by more than 75% of American medical schools. The program that Dr. Swartz conducts here is in general the same as the one that he has been teaching to medical students for over 25 years. In 1990, Dr. Swartz also founded The Morchand Center for Clinical Competence (TMC) at the Mount Sinai School of Medicine where he had been on the faculty since 1978. TMC is the largest academic program of its type for teaching and testing clinical skills in the United States. In December 2003, Dr. Swartz left Mount Sinai and is now Professor of Medicine at SUNY Downstate College of Medicine. We are fortunate in that Dr. Swartz will assume a full-time faculty status at the New York College of Podiatric Medicine beginning in July 2005. I am attaching a copy of the cover of Dr. Swartz's current textbook as well as syllabi from the pertinent courses.

Please do not hesitate to contact me if you need any further information.

Very truly yours,



Michael Trepal, D.P.M., F.A.C.F.A.S.  
Vice President For Academic Affairs And Dean

**New York College of Podiatric Medicine**  
1800 Park Avenue • New York, NY 10035

**SYLLABUS**

**Course Title:** Physiology Syllabus  
**Course Number:** DMETS 1218  
**Department:** Metabolic Sciences, Division of Pre-clinical Sciences  
**Credit hours:** 8  
**Grade type:** Letter grade  
**Revised Date:** 12-9-04  
**Course Director:** Patricia D. Wade, Ph.D.

**Director's Campus phone:** (410)-8179      **Other phone:** (home) 718-279-7870. May call either place for questions; at home please call before about 8:30 PM. (If you receive a message that the line is busy, do not leave a message. Call back.)

**Director's E-mail:** [pwade@nycpm.edu](mailto:pwade@nycpm.edu)

**Office Days/Hours:**  Mon.  Tues  Wed  Thur after class  
 Fri: call at home  By appointment, also in lab

**Course Coordinator:** P. Wade

**Other Faculty:** Dr. Alan Levine

**Course Description:**

In this Medical Physiology course we study the functioning of the normal human body with particular consideration of clinical deviations from normal. The functioning of the following areas will be covered: the cardiovascular, renal, respiratory, gastrointestinal, nervous and endocrine systems and membranes, muscle, bone. Regulatory mechanisms and the contributions of each system to homeostasis are emphasized, as are integration with clinical conditions. The laboratory part of the course is designed to provide the physiological framework for the clinical physical examination, as well as an introduction to a variety of clinical measurements.

**Course Goal(s) and Objectives:**

At the completion of the course the student should be able to:

1. Describe the function a particular mechanism accomplishes for the human body.
2. Give an analysis of how each area covered accomplishes its basic tasks.
3. Work basic problems in physiology, especially ones with clinical relevance.
4. Relate some common clinical conditions to physiological malfunction.
5. Explain what some basic clinical tests can tell the clinician about function.
6. Perform many elements of the physical exam and explain why these are done clinically.

**Required Text(s), assigned reading and audiovisuals: This text is not mandatory but is the source of much of the lecture material.**

Textbook of Medical Physiology, 10th edition, A. C. Guyton and J. E. Hall, W. B. Saunders Co., Philadelphia, 2000.

**Laboratory: Mandatory text:**

Textbook of Physical Diagnosis: History and Examination with Student Consult Access, Updated 4th edition, M.H. Swartz, W. B. Saunders Co., Philadelphia, 2005.

**Recommended Texts and Media Resources:**

1. Review of Medical Physiology, 21st ed., W. F. Ganong, Lange Medical Books/McGraw-Hill, New York, NY, 2003.
2. Stedman's Medical Dictionary, 27th ed., Lippincott Williams and Wilkins, 2000.
3. Best and Taylor's Physiological Basis of Medical Practice, 12th ed., J. B. West, Williams and Wilkins, Baltimore, 1991. **On reserve in the library only.**

**Laboratory:**

1. Clinical videos: On reserve in the library
  - a. The Physical Exam (Swartz)
  - b. Assessing Heart Sounds
  - c. Assessing Breath Sounds
2. Bates' Guide to Physical Examination and History Taking with Bonus CD-ROM, 8th edition, L. S. Bickley and P. G. Szilagyi, Lippincott Williams & Wilkins., Philadelphia, 2004.

