Attorneys dedicated to helping doctors with their disability insurance claims.

Ed Comitz’s Story

“Living an active lifestyle has always been important to me. It was not until I suffered a severe neck and head injury that I wondered if I could ever be active or enjoy sports again.

Because of potential spinal cord involvement, I ultimately underwent an emergency multi-level discectomy and fusion. While I have improved exponentially since the surgery, I still have limitations and struggles every day, and know that my condition can be aggravated if I do not take care of myself.

Most of my clients are physicians and dentists, and many have conditions similar to mine. As an attorney, I can keep working—if I drop a pen or get a cramp in my side, I can take a break or stretch then continue on. If I were a healthcare professional, though, I would be unable to sustain positioning for long periods of time, each and every day, and would be concerned about patient safety.

I am strongly committed to my clients and practice, am sympathetic to physical limitations and restrictions that others may not fully understand, and use my experience to provide my clients with the results they deserve.”

Comitz | Beethe: Healthcare and Disability Insurance Practice

Comitz | Beethe is an AV-rated law firm offering powerful strategies for healthcare professionals whose insurance carriers have wrongfully denied their disability insurance claims or attempted to stop paying benefits. We are very selective, taking only the few cases that are the right fit for both us and our clients. Accordingly, we are able to devote substantial time, resources and energy to each individual case. Our focus is to exceed each client’s expectations with prompt and informed personal attention, dynamic problem solving skills, and a studied strategy tailored to the best possible result.

We have a national reputation for intelligently and aggressively pursuing insured claimants’ rights, and a track record of successfully resolving disputes. Insurance companies have vast resources at their disposal, often making the disability insurance claim process as daunting as possible in pursuit of their own interests. In the face of what can seem insurmountable challenges, we can help shift the balance of power dramatically for our clients.

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UnitedHealthcare supports the physicians of the Arizona Medical Association.

People count on you every day, even your staff. We understand that you are the one who takes care and takes charge – but you’re not alone. UnitedHealthcare offers you the support and resources you need so that you can focus on what’s most important – your patients. We can help you, your staff and your patients navigate the health care system with greater efficiency and quality of care.

To learn how UnitedHealthcare can better serve you and your patients, visit UnitedHealthcareOnline.com.
We believe that communicating with you as a partner is vital to providing the best care for your patients. We also want to make the referral process as convenient as possible for you. Our secure, HIPAA-compliant, Internet portal lets you easily refer a patient and view their results online. Our Referring Physician Service line is a central point of contact to schedule appointments, arrange a telephone consultation with a Mayo Clinic physician or facilitate a hospital transfer. Staff can also answer questions about the many health insurance plans with in-network access to Mayo Clinic. Call toll free (866) 629-6362 or connect at mayoclinic.org/medicalprofs.

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As a photographer, I can control how others see the world. When a routine colonoscopy discovered colorectal cancer, I took control by choosing the finest team possible. My answer was Mayo Clinic.

Richard Rubenstein, Scottsdale, AZ
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The sky is falling, the sky is falling

With the well-documented difficulties of the ACA implementation, panic has taken center stage. Conservative pundits say “I told you so, the whole thing was a bad idea to begin with,” and ACA supporters insist that it will just take a little longer than planned for, that’s all. So is the sky really falling?

Not really. My practice hasn’t changed despite daily comments by patients on how the ACA is/will be affecting me. I am still amused by the Medicare folks’ worry about the impact of upcoming changes: of course they’re only concerned that the program will overwhelm their providers who in turn won’t be there for them. So, how are doctors responding to all of this? For those in the trenches like me, long-term thinking is - what does my afternoon schedule look like?

The full roll out of the ACA will happen, it’s just when, and at what political cost. To begin with, what was the government thinking in allowing everyone to sign up on day one without fully testing the system? How about starting slowly, i.e. if your last name begins with A or B, sign up week one? Studies have shown the chances of success on launching a program of this magnitude to be less than 5%. Nice work, guys, at $175M. And damage control from HSS comes in weekly email blasts trying to deflect and distract with comments on eliminating trans-fats from processed foods.

So what’s one to do? I would maintain staying the course. Life is day-to-day anyway, and this crisis will pass. Not that I was on board with the ACA. It was way too broad in scope, done hastily without looking at the unintended consequences, and will cost more than promised. Already, my new insurance premiums are looking to be about $200 more a month. And lastly, as has been the case all along, physician input is a polite afterthought.

The basic facts are that 20-30 million people will have access to insurance and that’s good for the health of the country. Pre-existing conditions will no longer be a factor in obtaining insurance - and who doesn’t have a pre-existing condition? On top of that, physicians may be paid for previously uncompensated care while patients now can take advantage of insurance, make appointments and have medical issues addressed.

There is a one degree of separation on who will be able to have the ability to get insurance. We all know someone in our family to which this applies. And the ultimate irony is that everyone is going to jump on the bandwagon despite their political views. A friend of a family member had her individual Blue Cross (California) insurance ‘cancelled’ (by law). She called to inquire about the exchanges AND subsidies, despite the fact they are in the top one percent of net worth and just to the right of Tsar Nicholas.

So despite the predicted doom and gloom, most of us will continue to do what we’ve been trained for and take care of patients. Not much else to do. I’ll let the others do the yelling and screaming - that doesn’t become us anyway. AM

Thomas Rothe, MD, is the 122nd ArMA President and a family physician living in Tucson, AZ.
LIVE FEARLESS
WITH THE CARD ACCEPTED BY 90% OF DOCTORS

BlueCross BlueShield of Arizona

An independent licensee of the Blue Cross and Blue Shield Association. Doctors based on internal analysis of providers in Arizona.
In this issue of AzMedicine, we hope to provide useful information regarding the implementation of the Affordable Care Act (ACA) and how it will affect medical practice in Arizona. It should be noted that we are not attempting to present a debate on the merits of the law. For those who do not know me personally, to declare my bias, I support a single payer Medicare for all health care system, so I have much to criticize about the ACA. But a critical analysis of the ACA is not our intent here.

The ACA was passed in 2010, many of its’ provisions have already taken effect, with full implementation of the health insurance exchange (the marketplace) just now started. Despite all this time and the vigorous political debate, surveys show that many Americans do not understand the ACA and many others hold incorrect assumptions. It should be noted that a recent survey showed many patients intend to seek information about the ACA from their physicians so it is important for all of us to have a working understanding of the law.

The recent coverage of the difficulties of the healthcare.gov website rollout is well known. It is important to emphasize to patients that they have until March 31, 2014 for the initial open enrollment period. It remains to be seen, of course, what will be the ultimate success of the exchange. Those states operating their own exchanges like California and Kentucky appear to be having a much more successful rollout. California just announced they are meeting early enrollment expectations, so it seems possible that the system may work eventually. Although the difficulty with the insurance exchange cannot be underestimated, on the other hand, the Medicaid expansion has been successful in enrolling large numbers of people.

The other recent controversy is the cancellation of policies in the individual market that do not meet the minimum ACA standards. Of course, insurance companies cancel policies frequently for economic reasons so this is nothing new.

