

COMMUNIQUE



APRIL/MAY 2011

IN MEMORIAM

STUART K. REMLEY, MD
12/20/1924 - 3/17/2011

JOHN H. HAGEMAN, MD
1/25/1935 - 3/30/2011

ICD 10 Seminar

Are you as ready as you should be for ICD 10? Join us on Wednesday, June 8, from 3:00 - 4:30 pm at The Academy of Medicine for a free session on everything you need to know to be ready for ICD 10. A flyer is included with this issue of the *Communique*. There is no charge for Academy members, but reservations are required. Contact Lee Wealton at 419/473.3206 or at lwealton@aol.com.

2011 Annual Medical-Legal Seminar

The 2011 Annual Medical-Legal Seminar will be held on Thursday, May 12, at 5:30 pm in the St. Luke's Hospital Auditorium. A flyer was included with the last issue of the *Communique*. If you did not get one and would like to attend please contact Lee Wealton at 419/473.3206 or at lwealton@aol.com.

Healthy Living News

The Community Relations & Communications Commission is recruiting contributors to The Academy Corner in *Healthy Living News*. Articles for the monthly publication are approximately 300 words and can be sent to Dr. Ron Shapiro at rshapiro@edok.com. Maintaining the presence of The Academy Corner in *Healthy Living News* favorably keeps The Academy of Medicine in the public eye, as well as its members.

Academy Mentorship Program

In 2006, the Academy Mentorship Program was formed to offer support to local pre-med students. One of the most fun and challenging parts of the program is a one on one mentoring relationship with a pre-med student. The Academy continues to recruit potential mentors for the program. If you have an interest in the program and would like to be a mentor, please contact Lee Wealton at 419/473.3206 or at lwealton@aol.com.

Coding Confidential

Q: A Nurse Practitioner sees a patient and the patient has chemo done on the same day. Do we bill the OV with 25 modifier under the NP's ID number and bill chemo under supervising doc in office?

A: Yes, assuming all other rules have been complied with. The office visit must be significantly more than the visit necessary to administer chemotherapy, it must be separately identifiable in the medical record and not part of the chemo note, it must be medically necessary (ex: a diagnosis was determined, treatment plan formed or reevaluated), and the OV service must be within the NP scope of license. Chemotherapy administration codes include an allowance for a brief, problem-focused office visit, so you should not be routinely billing an OV and chemo on the same day. Chemotherapy is not within the NP's scope of license. When the NP performs that service, he/she is following the physician's treatment plan instead of making his/her own medical decisions, so the services are "incident to" the physician's services and should be billed under the physician's ID numbers.

Coding Confidential is written by Kathy Stull, CPC, CMRS. Ms. Stull is president of Superior Resources, Inc. If you have a question for Coding Confidential, email it to KathyStull@SuperiorResources.info. Your question will be answered by return email and may be included in a future issue.

Academy Night at the Mud Hens

Academy Night at the Mud Hens will be held on Wednesday, August 10, 2011. The Toledo Mud Hens will play the Louisville Bats. Dinner will begin at 6:15 pm and the first pitch is at 7:00 pm. Tickets for the game and an All-American Dinner are \$25 for adults and \$23 for children 12 and under. The reception will be hosted by Steve Bogart and Hylant Medical Risk Practice. A reservation flyer is included in this issue of the *Communique*.

2011 Annual Academy Golf Tournament

The 2011 Annual Academy Golf Tournament will be held on Thursday, June 2, at Stone Oak County Club. The day will begin with a continental breakfast, followed by an 8:30 am shotgun start. Lunch and prizes will follow. A reservation flyer was included in the last issue of the *Communique*. If you did not receive one and would like to play please contact Lee Wealton at 419/473.3206 or at lwealton@aol.com.

Health Reform: Necessary, but will the Affordable Care Act be sufficient?

By *Johnathon S. Ross, MD, MPH*

Many physicians care about the injustice of a health care system that leaves 50 million of our patients, friends and family uninsured, but it is health care spending that threatens to destabilize the entire US economy. We need to cover the uninsured and control costs. There are 50 million uninsured Americans despite spending \$2.6 trillion annually. This is about 1/6 of the entire country uninsured and spending is at 17% of our GDP. The number of uninsured has grown by about a million each year for the past 20 years. Ohio has 1.48 million uninsured despite spending over \$80 Billion annually. Contrary to popular thinking, the uninsured are not the chronically unemployed or illegal immigrants. Almost 80% of the uninsured are working people and their children.

One of the reasons many of the working class uninsured cannot afford to purchase insurance is that their incomes have not kept up with medical cost inflation. In fact only the wealthiest 5% have come even close to keeping up. Medical inflation continues 3%-5% above the overall inflation rate. Over the past 30 years, working families would have needed above 100% real growth in income adjusted for underlying inflation in order to keep up with rising health care costs. Most have seen their incomes rise only a few percent or less.