**Required equipment:**

- |   |                                      |
|---|--------------------------------------|
| 1. tape measure and plastic ruler             | 6. tuning fork and percussion hammer |
| 2. pencil flashlight                          | 7. Welch-Allyn (oto-/ophthalmoscope) |
| 3. magnifying glass                           | 8. scrub suit                        |
| 4. blood pressure cuff with aneroid manometer |                                      |
| 5. stethoscope                                |                                      |

**All of the above are carried in or can be ordered from the bookstore.**

**Attendance policy for this course:**

If you need to pass, the only intelligent option is to attend.

Attendance is mandatory. Unexcused absences in excess of 25% of contact hours will result in failure of the course regardless of test scores. After the first lecture exam anyone maintaining an AH average on lecture exams is exempt from mandatory lecture attendance for the duration of the AH average. Attendance in laboratory is mandatory for all students. All absences from lab (excused and unexcused) must be made up. Failure to make up the lab will result in 2 points' being removed from the "How you work" segment of the lab grade. An unexcused absence from lab which is made up will still result in 1 point's being removed from that segment of the lab grade.

**Evaluation of student performance:**

Monthly exams plus 8 individual & 8 group quizzes	50%
Laboratory:	
Quizzes: 3	35%
Practical (P/NP: P=25, NP=0)	25%
Student presentation	6%
How you work (including: taking measurements on classmates, showing techniques, being present from beginning to end, etc., and assessment by instructor)	34%
Total lab	100% = 25%

Final Exam (cumulative on lecture material)		25%
Total for course	=	100%

**Final grade computation:** As above

**Missed evaluations:**

Make-up of exams: excused absence--full credit; unexcused--maximum 70%. Lecture quizzes may not be made up (may drop several of lowest grades).

**Method of examination review:**

Optional group review of exam by computer projection in the lecture hall, several days after the exam. Also students may examine exams in the Basic Sciences office after exam scores are posted and until the next exam (provided office staff is available).

**Procedure in the event of Remediation:**

Re-evaluation Exam if final average is between 65-69, remediation course if lower than 65. See student handbook.

**Additional Rules, Procedures and Requirements Specific to This Course: Hints for success (in lecture part of the course):** Since as a medical student you will have too much material to learn, studying in the most efficient manner is of paramount importance. Thus, please optimize your time spent in the following ways:

1. Always attend class. If you didn't hear it in the first place, you're not making use of a major chunk of your cerebral cortex in processing this material. In learning something new get it into the CNS in different modalities. Take notes. Do something active to make it your own.
2. Don't laugh: Review your lecture notes that night. Almost nobody does this but I assure you that, if you do, when it is time to study for the test, you will be 3/4 of the way there. The sounds of the lecture and its meaning still reverberate in your brain in a way that they will not even the next morning.
3. Do old test questions as if they were a problem set.
4. Come to reviews, call me at work or at home to get help.
5. Please do not write out the objectives or read every word in the optional text assign as Gospel. It's better to be very familiar with the concepts presented in class as evidenced by your ability to do old test questions than to get lost in the details of the text or in writing out objectives.
6. Set your sights high. "Unlikely candidates" can do very well in the course if they work in the right way. Surprise yourself and enjoy!

**Course Schedule and Assignments**

Date	Lecture Topics	Professor	Optional reading Chapters	Keywords
Week of	Introduction	Dr. P. Wade	Guyton &	Controlled quantities.