Table 1: ACA policies already in effect

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
<th>Number of People Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care</td>
<td>Preventive care (annual exams, mammograms, vaccines) must be free (no co-pay or deductible).</td>
<td>71 million</td>
</tr>
<tr>
<td>71 million people now have this coverage that they did not have previously.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children up to age 26 can stay on their parents’ policy</td>
<td>Children up to age 26 can stay on their parents’ policy. 3.1 million children added.</td>
<td></td>
</tr>
<tr>
<td>Eliminates lifetime caps and annual caps</td>
<td>Eliminates lifetime caps and annual caps.</td>
<td></td>
</tr>
<tr>
<td>Bans policy cancellation when you get sick</td>
<td>Bans policy cancellation when you get sick.</td>
<td></td>
</tr>
<tr>
<td>Bans pre-existing condition discrimination by 2014</td>
<td>Bans pre-existing condition discrimination by 2014.</td>
<td></td>
</tr>
<tr>
<td>80% of premium dollars (85% in large group plans) must be spent on healthcare, not insurance company profit, overhead and marketing.</td>
<td>80% of premium dollars (85% in large group plans) must be spent on healthcare, not insurance company profit, overhead and marketing.</td>
<td></td>
</tr>
<tr>
<td>Small business tax credits of up to 35% for employers with less than 25 employees.</td>
<td>Small business tax credits of up to 35% for employers with less than 25 employees.</td>
<td></td>
</tr>
<tr>
<td>Slowly close the “donut hole” for Part D prescriptions by 2020.</td>
<td>Slowly close the “donut hole” for Part D prescriptions by 2020. Already has a 50% discount on prescriptions for current seniors with 6.1 million people saving $5.7 billion.</td>
<td></td>
</tr>
</tbody>
</table>

Source: connectthedotsusa.com
The President’s promise that you may now keep these policies may vary considerably across the country since insurance is a state regulated industry. As usual, the devil will be in the details.

The ACA provisions already in effect are listed in table 1.

The ACA health insurance exchange is complex which is perhaps its’ greatest flaw. Most patients simply do not understand the details. It is important to reassure our patients that those currently covered by Medicare, Medicaid (AHCCCS) or employer based group health coverage (about 85% of all patients) are not participants in the insurance exchange. The ACA affects the other 15% who are without coverage or have insurance through the individual market. The idea of the exchange is to provide one stop shopping with easy side to side insurance comparisons, with eligibility and subsidies calculated in real time.

Dr. Marc Leib, the retiring AHCCCS medical director, points out in his article a very important distinction between the federal healthcare.gov website and the AHCCCS website in that the federal site is limited to the insurance exchange while the AHCCCS site checks eligibility for many other resources (including food stamps).

Each insurance company participating on the exchange will have four standard benefit plans as shown in table 2. Premiums are lowest in the Bronze plan but have the highest out of pocket expense. Within each plan, premiums are gender, occupation, and health status neutral. Rates can only vary by age and smoking status with the rate variance between the oldest and youngest patients limited to a factor of three. All plans have yearly individual and family maximum out of pocket expense.

Table 3 shows the percentage incomes of the 2013 federal poverty level that qualify for subsidy or tax credits. Most if not all of our non-professional employees would qualify for subsidies. See FamiliesUSA.org. for other family sizes.

Table 4 shows the maximum monthly premiums for a sample silver level plan. See kff.org/interactive/subsidy-calculator to see premiums for the other plan levels and for different family sizes.

The recent coverage of the difficulties of the healthcare.gov website rollout is well known.

<table>
<thead>
<tr>
<th>Table 2: Standard Sample Benefit Plan for Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>Preventive copay</td>
</tr>
<tr>
<td>PCP visit copay</td>
</tr>
<tr>
<td>Specialist copay</td>
</tr>
<tr>
<td>Urgent care copay</td>
</tr>
<tr>
<td>Lab test copay</td>
</tr>
<tr>
<td>Generic med copay</td>
</tr>
<tr>
<td>Brand med copay</td>
</tr>
<tr>
<td>ER copay</td>
</tr>
<tr>
<td>Imaging (MRI, CT)</td>
</tr>
<tr>
<td>Max out of pocket/per</td>
</tr>
<tr>
<td>Max out of pocket/fam</td>
</tr>
</tbody>
</table>

Source: Medical Economics, September 10, 2013, page 20
The Small Business Health Options Program (SHOP) online enrollment is delayed until November 2014, for coverage starting January 1, 2015. In the meantime, officials are encouraging small businesses (such as physician offices) to work with insurance brokers or agents as those who buy qualifying coverage through an agent may be eligible for tax credits of 35 percent.

The most important effect the ACA will have on medical practice is the influx of newly insured patients through both the Medicaid expansion and those newly insured on the exchange with a decrease in self-pay and charity patients. In addition, free preventive services will increase demand on already busy primary care practices. Primary care providers should note that they must register at the AHCCCS website to obtain the 100% of Medicare payment that the ACA provides for all PCP services for Medicaid patients.

One important billing issue that all practices need to be aware of is the increased use of high deductible health plans that patients may choose to keep premiums low. Another billing complication is the 90 day grace period for premium payment of a patient who has an exchange plan but stops paying the premium. During the first 30 days of the grace period, the insurance company is required to pay claims, but in the next 60 day period payment maybe withheld. It is, therefore, important to check eligibility at each visit. The ACA requires insurance premiums to be automatically deducted from checking accounts, but up to 25% of the uninsured eligible for the ACA tax credits do not have a checking account.

No one ever claimed the ACA was simple or easy.

Dr. Tom Rothe, in his ArMA President’s column, points out that some of the difficulties with the ACA but also advises us stay the course and do what we do, practice medicine. Helping our patients understand the ACA and obtain insurance coverage helps us provide the care our patients need.

On a personal note, my expected premium savings through the ACA

### Table 3: Income as a percentage of 2013 Federal Poverty Level

<table>
<thead>
<tr>
<th>Household size</th>
<th>100%</th>
<th>133%</th>
<th>150%</th>
<th>200%</th>
<th>250%</th>
<th>300%</th>
<th>350%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,490</td>
<td>15,282</td>
<td>17,235</td>
<td>22,980</td>
<td>28,725</td>
<td>34,470</td>
<td>40,215</td>
<td>45,960</td>
</tr>
<tr>
<td>2</td>
<td>$15,510</td>
<td>20,628</td>
<td>23,265</td>
<td>31,020</td>
<td>38,775</td>
<td>46,530</td>
<td>54,285</td>
<td>62,040</td>
</tr>
<tr>
<td>4</td>
<td>$23,550</td>
<td>31,322</td>
<td>35,325</td>
<td>47,100</td>
<td>58,875</td>
<td>70,650</td>
<td>82,425</td>
<td>94,200</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation

### Table 4: Maximum monthly premium for the Silver Plan

<table>
<thead>
<tr>
<th>Household size</th>
<th>100%</th>
<th>133%</th>
<th>150%</th>
<th>200%</th>
<th>250%</th>
<th>300%</th>
<th>350%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$19</td>
<td>38</td>
<td>58</td>
<td>121</td>
<td>193</td>
<td>273</td>
<td>318</td>
<td>364</td>
</tr>
<tr>
<td>2</td>
<td>$26</td>
<td>52</td>
<td>78</td>
<td>163</td>
<td>260</td>
<td>368</td>
<td>430</td>
<td>491</td>
</tr>
<tr>
<td>4</td>
<td>$39</td>
<td>78</td>
<td>118</td>
<td>247</td>
<td>395</td>
<td>559</td>
<td>653</td>
<td>746</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
marketplace will be about $500 a month decrease from my current $1,500 per month premium with a $7,500 per person annual deductible for my family of four. Twelve years ago this policy cost $300 per month. If only our fees had also increased by a factor of five in the last twelve years!

Finally, an excellent presentation on the ACA by Andrea Witte of Tucson is available at www.connectthedotsUSA.com. The presentation includes great general information regarding the ACA. AM

Michael Hamant, MD, is a family physician practicing in Tucson. He serves on the AzMedicine Advisory Council and as secretary on the ArMA Executive Committee.

