



January 2009

MIAMI MEDICINE

The Official Publication of the Dade County Medical Association

HAPPY
NEW
YEAR!

LOOK WHAT'S INSIDE...

- Message from your President 3
- Tobacco Dependency 5
- Physician Legal Alert 7
- Medicare Physician Fee Schedule . 8
- Information Technology 11
- Manpower Shortage in Medicine .. 13

ACG247 TechTip

Insider tips and secrets to get the MOST out of your computer and network. JAN 2009

3 Ways Technology Can Help Your Business “Go Green” and Save BIG

1. Have your network maintained remotely. Thanks to major advancements in virtual technologies, we can remotely access your computer network to perform regular maintenance and enforce sleep-mode settings, hard disk spin rates, CPU shutdown schedules, and more, to keep idle equipment from sucking loads of unnecessary power after hours. Not having to drive to our clients’ offices to perform repairs and maintenance not only means faster support for them, but also a lot less gas burned!

2. Allow employees to work from home. With high gas prices and employees traveling more than ever, the “virtual” office is becoming more of a necessity than a luxury. Allowing employees to work virtually from home or on the road will not only increase productivity, but also save you (and them!) on gas. Some companies are allowing employees to work from home one day a week as a perk, and many company owners enjoy the ability to work after hours and on weekends without having to trudge into the office.

3. Purchase energy-efficient PCs, servers, copiers and printers, and properly recycle old equipment. Hardware manufacturers are constantly coming out with “greener” alternatives. In some cases, energy use is cut by 25% or more! New high-efficiency printers use far less ink and toner, which means fewer cartridges piling up in landfills. And remember, never throw old devices in the trash! We can connect you with dozens of organizations that will gladly recycle your old PCs, monitors, laptops, PDAs, and cell phones!



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MESSAGE *from your* PRESIDENT:

PRESIDENT'S MID-TERM ASSESSMENT: *Achievements and Outlook*

Bernd Wollschlaeger, M.D., FAFAP, FASAM
President, Dade County Medical Association

When I assumed the position of President of our organization I asked myself the simple but important question: what is the most important issue I want to address during my presidency and how can I achieve my goal set for this year. I have had the privilege of serving in several leadership positions within organized medicine and learned from my mentors the following: listen to your peers, understand their needs, carefully draft and skillfully execute an action plan that meets their identified needs. I followed the advice given, mapped out the following strategy and carefully pursue its implementation:

1. LISTEN AND COMMUNICATE: at our request each and every hospital in Dade County provided a medical staff meeting schedule and I asked to speak at those meetings. During those meetings I do not only provide an update about the accomplishments of organized medicine but listen to comments, critique and questions. Many issues revolve around the erosion of medical staff autonomy and ambiguous medical staff bylaws. Furthermore, stagnating and slow Medicare reimbursement has beguiled many physicians. Their concerns are compounded by prepayment reviews requiring the submission of medical records. This delays Medicare reimbursement for several months and forces physicians to invest time and money to collect and copy these records. Also the tightening credit market and decrease of our patient's discretionary spending exacerbates the slow reimbursement process.

2. DEVELOP AN ACTION PLAN: after each meeting I categorize and summarize the complaints, critique and suggestions made. I identify the three most common issues and focus my energy on addressing and resolving them. During my 14 years of service I learned that a pragmatic approach and collaborative attitude is more effective than confrontation and belligerent chest beating. Therefore, I approach each party involved, trying to understand their perspective of the issues at hand and, if possible, to offer a compromise solution.

3. EXECUTE ACTION PLAN:

a. **Medicare Reimbursement and Prepayment Review:** I submitted a letter to The Miami Herald, which was published, expressing our concern about the performance of First Coast Service Options (FCSO), the regional Medicare administrator. That led to a meeting between high-ranking FCSO representatives and our Executive Committee during which we asked for a detailed review of complaints submitted by approximately thirty physicians (many of them non-DCMA members). Subsequently, I traveled to the FCSO headquarters in Jacksonville, met with the company's leadership and each department head to clarify the claims payment process and to identify problem areas. We agreed to limit and reduce the onerous prepayment review requirements. *I need your feedback to monitor the implementation of the agreement!*

b. **Medical Staff Issues:** we strongly support physician autonomy and self-governance because it has implications for patient advocacy and quality practice. Therefore, we provide complimentary membership for each medical staff president not currently a member of DCMA, a copy of the AMA Physician's Guide to Medical Staff Organization Bylaw and invite them to participate at our Board meetings. We will also continue to invite all medical staff presidents for semiannual face-to-face meetings to listen to their concerns and suggestions.

c. **Medicare/Medicaid Fraud and Abuse:** the rampant and out-of-control abuse of the Medicare/Medicaid system in Miami-Dade County jeopardizes the financial viability of the entire system and reduces the resources available for fair reimbursement of legitimate physician's services. Therefore, I contacted FMA President, Steve West MD, and he immediately arranged a meeting with the Office of the Florida Attorney General. On December 9th I participated in a meeting in Tallahassee with Bill McCollum, the Attorney General of Florida, and we agreed to develop a set of programs to engage and recruit physicians to assist in the identification of fraud and abuse cases. I feel very strongly that as physicians we MUST be part of the solution of this problem to prevent further erosions of our precious healthcare resources.