Jan. 3, 2005	Homeostasis Membrane Physiology	"	Hall: 1 4,5	Transport, membrane potential, action potential
Jan. 10	Skeletal Muscle: Transmission	"	7,6	Release of transmitter and postsynaptic events, pharmacology, contraction
Jan. 17	Skeletal Muscle, contd, Pathophysiology of Muscle	"	7,6 6,7	Mechanical properties
Jan. 24	Smooth muscle Cardiac Muscle	"	8 9,10	Electrical, mechanical and chemical properties, cardiac cycle, excitability
Jan. 31	Hemodynamics, The Systemic Circulation,	"	14,15	Pressures, velocities, R, Ohm's law, compliance, ANS effects
	Regulation of Blood Flow	"	17,18	Local control, nervous regulation
Feb. 7	Arterial Pressure	"	18,19	Short- and long-term control, hypertension
	and Cardiac Output Regulation	"	20	C.O. measurements, exercise
Feb. 14	Cardiovascular Pathophysiology	"	22-24	Failure, shock, abnormal heart sounds
	Body Fluids	"	16,25	Body fluid compartments, lymph, edema
Feb. 21	Renal Physiology	"	26-29	Properties of the tubular system, blood volume, salt regulation
Feb. 28	Renal Physiology Respiration	"	30,31	Acid-base reg., renal disease.
Mar. 7	Respiration	"	37,39 40-42	Mechanics Gas transport, resp. regulation, obstr./restrictive disease
Mar. 14	Gastrointestinal Physiology	"	62- 66,70	Reg. of motility & sec, digest., absorption. Thermoregulation
Mar. 21	Neurophysiology	"	72,73	Somatic sensations
Mar. 28	Neurophysiology	"	45-48 54-58	Spinal reflexes Equilibrium., basal ganglia, cerebellum, cerebral cortex
Apr. 4 Apr. 11	Spring Recess Neurophysiology	"	59,60	Sleep, brain waves, epilepsy, autonomic NS
	Special Senses	"	49,52,5 3	Vision, hearing, smell, taste

Apr. 18	Endocrinology	"	74-75	Hypoth./pituitary
			76-78	Metabolic hormones
Apr. 25	Endocrinology	"	80-82	Sex hormones.
	Bone Physiology	"	79	Vit. D, PTH, calcitonin., Ca++ regulation

### Laboratory Schedule and Assignments:

Physiology Labs will each be 2 hours. Each section (1= Mon, 2=Tu) will be subdivided into a 1-3 PM group (1a, 2a) and a 3-5 PM group (1b, 2b). The times for these groups will be reversed midsemester.

Dates Week of:	Laboratory: Topic	Laboratory Instructors	Lab Assignment	Key words
Jan. 3, 2005	Introduction to the Physical Examination	Dr. P. Wade, Dr. A. Levine, Mr. V. Jimenez	Swartz Ch. 5, 19, Hand-out 1. See hand-out for detailed reading assign.	
Jan. 10	Contd. from above, Skin, Head and Neck	"	Swartz Ch. 6, 7, 9, Hand-outs 1 and 2	
Jan. 17 <b>Note Mon. lab is Th.</b>	Contd. from above and Peripheral Vascular System	"	Contd., Swartz Ch. 13	
Jan. 24	Lab quiz 1 (tentative) and Peripheral Vascular System	"	Contd.	
Jan. 31	Heart	"	Swartz Ch.12, Hand-out 3	
Feb. 7 Feb. 14 <b>Note Mon. lab is Th.</b>	Heart contd. Student presentations	" Students	Contd. Present case with lab values	
Feb. 21	Lab quiz 2 (tentative) and Heart Contd. and Chest and Abdomen	Dr. P. Wade, Dr. A. Levine, Mr. V. Jimenez "	Contd. and Swartz Ch. 11, 15 and Hand-out 4	
Feb. 28	Chest and Abdomen		Contd.	
Mar. 7	Eye, Ear and Nervous System	"	Swartz Ch. 8, 9, 19 and Hand-out 5 and 6	
Mar. 14	Eye, Ear and Nervous System contd. And Musculoskeletal System	"	Contd. and Swartz Ch. 18, Hand-out 7 and 8	
Mar. 21	Musculoskeletal contd.	"	Contd.	
Mar. 28	Lab Quiz 3 (tentative) and Musculoskeletal contd., Practice for practical	"	Contd. and OSHA tape on blood, etc., Swartz, Hand-outs 1-8	
Apr. 4	Spring Recess			

Apr. 11	Practical Exam (tentative)	Clinical Faculty	OSHA tape on blood, etc., (for following weeks) Swartz, Handouts 1-8
Apr. 18	Practical Exam cont'd. and Blood	Clinical Faculty Mr. V. Jimenez	Contd. and Hand-out 9
Apr. 25	Blood		Hand-out 9

12/7/2004

# New York College of Podiatric Medicine

1800 Park Avenue • New York, NY 10035

## SYLLABUS

**Course Title:** PHYSICAL ASSESSMENT- I

**Course Number:** DPMED218

**Department:** Primary Podiatric Medicine

**Credit hours:** 2

**Grade type:** Letter Grade

**Revised Date:** 04/27/2004

**Course Director:** Mark H. Swartz, MD

**Director's Campus phone:** (410-) Other phone:

**Director's E-mail:** \_\_\_\_\_@nycpm.edu

**Office Days/Hours:**  Mon.  Tues  Wed  Thur  
 Fri  By appointment

**Course Coordinator:**

**Other Faculty:**

### Course Description:

Physical Assessment is a didactic course covering the principles of history taking and physical examination. The course employs the use of lectures, slide presentations and live classroom demonstration. The logic of interviewing and the development of a comprehensive work-up is stressed. The integration of the pathophysiologic correlation where appropriate, is instituted.