Patient Resources: Everything You Want (and Need!) to Know About the Health Insurance Marketplace

Are your patients confused about the Health Insurance Marketplace? With all the conflicting information in the media and in casual conversation, there’s no wonder.

The Health Insurance Marketplace is designed to make it easier for consumers to purchase health insurance and was created as a one-stop shop where individuals and families can shop for and purchase affordable health care coverage. Through the Marketplace, consumers can compare plans based on price, benefits, quality and other features before making a choice.

Open enrollment to obtain health insurance through the Health Insurance Marketplaces began on October 1, 2013, and will run through March 31, 2014. Those who do not obtain coverage during this time will not be able to purchase coverage through the Health Insurance Marketplace until the next open enrollment period, unless there is a qualifying event (marriage, birth of a child, etc.).

For more information about the Health Insurance Marketplace and how to obtain affordable health care insurance visit the HealthCare.gov website.

As the website undergoes federal work to fix its problems, patients can also continue to “shop” directly with insurance providers. This method eliminates the side-by-side comparison, but may be a good option for those who wish to stick with the same carrier.

Although this issue is continually evolving, following are a few resources you can provide to your patients to help cut through the clutter.

Cover Arizona is a collaborative effort engaging more than 600 non-partisan, non-profit organizations and their partners throughout the state of Arizona. The Cover Arizona website -- www.coveraz.org -- includes a news center, info regarding navigators/assisters and frequently asked questions. This includes links to the four Arizona organizations that were awarded funding by the federal government to help provide outreach and enrollment assistance for the Marketplace: Greater Phoenix Urban League, Inc., Arizona Association of Community Health Centers, Arizona Board of Regents – University of Arizona and Campesinos Sin Fronteras, Inc.

Health-e-Arizona Plus (HEAPlus), healthearizonaplus.gov is a website created by AHCCCS and DES to comply with new requirements for the AHCCCS Health Insurance and KidsCare eligibility and to connect with the Federal Insurance Marketplace (healthcare.gov). Patients who may qualify for AHCCCS can apply through this website. HEAPlus expands to the full range of AHCCCS benefits and local health access programs, and Nutrition Assistance (food stamps) and Cash Assistance benefits.

The Kaiser Family Foundation has created a comprehensive site with a wealth of information that is continuously updated, including a calculator for determining subsidy eligibility. This includes a patient-focused list of Frequently Asked Questions and Answers. Visit www.kff.org/aca-consumer-resources/.

Websites:

healthcare.gov
coveraz.org
healthearizonaplus.gov
kff.org

SOURCES:
connectthedotsusa.com
medicaleconomics.
modernmedicine.com
familiesUSA.org
healthcare.gov
kff.org
As the federally-facilitated Health Insurance Marketplace (HealthCare.Gov) continues to work out some kinks that will eventually allow for a smoother and faster enrollment process for Arizonans, we at Meritus are hearing from consumers who are both intrigued and interested in our new health insurance alternative that launched a few short months ago.

As you may already know, Meritus is Arizona’s only health insurance CO-OP—Consumer Operated and Oriented Plan, or cooperative. We’re a different kind of insurance company, because:

1. We’re member-driven and member-governed, meaning our members will provide direct input into how we provide benefits and services for them.

2. We reinvest all profits back into the organization to control premiums, improve benefits, and provide more health and wellness services.

3. Moving forward, the majority of the seats on our Board of Directors will be reserved for members, and the remaining seats will be filled by healthcare professionals and community leaders to lend expertise.

4. Meritus’ goal is to have our members be healthier in a year than the day they joined us.

As you can see, the distinction is pretty clear.

To get to this point, we relied on valuable input from a variety of individuals who helped us understand the situation as it existed prior to October 1, 2013.

When we received federal funding in 2012 to develop a non-profit organization that would operate as a CO-OP, we knew that in order to succeed we needed to hear from consumers, healthcare providers, small business employers and insurance brokers to shed some light on the current system and what (if anything) they would recommend to improve it.

Through months of intensive research – focus groups, online surveys and charrette-style sessions – we came away knowing what we needed to do. We understood what some of the challenges of – and expectations for – this new health insurance alternative for Arizona would be, and we discussed ways our partners could participate to create positive, engaged positioning of Meritus among consumers.

One of the key takeaways from all of this research was learning what wasn’t working in the current healthcare landscape. We heard about high deductibles and co-pays, hidden costs, confusing benefits, limited provider networks and a “complex” system that is difficult to navigate.

The result? We now offer:

- 30 HMO and PPO plans designed to be more
affordable for individuals, families and small business owners, regardless of income level.

• “Co-pay only” plans that eliminate coinsurance payments which can confuse members and providers.

• Plans with benefits like $0 primary care co-pays for all services, $0 for generic maintenance medications and $25 per month reimbursement for gym membership.

• Low co-pay alternative medicine benefits such as acupuncture, naturopathy and therapeutic massage.

• Friendly customer care representatives available to answer questions (in both English and Spanish) over the phone or by email.

Our goal is to help people make better choices for their healthcare, and we’ve designed a company built around that.

I would like to hear what you think, too. Feel free to email me anytime at koestreich@meritusaz.com.

Kathleen Oestreich is the CEO of Meritus. Prior to leading Meritus, she spent 10 years as CEO and COO at University Physicians Health Plans.

She has 20 years’ experience working with physician groups, implementing strategic growth initiatives in academic and community-based organizations and healthcare budgeting/reimbursement management. For a complete listing of benefits available for all plans as well as limitations and exclusions, please contact Meritus at www.meritusaz.com or 855.755.2700.

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To Being Outstanding

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The Affordable Care Act Expansion: Risks & Opportunities Affecting Healthcare in Arizona

The launch of the Patient Protection and Affordable Care Act (PPACA) brings both tremendous opportunity and uncertainty for Arizona hospitals, the patients they serve and their physician and other healthcare partners, especially in rural areas.

First and foremost, this new law offers the best chance in decades to extend health coverage to an estimated 30 million uninsured Americans. The addition of an estimated 300,000 individuals to the Medicaid rolls will exacerbate the impact of these underpayments.

Still, there remains significant uncertainty as hospitals and health providers prepare for full implementation of the health reform law in 2014. A handful of the most pressing issues are detailed below:

- **Under-compensated Care**
  While hospital costs for uncompensated care are expected to ease in the near term, the relief may be short-lived. Arizona hospitals are only reimbursed for about 70 percent of their costs in treating Medicaid patients. The addition of an estimated 300,000 individuals to the Medicaid rolls will exacerbate the impact of these underpayments.

- **Bad Debt**
The Federally-facilitated Marketplace also

First and foremost, this new law offers the best chance in decades to extend health coverage to an estimated 30 million uninsured Americans.
presents financial risk for hospitals. In an attempt to keep monthly premiums manageable, many of the new qualified health plans feature high deductibles. For patients unaccustomed to these plans or financially unprepared to pay their deductibles, hospitals may face additional bad debt.

• **Narrow Networks**
  
  Seeking to maximize profits, it is expected that many qualified health plans will operate under narrow networks. This has the potential to create access-to-care challenges for patients, especially in rural Arizona where provider options are fewer, and casts uncertainty upon reimbursement structures for hospitals and others. We at AzHHA will be monitoring this issue closely.

• **Physician shortages**
  
  Lastly, it should come as no surprise that the addition of more than a half-million Arizonans to the ranks of the insured could further strain our state’s health-provider network. Arizona already has a physician shortage, and ranks 40th among states in terms of its number of actively-practicing primary-care physicians. In rural areas, the problem is even more acute. It seems clear Arizona must reinvest in Graduate Medical Education and other programs in order to meet the state’s future primary-care needs.