What else have we accomplished and what's in the pipeline?

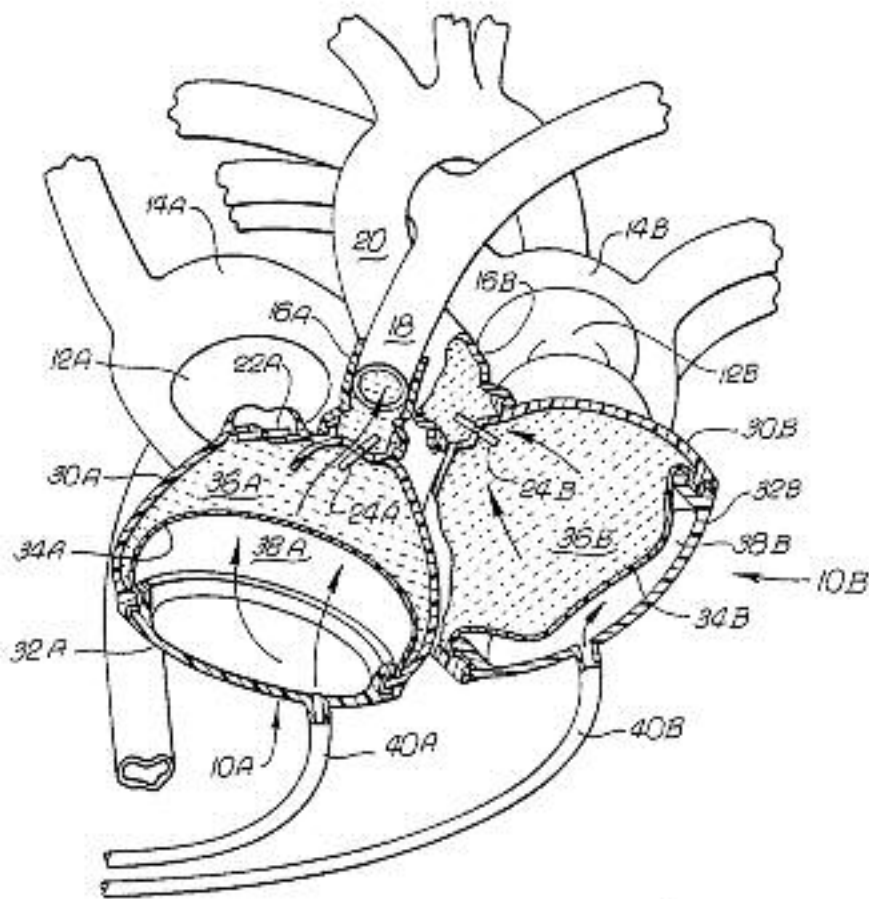
- I will continue to focus on membership retention and recruitment programs and initiated the reformation of a membership committee.
- Revised our web site to include valuable membership information and support material.
- Focus on the development of practice management tools to provide physicians the resources to practice medicine.
- Enhance the role of women in our organization and to promote their representation in leadership positions.
- Expand our relationships with other healthcare organizations including the University of Miami and the FIU School of Medicine and to develop collaborative partnerships.

You need you to join our DCMA to support these and other projects, which help you to practice medicine and to provide quality care to your patients.

What are you waiting for? Join today!

Yours

Bernd Wollschlaeger, M.D., FAFAP, FASAM
President, Dade County Medical Association



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TOBACCO DEPENDENCY: Help is Available for a Treatable Chronic Illness

By David Brown, MD

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Though tobacco use has declined below 20% in the United States, it remains the leading cause of death and disease and well above the 12% Healthy People 2010 target. Second hand smoke also contributes to a variety of illnesses and is targeted by Healthy People 2010. Nicotine is highly addictive, and cigarette smoking is its most addictive form due to the rapid absorption and delivery of the drug. Due to the stress-relieving properties of nicotine binding in the reward centers of the brain, many with minor stress or major mental illness self-medicate with cigarettes. Smoking rates are above 50% in those with serious mental illness. Nonetheless, most people now recognize the negative long-term health consequences, the burden of the experience of addiction, and the health benefits of recovering from addiction. Most of those who ever smoked have quit, most current smokers want to quit, and 40% of smokers quit for at least a day each year.