We already have what it takes to take care of everybody. The fixed overhead costs (buildings, nurses, doctors and equipment) of the health care system result in a large and expensive infrastructure that we all need in case we get sick. The infrastructure is maintained by patient use and payments. Since only a small number of individuals are actually receiving care at any time (20% of patients generate 80% of costs), these payments for fixed costs must be shared by everyone. If these fixed costs are not met, the infrastructure will shrink, degrade or even disappear. These fixed costs make up over 60% of spending and must be in place before a single sick patient can receive comprehensive care. We all must contribute if we want the care to be there when we need it.

Public financing (taxes) already accounts for 60% of total spending (Medicare, Medicaid, VA, public employees and the tax deductibility of health insurance). Business and personal out of pocket payments cover the rest. In the US, public spending alone exceeds the total per person health care costs of 8 European countries that cover all their citizens with better health outcomes. Businesses only pay about 20% of the total cost, yet they seem to exert an undue amount of influence over US health policy decisions. That's because about 60% of Americans receive their insurance coverage as a benefit of employment. These working people and their kids are the healthiest in our society and cost less to cover than the elderly, disabled and poor who have been left to public programs to cover.

You will hear conservative pundits complaining about health reform. They characterize it as a giant government takeover that "will ruin the best health care system in the world" (John Boehner actually said this recently!). Do we have the best health care system in the world?

According to Organization for Economic Cooperation and Development the best international comparison data show that Americans live shorter lives and lose more healthy years of life to treatable illness than most of our economic competitors. Our infant and maternal mortality exceeds theirs. We are not more expensive because we are older. We do not smoke or drink more, use

more doctor visits or hospital days or overstaff with nurses. We are in the middle of the pack regarding use of technology, joint replacements, transplants and on medical research articles published based on relative population size. We do feel we have better access to technology, although physicians in several other countries feel they have about the same level of access.

The one place we clearly lead is in the cost of our system where we spend almost twice as much as our economic competitors per capita. These excess health care costs are built into every American product and reduce our economic competitiveness. Our costs are rising much more sharply, although all the western democracies are struggling to control health care costs. Although our outcomes may be better for a few specific types of illnesses (breast cancer for example) by almost every general measure our outcomes are worse and our costs are twice as high. This is why health reform has been under serious ongoing discussion since the debate over Medicare which resulted in a universal national health insurance program, but only for those over 65 and the disabled. The passage of the Patient Protection and Affordable Care Act (ACA) is a continuation of that debate and has left us divided and confused. What has this law brought about so far and what does it hold for us in the future?

One year after the passage of the ACA several provisions have already gone into effect. The number of Ohioans affected is in parentheses:

- *Young Ohioans can keep or obtain insurance coverage on their family plans until age 26 (35,000).*
- *Insurance companies are prohibited from denying coverage to children with pre-existing conditions. (Many insurers dropped "child-only" coverage in response.) (unknown)*
- *High Risk Pools funded by the ACA now subsidize the uninsurable (1,100).*
- *Insurance companies may no longer impose lifetime dollar caps on enrollees. (unknown)*
- *The Medicare Prescription Drug benefit "doughnut hole" is being closed (110,000).*
- *Medicare beneficiaries can receive wellness checks and other preventive care without a co-pay or deductible (150,000). All private insurers will need to completely cover preventive care also.*
- *An estimated 127,800 small businesses in Ohio are eligible for the ACA's tax credit to help purchase health insurance for employees and of those, 38,900 are estimated to be eligible for the full credit. (unknown)*
- *Grants, matching funds and other resources now available will help transform the way Medicaid funds long term care by shifting away from institutional care toward home and community-based care. (unknown)*
- *Employers can obtain re-insurance to help subsidize coverage to early retirees 55+. This will be a major financial benefit to large employers and they are already taking advantage of it.*
- *Insurers will have to spend 80-85% of premiums on care. Primary care physicians will get increased payment from Medicare and Medicaid.*

By 2014:

- *Everyone will need to buy insurance or pay a fine. Those below 133% of poverty will be enrolled in Medicaid. Those from 133% of poverty to 400% of poverty will receive subsidies to purchase private insurance from among a range of insurers through state based insurance exchanges with standard benefits packages. Those who do not purchase insurance will be fined except for specific hardship cases. Cost sharing is limited to no more than 6 to 30% of premiums for those from 133 to 400% of poverty. There are no subsidies for those above 400% of poverty but they will be allowed to purchase insurance through the exchanges.*