The PPACA represents a once-in-a-generation overhaul of our nation’s healthcare system. The benefits are clear for Americans gaining health coverage for the first time, and for hospitals and health providers that have struggled with the costs of providing care to so many without insurance.

Just as clear is the need for vigilance at a time when our healthcare system faces such dramatic transition and so much potential for unintended consequences.

*Greg Vigdor brings more than thirty-five years of healthcare experience to the Arizona Hospital and Healthcare Association (AzHHA). Mr. Vigdor previously served as President and CEO of the Washington Health Foundation (WHF) since its inception in 1992. Mr. Vigdor’s educational background includes a Bachelor of Arts degree from the University of Connecticut, a Masters of Health Administration from the University of Washington and a Juris Doctor from George Washington University Law School.*

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**Opening 2014**

**St. Joseph’s Westgate Medical Center**

99th Avenue and Glendale (just west of the 101 Freeway)

Dignity Health, the parent organization of St. Joseph’s Hospital and Medical Center, Chandler Regional Medical Center and Mercy Gilbert Medical Center, has broken ground on a 35-acre medical campus in Glendale. The hospital, St. Joseph’s Westgate Medical Center, will include:

- An emergency department
- 24 inpatient beds
- Two operating rooms
- Diagnostic services
- 200 full time employees
- Medical office building

For additional information on the hospital, visit our website [StJosephsWestgate.org](http://StJosephsWestgate.org).
Between January 1 and September 30, 2014, AHCCCS expects the number of Arizona citizens enrolled in its programs to increase by about 375,000. Approximately 60,000 of these new members are the result of Medicaid eligibility expansion for adults with incomes of 100-138% of the federal poverty level (FPL). As of mid-November, the FFM was still experiencing implementation and operational difficulties. There is a necessary interplay between the FFM and AHCCCS eligibility programs. Information regarding AHCCCS applicants who are not financially eligible for Medicaid is transferred to the FFM to determine eligibility for the premium subsidy and selection of an insurance plan. Conversely, information about applicants to the FFM who might be eligible for Medicaid is transferred to AHCCCS for eligibility determination and enrollment in an AHCCCS contracted managed care organization.

AHCCCS recently launched Health-e-Arizona Plus (HEAplus), an expanded AHCCCS eligibility system that incorporates the ability to connect to the federal systems to share information necessary for proper enrollment of individuals in either AHCCCS or an Exchange plan. In addition to health insurance eligibility determinations, HEAplus also determines an applicant’s eligibility for the Supplemental Nutrition Assistance Program (SNAP or Food Stamps), Temporary Assistance for Needy Families (TANF), Sliding Fee Scale programs, Community Assistance Programs, Cost Sharing Reduction programs, and Premium Tax Credit programs.

Applications to the FFM, on the other hand, will only determine eligibility for health insurance (AHCCCS or Exchange plans), Premium Tax Credit and Cost Sharing Reduction programs. The FFM will not determine eligibility for the other assistance programs. Because of these limitations, applicants who believe they might qualify for any of the programs for which eligibility is not determined by the FFM should apply for assistance through HEAplus. Those applicants will be evaluated for eligibility for all programs. If the applicant only qualifies for Exchange-based insurance plans, applications to the FFM should be considered.
There was growing momentum in Washington earlier this year for repeal of the Sustainable Growth Rate (SGR) formula. All three congressional committees overseeing the Medicare program were discussing the elimination of this flawed formula. One reason for this is that the projected ten-year costs of repealing the SGR had decreased from over $300 billion to less than $140 billion.

Although these efforts recently stalled with the recent government shutdown, budget negotiations and debt ceiling debates, there is some renewed interest in solving this problem. Congress is once again considering repealing this Medicare payment methodology, but it does not come without costs. Most of the proposals under consideration involve either freezing physician fee schedules for ten years or freezing primary care fee schedule rates and decreasing specialist fees. They also involve increased use of performance measures to evaluate quality and adjust future changes in fee schedules based on those results.

However, time for an agreement is running short as we approach the end of the year. It is less likely that Congress will act next year with the 2014 elections rapidly approaching. At this time many national professional organizations are providing input on SGR repeal, but at this time it is unclear whether an agreement can be reached.

Marc Leib, MD, JD, is an anesthesiologist, attorney and past president of ArMA, and the current chief medical officer of the Arizona Health Care Cost Containment System (AHCCCS).
We all know that there are inevitable changes creeping up on us in healthcare, but what does that mean for patients, providers and hospitals? It means that as a hospital, we have to be the expert. We have to go straight to the source. The internet and social media have changed the way we get information but it is not always accurate and these sources are open for interpretation. News on TV and news articles can be editorial and not comprehensive. Patients trust their doctors to be the experts not only in their medical specialty; but healthcare laws. If the physicians do not have accurate information, patients may end up with a bill that they cannot afford. This is why we take the time with our doctors to ensure they have the information and the best resources so we can help them help their patients.

Changing healthcare laws is not something new; in this environment, we expect them to change every six months, so accurate information is crucial for compliance. As a hospital, we not only have to analyze the Arizona Laws, but the Federal laws and comply with the stricter laws to ensure compliance of both laws. THE Surgical Hospital of Phoenix is preparing for the Affordable Care Act (ACA) roll out to start in January 2014. This is where pre-existing conditions cannot be rejected by insurance companies.

Hospitals now have to fight for every dollar. With RAC Audits (Recovery Audit Contractor); hospitals have to invest money in monies we already had with their “take backs.” If hospitals are not precise, insurance companies will come back and take money that they have already paid for services rendered.

It’s incredibly important to be proactive on all of these changes. Being knowledgeable is not enough. We have hired new positions such as a Financial Analyst who analyzes the charges and reimbursements to ensure that the services we provide are also the services we are being reimbursed for. In some cases, insurance companies reimburse hospitals less than the surgery cost, which costs the hospital additional money. The Financial Analyst is also involved in our daily scheduling meetings to contribute to what the cost of supplies, implants and surgery costs versus what the
reimbursement is for. This isn’t something that needed to be analyzed before but now does with healthcare laws changing so frequently.

Another position added was an additional Collector and Financial Counselor. Even though the hospital is billing for services, it does not mean that it is reimbursed for the services provided. This additional Collector and Financial Counselor will be on site to educate the patient on what their insurance pays for, what the patient is responsible for and will have the knowledge of new healthcare laws to share with patients.

Fortunately, there are terrific resources out there to which patients, providers and hospitals have free access. Webinars are very resourceful and with live webinars there are often lawmakers and auditors on the phone answering questions. Medicare also has a resource that interprets the laws for those of us who may not have a Medical or Legal degree.

Most recently, Medicare added a new rule where patients that are considered “inpatient” have to stay a minimum of two nights. Hospitals now must evaluate, and possibly make changes, to their processes on the pre-operative side to make sure that all of patients are staying overnight within the doctor’s recommendation.

We may not be able to predict the future with new Healthcare laws; however, we will be prepared with the knowledge and meticulously memorize these new laws. We promise to provide the best care for patients and always work with our patients to make sure they understand their benefits so there are no surprise bills. If anyone has been sick or have had loved ones that are sick, we want healthy results because our lives are valuable. AM

Jess Martinez is the Director of Patient Financial Services at THE Surgical Hospital of Phoenix.