### Course Goal(s) and Objectives:

The goal of this course is to teach the podiatric medical student the skills necessary for history taking and performing a comprehensive physical examination. At the completion of this course, the student should be able to interview a patient acquiring as much information as possible related to the patient's illness. In addition, the student should be able to perform the cardinal principles of physical examination: inspection, palpation, percussion, and auscultation.

### Required Text(s), assigned reading and audiovisuals:

1. **Textbook of Physical Diagnosis: History and Examination** Mark Swartz, MD, Fourth Edition, 2002, W.B.Saunders
2. **Pocket Companion for Textbook of Physical Diagnosis:Third Edition.1998** MarkSwartz, MD,W.B. Saunders

### Required equipment:

### Recommended books, materials, media, equipment:

**Attendance policy for this course:**

Institutional Attendance Policy

**Last day to withdraw:** 2/3 of total number of lectures**Evaluation of student performance:**

Written mid-term and final examinations administered. Passing is 70%.

**Final grade computation:**

Grading weight is 50% each examination

**Missed evaluations:**

Make-up given according to Institution Policy and Procedures

**Method of examination review:**

Appointment to review with Department Secretary and/or Instructor

**Procedure in the event of Remediation:**

Review of lecture tapes, reading assignments, personal appointment with Instructor

**Additional Rules, Procedures and Requirements Specific to this Course:****Course Schedule and Assignments**

SESSION	LECTURE/LAB TOPICS	LECTURER	ASSIGNMENT
6/15/04 Tuesday 11:00-1:00	INTRODUCTION TO EVALUATION OF THE PATIENT general considerations concepts and principles of history taking and physical examination.	M. Swartz, M.D.	Corresponding Chapters in Textbook
6/22/04 Tuesday 11:00-1:00	COMMUNICATION SKILLS IN HISTORY TAKING special do's and don'ts to enhance your communication skills	M. Swartz, M.D.	Corresponding Chapters in Textbook
6/29/04 Tuesday 11:00-1:00	GENERAL SCREENING basic procedures preparation for the examination precautions to take during the examination the goal of the physical examination	L. Diamond, M.D.	Corresponding Chapters in Textbook

7/6/04 Tuesday 11:00-1:00	SKIN AND HEAD general considerations structure and physiology review of specific symptoms impact of skin disease on the patient physical examination description of lesions clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook
7/13/04 Tuesday 11:00-1:00	THE EYE general consideration structure and physiology review of specific symptoms impact of blindness on the patient ophthalmoscopic examination clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook

SESSION	LECTURE/LAB TOPICS	LECTURER	ASSIGNMENT
7/20/04 Tuesday 10:00-1:00	THE EAR, NOSE, THROAT AND NECK general consideration structure and physiology review of specific symptoms impact of deafness on the patient impact of voice disorder on the patient impact of head and neck disease on the patient physical examination clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook
7/27/04 Tuesday 11:00-1:00	THE CHEST general considerations structure and physiology review of specific symptoms impact of lung disease on the patient physical examination clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook
8/3/04 Tuesday 11:00-1:00	THE HEART AND PERIPHERAL VASCULAR SYSTEM general considerations structure and physiology review of specific symptoms impact of cardiac disease on the patient impact of vascular disease on the patient physical examination clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook

8/10/04 Tuesday 11:00-1:00	THE ABDOMEN general considerations structure and physiology review of inflammatory bowel disease on the patient physical examination clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook
8/17/04 Tuesday 11:00-1:00	THE ABDOMEN general considerations structure and physiology review of inflammatory bowel disease on the patient physical examination clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook
<b>8/24/04</b>	<b>MIDTERM</b>	<b>M. Kosinski, DPM</b>	
8/31/04 Tuesday 11:00-1:00	MALE GENITALIA general consideration structure and physiology review of specific symptoms impact of impotence on the man physical examination clinicopathologic correlations	M. Swartz, M.D.	Corresponding Chapters in Textbook
9/7/04 Tuesday 11:00-1:00	FEMALE GENITALIA AND BREAST general considerations structure and physiology review of specific symptoms impact of infertility on the woman physical examination	M. Swartz, M.D.	Corresponding Chapters in Textbook
<b>9/13- 17/04</b>	<b>VACATION</b>		
9/21/04 Tuesday 11:00-1:00	PHYSICAL DIAGNOSIS IN THE ELDERLY PATIENT structure and physiology basic principles of geriatric medicine the geriatric history physical examination clinicopathologic correlations	L. Diamond, M.D.	Corresponding Chapters in Textbook
9/28/04 Tuesday 11:00-1:00	THE MUSCULOSKELETAL AND NEUROLOGICAL EXAMINATION general considerations structure and physiology review of specific symptoms impact of musculoskeletal disease on the patient physical examination clinicopathologic correlations DEMONSTRATION OF COMPLETE PHYSICAL EXAMINATION	M. Swartz, M.D.	Corresponding Chapters in Textbook
10/5/04 Tuesday 11:00-1:00	PRINCIPLES OF PSYCHIATRIC MEDICINE general considerations review of specific symptoms	L. Diamond, M.D.	Corresponding Chapters in Textbook

	impact of psychiatric illness on the patient physical examination and interview/clinicopathologic correlations		
10/12/04 Tuesday 11:00-1:00	OVERVIEW OF PEDIATRIC MEDICINE general considerations the pediatric history examination of the newborn examination of the infant examination of the young child examination of the older child examination of the adolescent clinicopathologic correlations	L. Diamond, M.D.	Corresponding Chapters in Textbook
10/18/04 Monday 9:00- 11AM	<b>FINAL EXAMINATION</b>	M. Kosinski, DPM	

**Hints for success:**

Read corresponding chapters in required textbook prior to coming to class, Ask questions of the instructor where appropriate to clear up any ambiguity in the material presented. Review the videotapes in the library. Do not hesitate to review other physical diagnosis textbooks in the library that give a different perspective.

**New York College of Podiatric Medicine**  
1800 Park Avenue New York, NY 10035

**SYLLABUS**

**Course Title:** INTERNAL MEDICINE

**Course Number:** DPMED 2814

**Department:** Primary Podiatric Medicine

**Credit hours:** 4

**Grade Type:** August, 2004

**Course Director:** Sushama Rich, MD

**Director's Campus phone:**(212) 410-8072      **Other phone:** (212) 410-8178

**Director's E-mail:** [srich1@nyc.rr.com](mailto:srich1@nyc.rr.com)

**Office Days/Hours:** Mutual convenience

**Course Coordinator:** Sushama Rich, MD

**Other Faculty:** Guest Lecturers

**Course Description:**

A course administered by physicians (each physician according to his/her expertise) from the Metropolitan Hospital Center (a clinical facility of New York Medical College), covering systemic diseases. It is the same Internal Medicine course as is given to 3rd year medical students. This is a clinically oriented course requiring comprehensive, integrated understanding of Basic Medical Sciences.

**Course Goal(s) and Objectives:**

Students are expected to be able to describe gross abnormalities, symptoms, signs, clinical presentations, diagnostic procedures and treatment of systemic diseases. They should be able to apply their knowledge and understanding in a clinical setting under supervision of a clinician, (MD and DPM) in the podiatric and general medical contexts.

**Lecture Goals:**

By the end of each lecture group covering an organ system, the students should be able to

- a. Apply the knowledge acquired in basic sciences in the development of clinical diseases.
- b. Appreciate the role of Physiology and Pathology in the development of diseases
- c. Apply the knowledge acquired from Physical assessment in evaluation, and diagnosis of patients suffering from a clinical disease
- d. Recognize and describe signs and symptoms of conditions or diseases presented by patients.