Physicians have a central role in treatment of tobacco addiction, as well as in policy leadership. Most smokers visit a physician each year and physicians are respected community leaders. Physician intervention is among the most effective treatment strategies. Even simple advice to quit is effective. Nonetheless, the more rigorous the intervention, the more effective it is. The most effective approach combines the multiple evidence based methods. As with other chronic diseases, the chronic care model is the foundation of clinical care for the *chronic disease of tobacco dependence*. The key components of this model include: 1) systematically ask about and document tobacco use, 2) strongly advise all smokers to quit at each encounter, 3) assess the motivation to quit, 4) assist smokers to build self-efficacy to quit through a targeted combination of counseling, medication, and social support, 5) track all smokers under your care and arrange follow up using clinical information systems (since it is a chronic, relapsing disease), and 6) support policies proven to reduce tobacco dependence in communities such as tobacco user fees and smoke-free environments.

Through the *State of Florida Comprehensive Statewide Tobacco Education and Use Prevention Program*, free services are available to assist smokers to quit through multiple collaborating organizations. While media campaigns are underway to raise public awareness, physicians are in the best position to help our



patients access these resources. The Florida Quit-Line 877-U-CAN-NOW provides a series of free telephone counseling sessions and up to two months of free nicotine replacement therapy. The Consortium for a Healthier Miami-Dade County (www.healthymiamidade.org) has established a committee to coordinate and support county-wide policy and prevention interventions. The Area Health Education Centers (AHEC) Network is providing free group and individual counseling at locations throughout the state. We can run groups in your office or ours. We can train you or your staff in the latest evidence-based treatments including how to combine medication therapies, patient-centered counseling, and how to bill for tobacco treatment services. AHEC also can provide free patient education materials and tobacco-free policy development. Free online continuing education courses are available at www.aheceducation.com & tobaccocme.com (click on Florida AHEC professionals).

For a calendar of upcoming Continuing Education programs visit
<http://www.mdahec.org/CalendarCE.asp>

For Cessation Services visit
<http://www.mdahec.org/ProviderResources.asp>

or contact Ms. Helen Cuan, MSW, Tobacco Cessation Coordinator
at (305)597-3640 or e-mail her at SmokeFree@mdahec.org.

For consultation services or for patient education materials, contact
the University of Miami AHEC program at 305-243-2847.

References

- Healthy People 2010. Available at: <http://www.healthypeople.gov/>
Treating Tobacco Use and Dependence: 2008 Update. Available at:
<http://www.ahrq.gov/path/tobacco.htm>

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PHYSICIAN LEGAL ALERT: The Coming Threat of RAC Audits and How to Avoid Them.

By: Michael J. Schoppmann, Esq.
Physicians' Counsel, LLC

On October 8, 2008, without great fanfare within the physician community, The Centers for Medicare & Medicaid Services (CMS) has taken the next steps in the agency's "comprehensive efforts" to identify "improper Medicare payments and fight fraud, waste and abuse" in the Medicare program by awarding contracts to four permanent Recovery Audit Contractors (RACs) designed to "guard the Medicare Trust Fund."

RAC Audits: What are they?

- Recovery Audit Contractor (RAC) Audits are specialized Medicare audits that began as a demonstration/pilot program. The demonstration resulted in over \$900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008.
- The RAC Program was developed by Medicare to identify "improper" Medicare Payments not detected using previously existing error detection and prevention program efforts.
- Section 302 of the Tax Relief Health Care Act of 2006 makes the RAC program permanent and requires its expansion to all 50 states.

RAC Audits: What do they portend?

- By 2010, CMS plans to have four RACs in place that are responsible for identifying over-payments and underpayments.
- On October 6, 2008, CMS announced the names of the new national RACs. The new RACs are:
 - **Diversified Collection Services, Inc. of Livermore, California** – Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.
 - **CGI Technologies and Solutions, Inc. of Fairfax, Virginia** – Region B, initially working in Michigan, Indiana and Minnesota.
 - **Connolly Consulting Associates, Inc. of Wilton, Connecticut** – Region C, initially working in South Carolina, Florida, Colorado and New Mexico.
 - **Health Data Insights, Inc. of Las Vegas, Nevada** Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.
- Additional states will be added to each RAC region in 2009.

RAC Audits: How are they different?

- RAC Contractors are paid on a contingency fee basis
- RACS are financially incentivized to identify errors.
- RACS can draw on HPMP and CERT methodology and data.
- RACS are permanent and will build an automated, ongoing denial system.

RAC Audits: How do they operate?

- RAC's conduct audits by reviewing medical data and billing data.
- Automatic reviews vs. complex medical reviews:
 - Automatic review: a computerized analysis of claims and coding practices utilizing existing databases. These reviews identify errors such as duplicates in billing and inappropriate bundling or unbundling of claims.
 - Complex medical review: billing and coding experts review samples of medical records and billing documentation. These reviews identify billing errors and also lead to denials in payment based upon assertions of "no medical necessity" and "incomplete documentation."
- RACs will utilize presently existing auditing procedures and will, therefore, have an infrastructure to complete audits and demand overpayment – from their first day of operation.
- RACs determine whether documentation for medical services provided meet the Medicare Guidelines for payment and whether the services are medically necessary.