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The Affordable Care Act (ACA) is the leading driver behind the unprecedented changes occurring in the U.S. healthcare system. However, many Americans seem to believe the ACA is solely about expanding insurance coverage—a notion reinforced by recent massive media attention on the nationwide health-insurance exchange rollout. But the ACA is written to do much more than just provide insurance coverage. Perhaps its most far-reaching objective is to improve the quality of the U.S. healthcare system for patients and their families, while lowering costs and increasing access to care.

This larger strategy is grounded in the triple aim of better care for individual patients, better health for populations, and lower costs through quality improvement. Health Services Advisory Group, Inc. (HSAG)—Arizona’s Medicare Quality Improvement Organization (QIO)—continues to play a central role in championing these goals and objectives on behalf of the Centers for Medicare & Medicaid Services (CMS) and our 1 million Arizona Medicare beneficiaries.

Aligned with the ACA-mandated National Quality Strategy (NQS), and focusing on six specific priorities to achieve these three aims, the QIO Program is the largest federal network dedicated to improving health quality at the community level in the United States and its territories.1 As healthcare costs have doubled over the past three decades, financial pressures on patients, families, employers, and government budgets have created an atmosphere of uncertainty and fear of becoming ill and requiring medical care. By putting patients and their families at the center of a nationally conceived and all-encompassing quality strategy, patient activation is enhanced and the experience of receiving healthcare becomes more participatory, resulting in an improved outlook and a better quality of life. Moreover, patient centeredness leads to lower medical costs and reduces the need for some healthcare services as patients assume a more proactive role in managing and promoting their own healthcare.2

The ACA directly involves patients and families in healthcare decision-making processes by promoting health through individual care decisions, health system learning and improvement activities, and community-based interventions. This approach to patient-centered care has been defined by the U.S. Institute of Medicine as “Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”3

To ensure patient-centered care, HSAG and the QIO

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Howard Pitlik, MD, MPH, FACS
Mary Ellen Dalton, PhD, MBA, RN

“Quality is never an accident. It is always the result of high intention, sincere effort, intelligent direction, and skillful execution; it represents the wise choice of many alternatives.”

— William A. Foster

...patient centeredness leads to lower medical costs and reduces the need for some healthcare services...
Program promote responsiveness to beneficiary and family needs, provide opportunities for listening and addressing beneficiary and family concerns, provide resources for beneficiaries in health-related decision making, and provide feedback from information gathered from individual experiences to improve Medicare’s system of healthcare quality improvement.

Healthcare is personal, and the way we interact with and experience care is different for each person. The ACA, with its enormously complex structure and rules, can make paying attention to specific patient circumstances and needs a daunting task. But it is exactly this focus on the individual that leads to improved outcomes. To help bridge the gap between large, systemic changes in the U.S. healthcare system and the need for patient-centered care, QIOs work to recognize diversity by removing the socioeconomic, educational, and cultural barriers that can prevent access to healthcare. QIOs bring together healthcare providers and community stakeholders and convene learning and action networks that help meet the goals of the NQS, while involving patients in their own healthcare decision-making processes.

An example of this collaborative process took place on October 2, 2013, when HSAG invited providers, stakeholders, payers, patients, and governmental and private organizations from across Arizona to its No Place Like Home Campaign conference. This meeting, attended by more than 300 participants, was the culmination of a statewide effort to improve care transitions by reducing avoidable hospital readmissions. Through the diligent work of stakeholders statewide, Arizona ranked first in the nation in relative improvement rate for reducing hospital readmissions. The gathering celebrated attendees’ achievements and helped spread their innovative ideas for others to adapt and use in reducing hospital admissions and readmissions. Professionally made videos were created to help communicate how these innovations worked by emphasizing the viewpoint of the patients benefiting from these programs.

In addition, CMS and QIOs are developing and implementing patient and family engagement campaigns that promote personal involvement and empower beneficiaries and their families to make healthcare decisions that are tailored to fit their needs and preferences. In Arizona, HSAG is working with local senior center members to

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While many of the legal issues surrounding e-prescribing have been resolved in recent years, the Drug Enforcement Administration (DEA) issued an interim/final rule in 2010 which sets federal standards, rules and regulations for e-prescribing of Controlled Substances or EPCS. On April 4, 2012, Governor Jan Brewer signed into law legislation making the e-prescribing of controlled substances legal in Arizona. This article discusses what providers need to do to become EPCS-enabled and the myriad benefits from doing so.

In order for a provider to prescribe a controlled substance electronically, there are requirements for pharmacies; there are requirements for electronic health record (EHR) software companies; and there are requirements for providers. First of all, Surescripts, the non-profit national e-prescribing network that works directly with the federal Drug Enforcement Agency (DEA), must certify a pharmacy’s e-prescribing system for EPCS. In 2013, a number of Arizona pharmacy chains became EPCS-enabled, including Walgreens, CVS and late in the year, Safeway, Fry’s and Walmart. In addition, Surescripts must certify the EHR software system for EPCS. A number of EHR systems became EPCS-certified in 2013, including Allscripts ePrescribe, Cerner Corporation, DrFirst, Epic, NewCrop, NextGen and RxNT. While these companies now have EPCS-certified product versions available, it is important for a provider to double check that a certified version is in place. A third requirement is for a provider to undergo and complete an identity-proofing process similar to a credentialing process. When that is complete, a provider can be set up for access controls with a dual authentication device, the security system for EPCS.

**EPCS Benefits**

While these requirements address the technical barriers that must be overcome, the most fundamental obstacle is the lack of provider understanding of EPCS’ benefits. Since the prescribing of controlled substances is a separate process from writing other prescriptions, many providers fail to calculate the time and expense involved in manually completing a controlled substance prescription. EPCS saves valuable time as it allows a provider to manage all prescriptions electronically on one platform and in one workflow.

A study of EPCS implementation supported by the Agency for Healthcare Research and Quality found that EPCS was a better experience for many providers than they had expected. In addition to being easy to use, EPCS improved workflow, prescription accuracy, ability to monitor medications and coordination with pharmacists. Compared with controls, EPCS users reported a significant decrease in the perceived frequency of medication errors and drug diversion.

Here are the essential benefits of EPCS to prescribers and pharmacies:
• Uses one workflow for all electronic prescriptions
• Condenses record keeping for all of a patient’s prescription history
• Reduces fraud and abuse
• Improves legibility and decreases adverse drug events

EPCS is starting to take hold in Arizona. In a five-month period (May to October 2012), the volume of EPCS prescriptions grew dramatically from 196 to 6,545. The number of EPCS-enabled pharmacies increased from 263 to 411.

Steps for Providers to Begin EPCS
• Contact your EHR vendor and ask which of their products are certified for EPCS
• Complete identity proofing requirement
• Set up access controls
• Obtain dual authentication device or process
• Adhere to digital signature and audit requirements

To find out more or for answers to your questions about EPCS, please contact Arizona Health-e Connection, at (602) 688-7200.

1 J Am Med Inform Assoc. 2013 Jun;20(e1):e44-51. doi: 10.1136/amiajnl-2013-001349

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Continued from page 21

create an interactive, fall-prevention Web site where seniors can access information and resources to help them continue living safe and independent lives free of falls and their debilitating consequences.