- e. recognize and the symptoms and signs of conditions or diseases presented so as to categorize them according to the organ system primarily affected,
- f. Understand the etiologies, risk factors and genetics behind the development of conditions or diseases presented by patients.
- g. Recognize the importance of careful history and physical examination in determination of the range of obvious and subtle symptoms and signs of conditions or diseases presented by patients.
- h. Recognize the most common causes for various diseases.
- i. Recognize and describe the first steps in evaluation of patients.
- j. Recognize the importance of work up sheets in diagnoses and differential diagnosis for various diseases
- k. Understand how to evaluate, diagnose, and treat patients with various clinical conditions.
- l. Recognize the importance of co-morbid conditions in the prognosis of patients
- m. Present (when applicable) and correlate podiatric symptoms and signs appearing coeval with patients' systemic conditions or diseases.
- n. List and interpret adjunctive test procedures (lab, x-ray, MRI, EKG, etc.) that help to confirm related systemic and podiatric diagnoses.

### **LECTURE GROUPS:**

Cardiovascular Disease, Pulmonary and Critical care medicine, Renal disease, Gastrointestinal disease, diseases of the Liver and Biliary system, Hematologic disease, Oncologic disease, Metabolic disease, Endocrine disease, Women's health, Men's health, Diseases of bone and Bone mineral metabolism, Musculoskeletal and connective tissue diseases, Infectious diseases, The aging patient

### **Method of Student Evaluation:**

Written examinations – **Four written examinations will be given.** Each examination will consist of 50 multiple choice questions. Most questions will be in the form of a clinical vignette with laboratory values and diagnostic studies. **Each exam will be worth 25% of your final grade.** Up to 50% of the examination questions will derive from the required text, and the rest from lectures and handouts.

### **Method of Examination Review:**

Review of questions and answers - Discussion in class (after examination) of questions on examination, correct answers and other answer choices.

### **Required Texts:**

**CECIL'S ESSENTIALS OF MEDICINE, 6<sup>th</sup> ed.** WB Saunder's, Philadelphia 2004

### **Reference Texts:**

**CECIL TEXTBOOK OF MEDICINE**, 19th Ed., WB Saunders, Philadelphia 1992

**HARRISON'S PRINCIPLES OF INTERNAL MEDICINE**, 13th. Ed., McGraw-Hill, New York 1994

**GUYTON AC, HALL JE: TEXTBOOK OF MEDICAL PHYSIOLOGY**, 9th. Ed., WB Saunders, Philadelphia 1996

**NEW ENGLAND JOURNAL OF MEDICINE**

**ANNALS OF INTERNAL MEDICINE**

**Attendance and Lateness Policy:**

ATTENDANCE at all lectures is mandatory with a limit of one (1) unexcused absence during the period of the Internal Medicine-1 course. Additional absences must be documented by a physician's note (or a similarly acceptable source depending upon the reason for absence), submitted to the course coordinator by the first lecture session following that absence

LATENESS is strongly discouraged, and two (2) late arrivals (a late arrival defined as entering the classroom after attendance has been taken) will be equivalent to one unexcused absence.

## Course Schedule and Assignments

DATE	LECTURE/LAB TOPICS	LECTURER	ASSIGNMENT
Tuesday 11/16/04 10a.m-12p.m	Cardiology	Dr.Bousvaros, Dr.Chaudhari Dr.Kamenetsky	Ch, 3, 4, , 6, 9
Wednesday 11/17/04 9a.m-12p.m	Nephrology	Dr. Baumstein	Ch,24, 25, 26, 27
Friday 11/19/04 9a.m-11a.m	Cardiology	Dr.Bousvaros, Dr.Chaudhari Dr.Kamenetsky	Ch, 8, 11,
Tuesday 11/23/04 9a.m-12p.m	Cardiology	Dr.Bousvaros, Dr.Chaudhari Dr.Kamenetsky	Ch, 7, 13
Wednesday 11/24/04 9a.m-12p.m	Nephrology	Dr. Baumstein	Ch, 28, 29, 30, 31
Tuesday 11/30/04 9a.m-12p.m	Cardiology	Dr.Bousvaros, Dr.Chaudhari Dr.Kamenetsky	Ch 5, 12, 19
Wednesday 12/01/04 9.a.m-12p.m.	Pulmonary Medicine	Dr. Newman Dr. Matejak	Ch 14,15, 16, 17
Friday 12/03/04 9.a.m-11a.m	Pulmonary Medicine	Dr. Newman Dr. Matejak	Ch, 19, 20,
Tuesday 12/07/04 9.a.m-12p.m.	Pulmonary Medicine	Dr. Newman Dr. Matejak	Ch, 21, 22, 23
Wednesday 12/08/04 9a.m.-12p.m.	Gastrointestinal diseases	Dr. Williams	Ch 32,34, 35