RAC Audits: How to prepare?

- Consider moving toward and utilizing an EMR (Electronic Medical Record).
- Make sure your billing staff (either internal or external) is properly qualified, trained and provided with continual training/updates.
- Utilize certified billing and/or coding experts on a yearly or biennial schedule to ensure compliance, update templates and train staff.

Physicians' Counsel, LLC, www.physicianscounsel.com, has offices in Altamonte Springs and practices throughout the state of Florida. The firm's practice is solely devoted to the representation of health care professionals. Mr. Schoppmann may be contacted via email – mschoppmann@physicianscounsel.com.



IDTFs

On October 20, 2008, the Centers for Medicare and Medicaid Services (CMS) issued the Final 2009 Medicare Physician Fee Schedule (MPFS). The Final 2009 MPFS provided both good and bad news for physicians. The proposed 2009 MPFS was the subject of recent articles. One of the articles addressed a proposal by CMS to require physicians who furnish diagnostic testing services to meet most of the quality and performance standards required for Independent Diagnostic Testing Facilities (IDTF), as well as require such physicians to enroll as an IDTF for each practice location providing diagnostic testing services.

The good news is that, pursuant to the Final 2009 MPFS, CMS will not, at this time, require physicians to enroll as IDTFs. CMS indicated that it is deferring this requirement in order to further review comments and work out the accreditation standards for those entities providing imaging services as required by Section 135 of the Medicare Improvements for Patients and Providers Act of 2008, which accreditation standards are to be implemented by January 1, 2012.

For the bad news, pursuant to the Final 2009 MPFS, CMS is now requiring all mobile entities that furnish diagnostic testing services to: (i) enroll in the Medicare Program, as an IDTF; and (ii) bill the Medicare program directly for the services furnished to Medicare beneficiaries. With regard to the furnishing of services to Medicare beneficiaries, in the preamble to the Final 2009 MPFS, CMS includes entities which lease equipment and provide technicians who conduct diagnostic tests in the office of the billing physician and furnish testing under the supervision of a physician in that office.

As such, it is now the position of CMS that a mobile entity providing diagnostic testing services must enroll as an IDTF for services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or a fixed base location and must bill for the services they furnish, unless they are billing under arrangement with hospitals. The Final

2009 MPFS do, however, appear to provide physicians and mobile entities with ways to plan around these new restrictions.

There appears to be some confusion as to whether these enrollment and billing requirements apply to all diagnostic testing services furnished by a mobile entity or just to diagnostic imaging services furnished by them.

Aside from the confusion regarding a potential distinction between diagnostic testing services and diagnostic imaging services, the result of these revisions is to, for the most part, put an end to those arrangements between mobile testing companies and physician offices pursuant to which the mobile company leases the equipment and technicians, who conduct the diagnostic tests in the physician's office, to the physician practice, which test is furnished under the "supervision" of the physician who, in turn, bills for the technical component of such diagnostic tests.

To make matters worse, since CMS is of the belief that most mobile entities are already billing for the services they furnish, whether the services are provided in a fixed-base location or in a mobile facility, it is anticipated that these revisions will become effective January 1, 2009. As such, this will not leave physicians and mobile entities much time with which to either restructure or terminate their relationships.

Additional matters addressed in the Final 2009 MPFS can be found on page 9 of this issue of Miami Medicine.

Information in the articles on pages 8 and 9 are not a substitute for legal advice. The information and suggestions are general in nature and may not apply to all physician/practice situations. It is recommended you obtain legal advice from a qualified attorney for a more specific application to your situation. This information should be used as a reference guide only.

Final 2009 Medicare Physician Fee Schedule

Mitchell F. Green, Esq.

New Anti-Markup Provisions

The article on page 8 addressed the proposed revisions to the anti-markup provision for diagnostic testing services billed by physicians and suppliers. The anti-markup provisions generally limit how much physicians can bill Medicare for diagnostic tests performed in their offices or within group practices. In rules finalized by the Centers for Medicare & Medicaid Services (CMS), it adopted the hybrid approach originally proposed by it, with some modifications. It is important to note that these new rules take effect on January 1, 2009.