By including the voice of the beneficiary in all its activities, HSAG is leading the way to patient-centered care. As the culture of U.S. medicine continues to shift toward more accountability and knowledge sharing, patients will benefit from more public reporting and transparency. Furthermore, their participation will continue to drive the increased availability of preventive services offered by healthcare providers. The combined efforts to improve outcomes and lower costs are creating a more personal and less bureaucratic Medicare that is no longer a passive payer of services but rather an active purchaser of healthcare. All of these changes are powered by the ACA and foster collaboration at all levels of care, put the patient at the center of care, and improve the quality of U.S. healthcare into the foreseeable future. AM


Mary Ellen Dalton, PhD, MBA, RN, is Chief Executive Officer; Howard Pitlik, MD, MPH, FACS, is Vice President, Medical Affairs & Chief Medical Officer; Keith Chartier, MPH, Communications Project Manager at Health Services Advisory Group, Inc., assisted with this article.

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New standards coming Jan. 1 can help physicians streamline payment

Source: American Medical Association

New federal standards governing how health insurers conduct electronic transactions with physicians should help reduce administrative hassles, cut paperwork burdens and free up time to spend with patients. Free toolkits at www.ama-assn.org/go/simplify from the American Medical Association (AMA) can help physicians take advantage of the changes.

The rules, called for under the Affordable Care Act (ACA), require health insurers to standardize business practices for electronic funds transfers and electronic remittance advice. Set to take effect January 1, the rules will make it possible for medical practices to automate the time-consuming process of manually matching payments from insurers with claims that have been submitted.

“The new rules can benefit physicians by eliminating many mundane and costly manual tasks like depositing checks, while cutting red tape and speeding payments,” AMA President Ardis Dee Hoven, MD, said in a news release. “This is a great opportunity for physicians to begin incorporating electronic payments and remits into their practice and reaping the benefits. The AMA’s toolkits and resources will help guide physicians through the necessary steps.”

The Centers for Medicare & Medicaid Services estimates that approximately one-third of claim payments across the industry currently are transferred electronically, and insurers’ reliance on electronic funds transfers is expected to increase. Medicare rules already require physicians who are new to the program or who update their enrollment information to be paid via electronic funds transfer.

The AMA toolkits on electronic funds transfers (www.ama-assn.org/go/eft) and electronic remittance advice (www.ama-assn.org/go/era) include informative sections on getting started with electronic transactions, key questions to ask vendors, guidance about information technology solutions, and an outline of the rules and standards for electronic transactions.

“A recent survey by the RAND Corporation shows that the professional satisfaction of physicians is affected by the burdens of overlapping rules and regulations,” Dr. Hoven said. “The new toolkits are part of the AMA’s ongoing commitment to help physicians with resources that enhance professional satisfaction and practice sustainability—a key pillar in our five-year strategic plan.” Learn about the AMA strategic plan at http://www.ama-assn.org/go/strategic-focus.

Visit the AMA website at www.ama-assn.org/go/simplify for updated information and resources that can help physicians generate savings using electronic transactions. AM
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At Snell & Wilmer, some things never change.
The incidence of coccidioidomycosis has increased significantly over the last decade with the majority of cases reported nationwide occurring among Arizona residents. In 2007, the Arizona Department of Health Services (ADHS) recommended that all patients presenting with community-acquired pneumonia (CAP) be tested for coccidioidomycosis. The recommendation was made in response to multiple studies that attributed a substantial proportion of CAP to primary pulmonary coccidioidomycosis. In Pima County, a University of Arizona study found serologic confirmation of coccidioidomycosis in 29% of all CAP patients. Studies in Maricopa County have found that 15-17% of CAP is due to coccidioidomycosis. It is likely that this infection is a common cause of community-acquired pneumonia in endemic areas such as central and southern Arizona. The Arizona Department of Health Services continues to recommend testing for coccidioidomycosis on patients with CAP.

The studies also noted low testing rates for coccidioidomycosis: only 2% and 13% of patients presenting with CAP in two healthcare systems in the metropolitan Phoenix area were tested suggesting that large numbers of patients remain undiagnosed. Clinical diagnosis of primary pulmonary coccidioidomycosis is difficult and laboratory testing is required. While antifungal therapy is usually not necessary, the spectrum of disease is vast and treatment may benefit groups at risk for severe or disseminated disease. An early diagnosis has many additional benefits including:

- providing an opportunity for patient education
- decreasing the need for invasive and expensive tests
- avoiding unnecessary empiric therapy
- allowing for earlier detection of complications (e.g. dissemination)

Without a vaccine and fungicidal therapies, education to increase testing rates is the best tool that we have to fight this disease. Many physicians in Arizona are unfamiliar with the disease. A 2007 survey by ADHS found that 62% of clinicians felt confident in their ability to diagnose coccidioidomycosis and 41% reported lacking a working knowledge of the different laboratory tests used to detect coccidioidal antibody. ADHS is working in conjunction with the Valley Fever Center for Excellence (VFCE) at the University of Arizona to increase awareness and recognition among clinicians and the general public about coccidioidomycosis. Free continuing medical education and clinical guidelines are available online through the VFCE website: http://www.vfce.arizona.edu. For educational materials for clinicians or the general public, please contact the Arizona Department of Health Services through our website (www.valleyfeverarizona.org) or use our online order form: https://www.surveymonkey.com/s/cocciorderform

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Physicians are trained to work through hardship and to be at their best despite illness, pain, or injury. It is not uncommon to hear of physicians going to work even if they are under the weather, suffering pain, or worse. For example, a recent article in the Journal of the American Medical Association (JAMA) reported that more than three out of five residents continued to work while sick. At one hospital, 100% of the residents had done so. This is a practice that organizational psychologists term “Presenteeism,” and it becomes ingrained in many physicians, as patient demands and modern medicine require long hours and largely inflexible schedules.

Physicians who develop chronic medical conditions, such as degenerative disc disease, nerve disease, or repetitive use injuries may be tempted to try to work through the pain. In many instances, physicians will reduce their hours or stop performing certain procedures in an attempt to continue practicing for as long as they can. Some will shift to performing more administrative work and spend less time on patient care. Disability insurers have long capitalized on physicians’ work ethic, marketing and selling policies to them with high monthly benefits at attractive prices.

However, continuing to work through adversity can frequently have unintended consequences, both professionally and personally. Many chronic conditions are also progressive, and the choices a physician makes can have long-lasting repercussions on his personal and professional life.

The issues we see with “Presenteeism” broadly fall into three categories: (1) physicians who continue to practice despite physical limitations; (2) physicians who alter their practices to accommodate their limitations without filing a disability insurance claim; and (3) physicians who alter their practices to accommodate their limitations and then file a disability insurance claim.

Pursuing any of these paths can lead a physician to a place where he or she does not want to be: without the means to make a living and without disability insurance benefits. To understand why, let’s consider how going down each path typically plays out.

The Physician In Denial

Unfortunately, many physicians may not realize the severity and scope of their limitations, and continue to practice as they always have, despite their deteriorating physical condition. If anything should happen to a patient under these circumstances, the results can be catastrophic, both for the patient and physician. Regardless of whether the physician’s medical condition played a role in the injury, the first argument a plaintiff’s malpractice attorney will make is that the physician should not have been practicing because of his medical condition, an argument that will resonate with a jury.

In addition to the psychological trauma associated with injuring a patient, continuing to practice despite physical limitations can subject the physician, his practice, and the office at which the procedure was performed to significant
civil liability, including potential punitive damages for acting recklessly. It can lead to a physician’s license being suspended or revoked, and it can lead to a physician being fired from his position, essentially forcing him out of practice, whether he wants to leave or not.

Equally as frightening, though, is the possibility that the physician will have no insurance coverage to pay the award. Malpractice policies and state laws frequently prevent insurers from paying awards of punitive damages or covering acts resulting from gross negligence or intentional misconduct. A malpractice insurer may deny coverage for a claim on the basis that the physician knew or should have known that he was unfit to practice, and therefore his decision to operate on a patient was reckless, leaving the physician exposed to personal liability.