Friday 12/10/04 9a.m.-11p.m	REVIEW	Dr. Rich	
Friday 12/17/04 10am - 12noon	Exam # 1		
Tuesday 1/04/05 9a.m.-12p.m.	Gastrointestinal diseases	Dr. Williams	Ch, 35-38
Friday 1/07/05 9a.m.-11p.m	Gastrointestinal diseases	Dr. Williams	Ch,39-45
Tuesday 1/11/05 9a.m.-12p.m.	Hematology	Dr. Voudouris	Ch, 46- 49
Friday 1/14/05 9a.m-11p.m.	Hematology	Dr. Voudouris	Ch, 50-53
Tuesday 1/18/05 9a.m.-12p.m	Hematology	Dr. Voudouris	Ch, 54-58
Friday 1/21/05 9a.m-11p.m.	Endocrinology	Dr. Cobbs	CH,64-65
Tuesday 1/25/05 9a.m-12p.m.	Endocrinology	Dr. Cobbs	Ch, 66-69
Friday 1/28/05 9a.m-11p.m	Endocrinology	Dr. Cobbs	
Friday 2/04/05 9am - 11am	EXAM # 2		

Tuesday 2/08/05 9a.m-11p.m	Endocrinology	Dr. Cobbs	Ch, 72-74, 76
Thursday 2/10/05 9a.m.-1p.m	Women's health	Dr. Henderson	Ch 70
Tuesday 2/15/05 9a.m-11p.m	Men's health	TBA	Ch 71
Thursday 2/17/05 11a.m-1p.m	Musculoskeletal and Connective tissue disease	Dr. Shookster	Ch 77-80
Tuesday 2/22/05 9a.m-11p.m	Musculoskeletal and Connective tissue disease	Dr. Shookster	Ch 81-83
Thursday 2/24/05 11a.m-1p.m	Musculoskeletal and Connective tissue disease	Dr. Shookster	Ch, 84, 85
Thursday 3/03/05 9am - 11am	EXAM # 3		
Tuesday 3/08/05 9a.m-11a.m	Musculoskeletal and Connective tissue disease	Dr. Shookster	Ch 86-89
Thursday 3/10/05 11a.m-1p.m	Infectious diseases	Dr. Lennox	Ch 106
Tuesday 3/15/05 9a.m-11a.m	Infectious diseases	Dr. Lennox	Ch 107
Thursday 3/17/05	Infectious diseases	Dr. Lennox	Ch 95, 105

11a.m-1p.m			
Tuesday 3/29/05 9a.m-11a.m	Geriatrics	TBA	Ch, 132
Thursday 3/31/05 11a.m-1p.m	REVIEW	Dr.Rich	
Tuesday 4/05/05 9am - 11am	FINAL EXAM		

September 28, 2004

## **Internal Medicine**

### **Clerkship Goal:**

The rotation in Internal Medicine is designed to acquaint the primary podiatric medical student with the practice of internal medicine and its subspecialties. It will offer practical experience in the medical assessment of patients and establish consultation judgment.

### **Clerkship Objectives:**

At the conclusion of this rotation, the student will possess the knowledge, understanding and skills necessary to evaluate medical patients. The student will gain an appreciation for:

- The technical skills needed to manage a hospitalized patient
- The interrelationship between basic science knowledge and internal medicine
- The skills necessary to develop a logical and appropriate differential diagnosis
- The skills necessary to present a case to an attending physician in a logical, coherent manner

### **History Taking:**

The student will gain an appreciation for a thorough history and review of systems in formulating a differential diagnosis by interviewing the hospitalized patient. The student will sharpen their history taking skills, and develop a logical approach to patient assessment.

### **Physical Examination:**

#### **Head**

- The student will gain experience performing examination of cranial and facial structures

#### **Eyes**

- The student will gain experience with the use of the ophthalmoscope and be able to visualize retinal vessels and the optic nerve head.
- The student will perform confrontational visual field testing and assess pupillary reaction, extra-ocular muscles and related ocular structures.