The Final 2009 Medicare Physician Fee Schedule (MPFS) includes two alternative methods for applying the anti-markup provisions. Alternative 1 would require that the anti-markup provision apply in all cases where the professional component and the technical component of diagnostic testing services were purchased from an outside supplier or where the services were performed or supervised by a physician who does not share a practice with the billing physician or physician organization. Under this provision, CMS would consider a physician as “sharing a practice” with another physician or physician organization if the physician performed “substantially all” of his or her professional services for the billing physician or supplier. In the Final 2009 MPFS, CMS defined “substantially all” as at least 75% of a physician’s services. In such circumstances the anti-markup provisions would not apply. CMS indicated that its definition of “substantially all” was intended to align the anti-markup rule with the physician self-referral (Stark) rules.

CMS indicated that in those situations where the arrangement did not comply with the first alternative, they could be analyzed under a second “site of service” alternative. In the case of alternative 2, the technical component of diagnostic testing services performed in the “office of the billing physician or supplier” would not be subject to the anti-markup rule. CMS indicated that restrictions on the location of where diagnostic tests were conducted and supervised were critical in

ensuring that the billing physician or supplier have “sufficient control and a proper nexus to the individuals conducting and supervising” the tests.

CMS indicated that by requiring the technical component of diagnostic tests to be conducted and supervised in the office of the billing physician or supplier, this created sufficient control and nexus. In the final rule, CMS defined the “office” of the billing physician or other supplier as any medical office space, regardless of the number of locations, in which the ordering physician or other ordering supplier “regularly furnishes patient care” and includes space where the billing physician or other supplier furnishes diagnostic testing, if the space is located in the “same building” in which the ordering physician or other ordering supplier regularly furnishes patient care. The term “same building” has the same meaning as the defined in the Federal Stark self-referral rules. With respect to a billing physician or other supplier that is a physician or organization, the office of the billing physician or other supplier is space in which the ordering physician provides “substantially the full range of patient care services” that the ordering physician generally provides.

CMS noted its belief that both alternatives contain measures for determining whether a physician shares a practice with the billing physician or other supplier of a diagnostic test for purposes of determining whether or not the anti-markup provision applies.

by Mitchell F. Green, Esq.

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TECHNOLOGY

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Medical Information Technology

Health Information Technology and The New Administration:

PRESIDENT-ELECT OBAMA PUSHES NEW TECHNOLOGIES

By Bernd Wollschlaeger, M.D., FAAFP, FASAM

During the presidential election campaign both leading Republican and Democratic candidates emphasized the importance of health information technology to improve and reform our ailing healthcare system.

President-Elect Obama has outlined the core component of his health IT proposal on his web site as follows: to invest \$10 billion a year over the next five years to promote broad adoption of standards-based electronic health information systems, including electronic health records. He also plans to phase in requirements for full implementation of health IT and appoint the nation's first chief technology officer (CTO) to coordinate the government's technology infrastructure, work on issues of transparency, and "employ technology and innovation to solve our nation's most pressing problems." Obama pledged to appoint a CTO to ensure that federal agencies have access to the best IT infrastructure policies and services. The CTO's role is to ensure the safety of government networks and coordinate efforts with agency CTOs and chief information officers.

The primary goal of the Obama healthcare plan is to increase access to care and decrease healthcare costs. This will require the installation and implementation of new information management system as a virtual infrastructure to manage the anticipated demand for medical services to be provided to previously uninsured patients.

His transition team already includes two technology advisers: Washington technology policy expert Julius Genachowski, an Internet business veteran and former executive of Barry Diller's IAC/InterActiveCorp.; and Sonal Shah, a tech execu-

tive from Google's philanthropy division, Google.org. Obama's choice of two technology experts to help guide his transition into office has bolstered his previous assertion that technology will play a major role in the new administration. And Obama has made it clear that health information technology will play a central role in his plan to overhaul the health system.

Already, leading healthcare IT proponents are supporting Obama's proactive position regarding healthcare IT implementation. For example, the independent, non-profit, eHealth Initiative applauded President-Elect Obama's inclusion of electronic medical records for every doctor's office and hospital in the country in his Economic Recovery Plan, key elements of which were announced as part of his December 6, 2008 Weekly Radio Address.

We should not wait for the implementation of those plans but start preparing our offices for the digital revolution. This will include targeted and systematic identification and extraction of relevant information from patient health records to be later transferred into electronic medical records. A proactive attitude and guided efforts as described above will help us to reduce the friction associated with the implementation of new technology solutions. I will provide tips and support regarding this topic in an upcoming issue and will post those tips on our web site, too.

Disclosure: *The author is a practicing family physician, addiction specialist and computer consultant. In addition, he is a founder and managing partner of a medical IT company.*

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DCMA Attorney Referral Program

With the assistance of our General Counsel, J.A. Ziskind, a group of prominent specialty and many board certified attorneys who regularly represent medical professionals has agreed to provide counsel to DCMA Members. Not only have we sought a group of the most competent attorneys in their specialty but the individual lawyers have agreed to a twenty-five percent (25%) professional courtesy discount off of their normal hourly rate. If you have suggestions on adding any other specialty areas please contact us and we will fill that need.