Adding insult to injury, the physician’s disability insurer will then argue that losing one’s license to practice is a “legal” disability, rather than a medical disability. The insurer will claim that the license suspension or revocation, rather than a medical disability, is what actually prevents the physician from practicing, and deny the claim on that basis.

Therefore, a physician who pushes himself or herself too far can end up in a situation where he or she (1) is personally liable to a patient, (2) has no financial means to pay the judgment, (3) can no longer legally practice, and (4) is not able to collect disability insurance benefits. This can obviously be financially and emotionally devastating.

The Physician Who Changes His Occupation

Even when physicians can modify their practices or schedules so that they do not risk injuring themselves or a patient, the consequences can nevertheless be profound. The physician may be physically forced to perform fewer procedures or to work fewer hours over time, until he or she finally reaches the point where there is no choice but to file a disability insurance claim. Unfortunately, modifying one’s practice over time can make it difficult, if not impossible, to collect disability insurance benefits at the time they are most needed.

One of several issues we frequently see with this course of conduct is that, by reducing hours and limiting procedures, physicians change their occupational definition. Most disability insurance policies sold to professionals are touted as “own-occupation” policies, meaning that a physician is entitled to benefits if he is unable to perform the substantial and material duties of his occupation. However, those policies define a Physician’s occupation as “the occupation in which you are regularly engaged at the time you become totally disabled.” If a physician has gradually wound down his practice, and is working a reduced schedule performing only certain procedures, he has effectively changed his occupational definition from a full-time clinical physician to something less.

For example, an OB/Gyn with degenerative disc disease may first stop performing Caesarean deliveries because he or she does not have the ability to bend, flex and turn as necessary in order to safely finish the procedure. As the condition progresses, the physician may stop performing laparoscopic procedures, then stop handling vaginal deliveries, to the point where the only actual medicine he or she is performing consists of routine well-woman examinations. By that time, the physician’s occupation is no longer an OB/Gyn, but something more like “an OB/Gyn who works part time, 3 days a week; largely responsible for overseeing associate physician, nurse practitioner and staff; involved in office administration.” By gradually changing responsibilities prior to filing a disability insurance claim, the physician in the example above may find it very difficult to prove that he or she is, or ever will be, totally disabled from what now is less

Continuing to work through adversity can frequently have unintended consequences, both professionally and personally.
strenuous, part-time work involving non-clinical practice management.

**The Physician Who Trusts His Insurance Company**

Some disability insurance policies also offer “residual disability” or “partial disability” riders. At first blush, this coverage seems like it would be well-suited for individuals with chronic and progressive medical conditions: the disability insurer will pay benefits if the physician is unable to work full-time, allowing the physician to limit his practice while preserving his pre-disability occupational definition. In practice, however, the residual disability benefit is not as attractive.

First, claiming disability benefits will give the insurer free reign to demand extensive financial records under the auspices of “investigating” the extent to which a medical condition has reduced a physician’s income. Insurers will pore over CPT codes, profit and loss statements, employment agreements, balance sheets and similar documents to see if there is some reason, other than the medical condition, that could plausibly explain the drop in income. If so, they will often deny the claim based on an inability to prove that the condition caused the loss in earnings.

Even if the claim is paid, it is based on how much the insurance company thinks you can work, not on how much you are actually working. So if the insurance company thinks that you can work making 75% of your pre-disability earnings, but you are only making 50%, it will reduce your benefit amount accordingly.

The residual disability benefit is also often more attractive to a disability insurer because the maximum benefit period is often shorter for residual disability claims than it is for total disability claims. If an insurer can characterize a claim as residual rather than total, it may only need to pay benefits for 60 months or to age 65, whereas a claim for total disability benefits could be payable for life.

With this backdrop and scrutiny, it is not surprising that very few residual disability claims ever turn into total disability claims, even if the physician stops working completely. The insurer will continue to pay a fraction of the benefits until the maximum benefit period has been reached, at which time the insured will be left without any coverage at all.

To complicate matters, we often see overlap between two or more of these categories. For example, a physician will work too long and risk hurting a patient, then react by immediately limiting his schedule, and then at some point down the road look to his disability insurance policy for coverage. The physician will often only seek legal help after a claim is denied or terminated, at which point the time, effort and expense of putting the claim back on track, as well as the risk of an unfavorable result, increase exponentially.

The best solution to avoiding these pitfalls is to engage experienced legal help early in the process, before a claim has been filed and before any work schedules have been altered. Although it can be a difficult pill to swallow for physicians who have been trained to push through adversity, it is necessary to understand and accept the limitations imposed by one’s condition, as well as the rights available under a disability insurance policy, as early as possible.

Sources:


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The adequacy of informed consent is always involved when performing a treatment or procedure. The physician is responsible for obtaining the patient’s informed consent prior to any treatment or procedure. Informed consent means providing sufficient information to reasonably allow an informed decision. The more invasive or risky the treatment or procedure, the more detail the physician should provide.

Recent court decisions by the Wisconsin Supreme Court and the Maryland Court of Appeals clarified that proof of medical negligence is not required for plaintiffs to bring an informed-consent claim. Both of these courts reaffirmed it is necessary to communicate “all relevant treatment alternatives” to enable the patient to make an intelligent and informed choice. Physicians should thoroughly discuss potential complications; realistic expectations of the benefits; and all possible alternatives to the proposed treatment or procedure. This discussion should be documented in the patient’s record in detail including questions asked and answers given. Additionally, the patient should be asked to sign a procedure specific consent listing the risks, benefits and all alternatives to the proposed treatment, including doing nothing.

If sedation will be administered, the physician should explain what level of consciousness will be maintained, the credentials and expertise of the personnel who will be monitoring the patient and all associated risks. Physicians should review pertinent state laws to determine if there are any restrictions regarding the administration of sedation in a physician’s office.

Patients have the right to know the physician’s training and experience level in performing the treatment or procedure. The skill level of the physician and the physician’s staff are directly related to the risks of a particular procedure. Information should also be provided regarding any additional risks presented by performing a procedure or treatment in the physician office, in an outpatient facility or a spa/salon. Detailing the limited experience of the physician’s and physician’s staff may be uncomfortable, but an honest discussion is important to allow the patient to make an informed decision about whether to proceed.

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Very 62 minutes, someone in the United States loses their battle with skin cancer. One in five Americans will develop skin cancer during their lifetime. Melanoma, the most deadly form of skin cancer, is the most common form of cancer for adults between the ages of 25 and 29.

And while much publicity is given to breast, prostate, lung and colon cancer, there are actually more new cases of skin cancer diagnosed each year than for all four of the other cancers combined. In fact, skin cancer is the most common form of cancer in the United States. For a disease that is highly preventable, these startling statistics, provided by the Skin Cancer Foundation, are a stern reminder to practice year-round sun protection. With summer just around the corner, there’s no better time than now to commit to a few simple and potentially life-saving sun safety tips.

“Getting out and enjoying the sun can be invigorating and soothing and, in moderation, has been shown to provide some health benefits,” says Dr. Walter Quan, Medical Oncologist at Cancer Treatment Centers of America (CTCA) in Phoenix. “Exposure to sunlight increases Vitamin D production, which has a wide range of positive health benefits including, ironically, possibly inhibiting the growth of some cancers.”

But those benefits come with a dangerous tradeoff as more than 90 percent of all skin cancer cases are related to the sun’s ultraviolet rays. Looking for more visible evidence? Up to 90 percent of all changes to skin commonly attributed to aging, such as sagging, wrinkles and discoloration, are caused by the sun.