- Employers of more than 50 individuals must provide insurance or pay into a fund that will help subsidize coverage for the uninsured.
- CBO estimates about 32 million of the 50 million uninsured will be covered, about half by expanded Medicaid and half by private coverage in the exchanges.
- Revenues needed for these programs are about \$100 billion yearly (about a 4% increase in current annual spending). Physicians usually get about 20% of spending on health care so the ACA will likely increase physician incomes by \$20 billion.
- Revenue is raised from taxing insurers and reducing excess payments to their Medicare Advantage plans, by taxing pharmaceutical companies and tanning salons, and by reducing the deductibility of some medical expenses and high cost health plan premiums. There are also assumptions of savings in Medicare and Medicaid based on changes in payment approaches. (See below)
- Five year grants for state based malpractice reforms are part of the ACA. Texas passed strong limits on malpractice awards seven years ago. This lowered malpractice premiums by over 50%, but has had little effect on health care cost growth.

There are many other good public health and quality improvement ideas in the ACA. Sadly, there are fewer that are likely to control costs. We already have evidence from the one state with ACA like reform-Massachusetts. They have reduced the number of uninsured to only 4%. This is less than 1/4 the national rate. However, costs continue to rise sharply despite reform. It appears that you can cover most Americans with a mandate to buy private insurance, but if you leave the for profit medical industrial complex untouched, costs will continue to rise unabated. Although some pundits claim that the health information technology, bundled payments and accountable care organizations promoted by the ACA will help to control costs, there is little supportive data from trials of these approaches under Medicare or to suggest that information technology will lower costs, though it might improve the quality of care.

If the ACA is unlikely to be highly effective in coverage and cost control, what are the alternatives. All the other advanced countries have covered everyone using one of three approaches.

A national health service (e.g. Great Britain, Sweden) is true socialized medicine where the doctors, nurses and other providers are public employees and the hospitals are publicly owned. A national health insurance with many not for profit insurers with a single negotiated fee schedule and very tight public insurance regulation (Germany, Netherlands, France) and lastly, single payer national health insurance (Canada, Taiwan, Australia and our own version for seniors, Medicare). These are the systems that have been proven to provide universal coverage and cost half per capita.

It is worth noting that our own example of a single payer, Medicare, has actually had better cost control than private insurance over the past 40 years and has been more innovative (e.g. DRG's, the RVU fee schedule, and public reporting of outcomes.) Medicare is our best example of a successful American national health insurance system. It is funded by taxes that are placed in a trust fund (an efficient way to collect the needed revenue) and involves everyone in paying their fair share. A single insurer is hired, by competitive bid, to just process the Medicare bills according to a single fee schedule. This simplicity keeps insurance overhead for Medicare at less than 3% of premiums. Private insurers will waste more than five times as much on administration and profits even with the restrictions of the ACA. Under traditional Medicare, doctors practice privately and are not employees of government. Hospitals are privately managed by their community based boards. Medicare is not socialized medicine. It is social insurance just like Social Security.

When we created Medicare in 1965, Canada created a Medicare system for Canadians of all ages. They even call it Medicare just as we do. Prior to 1965, Can-

ada had a private insurance system just like ours. Their ability to control costs and provide care to all is proof that such a system can be changed and could work for all of us especially given our much more generous funding which is about twice as much per capita. Taiwan also had a system like ours, but with many more uninsured (40%). Just over a decade ago, after study, they rejected the private insurance model and created a single payer Medicare system for all Taiwan's citizens. They made the transition in just a couple years and covered everyone with no significant increase in spending. The Canadians covered everyone, the Taiwanese covered everyone, and we did it for seniors with social insurance that provides better administrative value, better cost control and better outcomes.

The ACA continues under serious challenge politically. The individual mandate is possibly unconstitutional. Although there are many good aspects to the ACA as mentioned above, evidence suggests that the ACA will still leave almost 20 million Americans uninsured and will not control overall costs very effectively.

On the other hand, there is good evidence that an improved and expanded Medicare would cover everyone for no more than we spend now given the large administrative savings that would result from the simplicity of this type of reform. It would improve outcomes and control costs as similar systems have in other developed nations. Medicare is constitutional. Many of the financial interests that are profiting from the current system will fight against the increased public accountability the ACA or an improved and expanded Medicare for all would bring to the health care system. Political challenges will remain either way. An improved and expanded Medicare for all is likely to save more money, save more lives while allowing us to practice without the hassles that are the hallmark of the private health insurance system. Physicians must choose to show leadership on this tough political problem. We need to support covering everyone and cost control. Doing nothing is not an option.

Editor's note: If you would like a power point presentation and/or his paper on the politics of health reform that was published in the *American Journal of Public Health* in May of 2009 (pre ACA), please contact Dr. Ross.

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