This is a unique program and will prove successful to the extent our Members utilize this program. Below is the list of attorneys who are on the panel, including their specialty and telephone numbers. If you have any questions or comments on this program, please do not hesitate to contact J.A. Ziskind, Esq. at (305) 577-4888.

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COMING: Manpower Shortage in Medicine

John C. Nordt, III, M.D.

SPINE CENTER OF MIAMI
John C. Nordt, III, M.D. and Associates

Manpower shortages in medicine are anticipated in the next 10 or 15 years because of a reduction of participation of qualified people to practice medicine. 801 medical graduates finish medical school in the state of Florida and over half of them leave the state for postgraduate training and statistically never return. The debt of a medical student when he finishes postgraduate training is upwards of \$200,000. The average cost of a house in the South Florida area is over \$1 million and the private schools which are pretty much mandatory are at \$20,000 a child. This puts an incredibly high cost towards the cost of living in South Florida. This is also true in San Francisco, another expensive area to live. An interesting statistic is that half of the orthopedic surgeons in the State of Florida are fifty-five years of age or older. This is a significant problem, but has not reached the Midwest yet because a typical house might be \$350,000 on an acre or two and reimbursement from health insurance, including Medicare supported health insurance, is 120-130% of Medicare, whereas in the Miami area for PPO's and HMO's, reimbursement is 80% of Medicare or less. Economics is a big part of sustaining a practice. Medicare unfortunately has set a fictitious standard of reimbursement which is 20 cents on the dollar. An orthopedic surgeon replacing a hip in 1984 would receive \$5,000 or \$6,000 for the total hip and in today's dollars that might mean \$10,000. Unfortunately, reimbursement is anywhere from \$1500 to \$1600 or less. Thirty-eight percent of total hip arthroplasty fellowships are not really filling and the two most popular fellowships in orthopedic surgery are spine surgery and sports medicine. The others are slowly diminishing and will continue to diminish because of reimbursement issues. The thin thread of this is money. Medicare only pays 20 cents on the dollar and the subsequent adoption of these fees by other insurance companies has reduced the ability to balance bill and sustain a practice. The University of Florida orthopedic residency program produced four residents a year and the University of Miami seven. The past two years all have left the State of Florida.

At 20 cents on the dollar, a spine surgeon in Miami might pay \$150,000 year for \$250/\$750 coverage when the aver-

age settlement or judgment in Dade County is close to a million dollars. Consequently, most doctors have been economically removed from participating. Malpractice insurance rates may be appropriate from a business standpoint and the risk managers and the actuarial people are the ones who set this standard which is based on current risk and loss. If a physician could collect what he or she bills then they would be able to pay this easily.

In South Florida that is not the case.



Medical liability has been corrected in California to some extent with \$1 million/ 3 million coverage for \$30,000/ \$35,000 for a spine surgeon, but that came from tort reform in the late 1970's and it took 10 years before the state had to sue the insurance companies to reduce the rates.

The other issues in medical insurance are as follows. Medical Insurance is the perceived cost of medical care by most lay people. Medical Insurance is a monthly premium.

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The monthly premium is divided up into medical care, administrative cost and profit. The profits are soaring at this point. That money should go for health care. Florida Power and Light, as the sole provider of energy in South Florida, by law is limited in profitability. Yes, there are other perks and increased salaries, etc., but by law, the profitability, because of their being a sole provider, is limited.

Every person who earns a living sends money to Washington, D.C. in a tax such as social security or Medicare. This money is in turn doled out to the insurance companies participating as HMOs. Medicare pays an HMO \$1,000 or more/person/month. Three hundred thousand, or six hundred thousand, people participate in one insurance company here in Miami. This money, by law, should be going to medical care, not for excess profitability. It seems the government has let private business take care of the medical care, as long as they abide by the fairly loose rules of Medicare. There does not seem to be oversight in this area.