#### **Ears, Nose, Mouth, Throat and Neck Examinations**

The student will practice examination of the

- Ears: including the external auditory canal, tympanic membrane and related structures
- Nose: including turbinates, septum and related structures
- Mouth and Throat: including buccal mucosa, tongue, hard and soft palate, uvula, tonsils, tonsillar crypts and dentition
- Neck: including trachea, thyroid, carotid and subclavian arteries for bruits, and jugular veins for distention.

#### Cardiopulmonary Examination

The student will gain experience in the examination of the heart, lungs and related structures, specifically:

- Heart: a) assessment of rate, rhythm and B.P.  
b) auscultation at cardiac listening posts; aortic, pulmonic tricuspid, mitral and Erb's point  
c) introduction to assessment and grading of heart murmurs
- Lungs: a) auscultation of all lung fields  
b) tactile fremitus  
c) assessment of adventitious breath sounds

#### Abdominal Examination

- The student will practice techniques of inspection, auscultation, percussion and palpation of the abdomen and related structures.
- The student will practice inspection of abdomen for asymmetry and masses, auscultation of bowel sounds, auscultation of abdominal aorta, percussion of liver and spleen, palpation of four quadrants of the abdomen, palpation of liver, spleen, kidney and abdominal aorta.

#### Lymphatics

- The student will practice assessment of the lymphatic system, including examination of the lymphatics of the head, neck, axilla, groin and popliteal regions.

## Extremities

- The student will practice techniques of examination of the upper and lower extremities, including vascular, dermatologic, neurological and musculoskeletal assessment.

During the internal medicine rotation, the student will also gain experience in the following areas:

- Interpretation of pertinent laboratory data and recognize abnormal EKG findings
- The fundamentals of fluid and electrolyte balance
- The diagnosis and management of commonly encountered medical conditions, such as diabetes, hypertension, cardiopulmonary disease, and rheumatologic disorders
- The diagnosis and management of common coagulopathies
- The diagnosis and management of commonly encountered infectious diseases, including bone and soft tissue infections and immunodeficiency syndromes
- The diagnosis and management of common neurological disorders, such as paralysis agitans, CVA, Alzheimers disease, neuropathy and myopathy

During this rotation the student will also:

- Appreciate the importance of the doctor/patient relationship by displaying an open, responsive attitude toward patients, showing empathy for their complaints, and respecting their need for privacy, dignity, and confidentiality

**SENIOR CLERKSHIP - CONTACT PERSON AT SET HOSPITAL**

SITE	REPORT TO	TEL/PAGE #	FAX	SECRETARY
<b>INTERNAL MEDICINE</b>				
<b>Long Beach Medical Center</b> Bob Biller, DPM Section Chief, Div of Podiatric Dept of surgery-IM 455 East Bay Drive Long Beach, NY 11561	Dr. Biller Medical Staff Lounge First Floor @ 7:00 AM	(516) 897-1013	(516)432-3479	None
<b>Metropolitan Hospital Center</b> Ronald Cobbs, MD Deputy Chief of Internal Medicine 1901 First Avenue Rm# 704 New York, NY 10029	Dr. Cobbs Department of Medicine Rm#704 @ 8:00 AM	(212) 423-6771	(212)423-8099	Aida
<b>NY Methodist Hospital</b> Stanley Sherbell, MD Exec Vice President For Medical Affairs Buckley Pavilion -8 <sup>th</sup> floor Brooklyn, NY 11215	Teresa Student Affairs Coordinator - 8 <sup>th</sup> floor @ 9:30 AM (1 <sup>st</sup> Day only)	(718) 780-3284  (718) 780-3284	(718)780-3287	Teresa
<b>Lincoln Medical &amp; Mental Health Center</b> Vihren Dimitrov, MD 234E 149 <sup>th</sup> Street, Bronx NY 10451	Dr. Dimitrov 1 <sup>st</sup> day Room 822-8 <sup>th</sup> floor @ 7:30 AM	(718) 579-5910	(718)579-4836	

*Fort Dodge Oral & Maxillofacial Surgery, P.C.*

*\*Terry L. Hopper, D.D.S. • \*Eric R. Pearson, D.D.S. • Eric C. Knox, D.D.S.  
\*Diplomates of American Board of Oral & Maxillofacial Surgery*

May 20, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3122-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

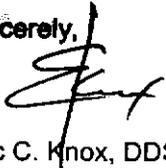
**To Whom It May Concern:**

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to the H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,



Eric C. Knox, DDS

ECK:jrp