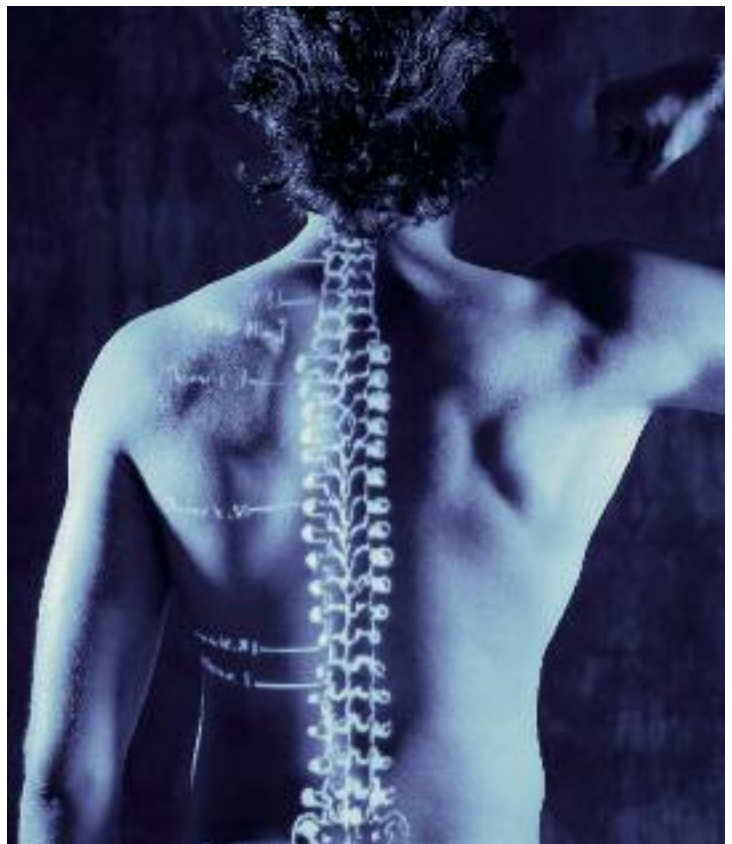
The insurance company is the interface between the patient and the actual cost of medicine, which was pointed out by Donna Shalala's town meeting in late January of 2008 at the University of Miami. The perceived cost of medicine is the premium paid. The actual cost is the combination of physician's fees and hospital fees. If one has car insurance, then you know what you are buying. You get your liability, you get your medical and you get your collision, all substantiated and known. For health care insurance, it is not known what you are purchasing.

Health care insurance is a moving target and depending on the contracted arrangement, a hospital will bill anywhere from 100% of what they can bill, down to 25% of what they can bill and some insurance companies will not even be participants because the hospitals will not allow their fee schedule. Doctors have been reduced in their reimbursement, so that really only 10% or 15% or less of the overall medical dollar goes to physicians.

The hospital lobby and the insurance lobby are significant in their control, such that Medicare will increase the HMO reimbursement rate next year by 13% tied to the EMI Index and at the same time tentatively reducing physician's fees another 10.1% by July 1st, 2009. If the sustained growth rate formula by Medicare is unchanged, tying physician's fees to productivity in a negative way, then the temporary fix may occur July 1st. In 18 months, the reduc-

tion in Medicare fees will then be 25%. That brings us down to less than 10 cents on the dollar.

One cannot sustain a viable medical practice. Total joint fellowships are not filling and I perceive that a physician might oversee five rooms in an operating room with physician assistants doing the total joints and being supervised by one physician. If the rate of reimbursement drops, then it will become a wholesale technical exercise and physicians will go by the wayside.



A heart surgeon used to get \$6,000 or \$7,000 for splitting open a sternum, stopping the heart, replacing the valve or triple bypass, starting the heart, closing the chest and the patient goes home in four or five days. Presently, in today's inflation, since the mid 80s, that rate would be anywhere from \$10,000 to \$12,000. The heart surgeons that are employed by hospitals now are receiving \$1200 to \$1500 and few are in private practice. It is my understanding that 75 % cardiovascular residencies have not filled and this will continue to reduce.

On to another issue as far as gender, 55% of medical school graduates are women and diversity is welcomed and

wonderful. It is shown clearly that a third of these women doctors will be in part-time practice in approximately 10 years limiting their availability for medical care. The upwelling of baby boomers, those born after 1945 and are retiring, is going to seriously tax the system, as well as the manpower of medical care. Geriatrically trained physicians, as well as primary care physicians, are becoming fewer and fewer because of their need to increase the number of patients due to HMO dictums, the work load, and poor reimbursement.

A total hip arthroplasty in 1992 was \$1900 (American Academy of Orthopedic Surgeons (AAOS) NOW OCT. 2007) and is now down to \$1200 or less in the Miami area and this will continue to be reduced. The parameters of orthopedics can parallel others. The practice of general surgery is all but extinct because of gallbladder surgeries being \$800 or less, instead of \$3,000.

The best and the brightest are not going to go into medicine and they will end up going into more profitable businesses. A very good friend of mine's son is at MIT and he finished his junior year with straight A's. His advisor basically said that he should not take the MCAT'S and advise him to not go into medicine because he is too smart. It would be an interesting statistic to find out what colleges are recommending for their graduates. I believe strongly that medicine is not going to be one of the strong suits.

Back to the issue of reimbursement for physicians, I do not believe physicians really want more money, they would just like the same money that they received 20 years ago. Most of the doctors that are my age are retired and the younger ones are anxious to be employed because they realize the huge expense of opening a practice and the lack of reimbursement. Subsidization by the hospitals is almost mandatory which will remove the sovereignty from the physician and the out-of-the-box thinking that is required for really good medical care then physician allegiance will shift to their employer and away from the AAOS.

I recently was elected to be on the Board of Counselors of the American Academy of Orthopedic Surgeons and I went to an orientation meeting in Chicago in early March. The discussion in the morning had to do with industry participation with physicians and the issues with ethics and professionalism regarding that. Economic stability is not something that is created or supported by organized medi-

cine at this point in time. I asked a question towards the end of the session at 10 minutes of 12 and the questions went such that my chief in training in the late 1970's never received money from industry. Now, individuals, both academic and non-academic people, are receiving money from industry and be that as it may if it is legitimate, then so be it, because where else can industry develop new techniques and ideas except from the medical profession? The question I asked the speaker, Dr. Rankin, is can you link the participation in industry with the lack of reimbursement to physicians set by Medicare and subsequently adopted by other insurance companies? There was silence in the room and one could have heard a pin drop. He adjourned without answering the question and he came to talk to me stating that certain things sometimes just cannot be discussed in public. I also feel Dr. Rankin's comment shows that I have always suspected, that there is a serious disconnect with organized medicine in trying to correct this problem. The AAOS needs to adapt a 1985 or 1984 fee schedule for all orthopedic procedures and distribute that to the Fellows. That will empower them with a real alternative fee schedule different from the reducing one of Medicare, which is falsely low. We should also be able, as any other business, to deduct from our taxes that which we cannot collect, in other words, if a total hip is \$5,000 and we only get \$1,000, we should be able to deduct \$4,000 just as any business can deduct losses.

In the end, I feel that there is a real issue with manpower and the thin thread is reimbursement as dictated by the government. Maybe they want universal health care, I do not think physicians should be second-class citizens, nor should patients have their care rendered by the government. Medical care should not be hugely profitable. There is good money for support of systems without windfall profits.

In the end, a manpower shortage is anticipated with a lack of certain specialties trained. The lighter specialties will continue to be adequate and more difficult ones such as general surgery, thoracic surgery and anesthesia will be reduced in numbers, due to poor economic stability. The AAOS has been supportive of academics and recredentialing and recently in politics as an Association. The support of the private practitioner in the trenches earning his own salary must be championed by the AAOS. The economic stability must be preserved to remain a viable deliverer of musculoskeletal healthcare.

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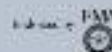
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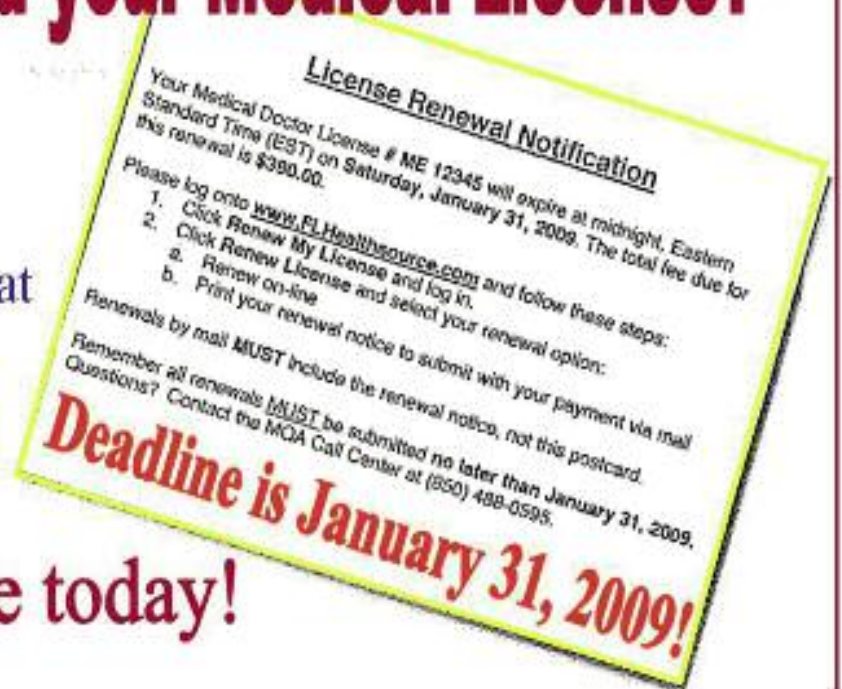
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To do this, physicians should know and maintain their password which is used to change information in the NPI system, reset their password once a year and review their NPI record to make sure the information is accurate.

Visit the Web site:

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to correct, add or delete information in your NPI record. User ID and password is required to log on to the site. If you have forgotten your password, enter your user ID and click "reset password."

Call (800) 465-3203 if you have questions or problems accessing the system.



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IE: address change, status, etc.

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Go to http://ww2.doh.state.fl.us/mqaservices/flhealth_index.asp then click on License/Provider.

From there you enter your password, etc., to update.

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