Fortunately, decreasing the risk of developing this deadly disease is as simple as remembering the ‘three S’s’ – shade, sunscreen and sunglasses. To avoid the most potent cancer-causing rays, stay out of the sun whenever possible and especially between the hours of 10 a.m. and 4 p.m. Beautiful early morning and evening hours are the perfect time to safely enjoy outdoor activities.

When venturing outdoors be sure to lather on plenty of sunscreen. A general guideline is to apply at least two tablespoons of sunscreen over the entire body 30 minutes before going outside and again every two hours or after swimming or excessive sweating. Choose a broad spectrum (UVA/UVB) sunscreen with a minimum SPF of 15. Higher SPFs are especially important for longer sun exposures, those who are more prone to burn than tan and when taking medications that increase photosensitivity. While many sunscreens claim to be waterproof, no sunscreen is completely waterproof so it’s important to reapply immediately after swimming or sweating.

Sunglasses with lenses that absorb and block UV are a strong defense against serious conditions ranging from cataracts to melanomas of the eye and eyelid. Along with wearing the right shades, clothing can be one of the most effective forms of sun protection. Select densely woven and bright or dark colored fabrics for the best defense. For even more protection, seek out clothing with SPF protection built-in. Look for a UPF label with a rating of 30 or higher for the best defense.

In addition to seeking protection from the sun, tanning beds should be avoided completely. According to the U.S. Department of Health and Human Services, ultraviolet radiation is a proven human carcinogen. Frequent tanners receive as much as 12 times the annual average ultraviolet radiation dose and are 2.5 times more likely to develop skin cancer. Studies show first exposure to tanning beds in youth increases the risk of developing melanoma by 75 percent.

While skin cancer is the most common of all cancers, it is also one of the easiest to cure if diagnosed and treated early. When combined with annual skin examinations by a health care professional, monthly self exams are the best way to detect skin cancer. Schedule an appointment with a primary care physician or dermatologist for moles or skin changes that are:

A - Asymmetric
B - Borders that are irregular or ragged rather than smooth
C - Color variation in the same mole (a mole that is more than one color or if you notice that a mole has changed color, particularly if it has become black or dark)
D - Diameter of more than 6 mm, that is, a new or enlarging mole that is larger around than the eraser on a #2 pencil
E - Elevation or heaping up of a pre-existing mole

By following the ‘three S’s,’ avoiding tanning beds and performing routine skin checks, the chances of developing skin cancer can be greatly reduced. For those who receive a skin cancer diagnosis, Cancer Treatment Centers of America can provide state-of-the-art, integrated and personalized treatment options.
Lung cancer is a terrible disease. Hearing about a loved one, or you, who has been given a diagnosis of lung cancer brings out all the basic emotions of fear, hopelessness, and loss. Many are ashamed, thinking that their years of “weakness” in not stopping smoking will now cause their death, leaving their families without support, companionship, love.

When we diagnosed my father with lung cancer, our oncolologist explained to him that the cells under the microscope were an “angry” disease, meaning aggressive, relentless, life taking.

Lung cancer is all that and more. It is an insidious disease, often with no symptoms until the tentacles of the disease have spread far beyond the lungs. Indeed only about 15% of lung cancers are diagnosed at an early stage, with only 3.5% of patients with distant spread living 5 years.

Lung cancer is a common disease. We hear about the rallies and races for breast, colon, and prostate cancer, but few are held for lung cancer. Again there is a perception that “cigarettes are dirty, and you could have stopped!” This, despite the fact that lung cancer is leading cancer killer of men and women in the United States, and surpassed breast cancer as the number one cause of cancer deaths in women in 1987. In fact, lung cancer causes more deaths per year (160,000) than deaths due to breast, colon, and prostate combined.

Smoking does cause the majority of lung cancer, but there are other risk factors. Second-hand smoke is a known risk. Radon, a colorless, tasteless gas may cause up to 15,000 lung cancer deaths yearly. Occupational exposure to asbestos, uranium, and coke, which is used in furnaces and foundries, also produce their share of lung cancer deaths.

Lung cancer is not just the “Marlboro” man’s disease. It is a woman killer too. When women became “liberated,” and started smoking more the number of lung cancers identified in women rose dramatically, some say up to 106% increase. Some types of lung cancer are also more common in certain genders and ethnic groups.

With over 375,000 Americans living with lung cancer, and over 220,000 new cases of lung cancer expected to be diagnosed for 2012, there is a growing need for early screening, detection and advanced treatment options.

Cancer Treatment Centers of America® (CTCA) in Goodyear has recruited some of the top doctors in the country to lead our new lung clinic. The clinic will offer new types of molecular testing to target and “personalize” the fight against individual types of lung cancer.

And now we have an approved screening technique to help find early lung cancers in the highest risk people. Finding cancer early is the key to getting as close to a cure that we can.

As a doctor working at CTCA, I am given hope, more hope than we have ever had in the modern fight against lung cancer. Because it is a fight, a battle, a war – and with more tools, more research, and more help from individuals caring for their health, we will fight for the cure. AM

J. Francis Turner, Jr., MD, FACP, FCCP, FCCM, is the Director of Interventional Pulmonology at Cancer Treatment Centers of America®.
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Free app allows ArMA members to send HIPAA-compliant texts, photos

The Arizona Medical Association (ArMA) is pleased to announce the launch of our newest member benefit! Beginning in January 2014, ArMA members will have free access to a “physician-centric smart phone app” that enables you and other users to exchange patient information in a secure, HIPAA-compliant manner.

DocbookMD is a convenient way to share patient information at the point-of-care. It enables users to attach high-resolution images (e.g., EKGs, X-rays, photos) and other content (e.g., discharge summaries, test results, medical history) to any message.

A unique feature of DocBookMD is the ability for you to build a “Care Team” in order to communicate with non-physicians (e.g., nurses, PAs) at your practice, and at your discretion.

DocbookMD also features accurate contact information on physicians in Arizona – including phone numbers and email addresses – as well as details on local pharmacies across the state.

More than 21,000 physicians are now using DocbookMD across the U.S. In Arizona, the DocbookMD app is available to ArMA member physicians January 1, 2014.

DocbookMD says that every message that is sent using the app meets the HIPAA requirements for “encryption and the security of protected health information.” The company explains that, “This is accomplished through technology that keeps everything encrypted on the DocbookMD server. Messages are not downloaded to the phone, but are viewed from the phone.”

Finally, DocbookMD points out that, “Physicians who text each other clinical information risk exposing themselves to privacy and security violations of HIPAA.”

DocbookMD works on iPhones, iPads and Android devices – and it can be used on multiple devices (e.g., one phone and one tablet per user).

In January 2014, ArMA members can download the DocbookMD app in the App Store or Google Play.

Additional information and resources such as video tutorials and testimonials are available at www.docbookmd.com. ArMA members can also contact Docbook support at 888-930-2048 or via email at support@docbookmd.com with questions related to the DocbookMD app.
Your care team is now just a tap away.

DocbookMD is a free benefit for ArMA members.

DocbookMD has now made it easier than ever to engage and communicate with your non-physician colleagues in a new feature to our app called Care Team. With Care Team, physicians can invite members of the patient care team to join them on DocbookMD to communicate in a secure, fast and efficient way through their mobile device. Now, all of those caring directly for patients can share messages and images like X-rays, EKGs and images of wounds or rashes wherever and whenever they need to. Simply download the app from either the App Store or Google Play and start building your Care Team.

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About Comfycozy’s
On March 30, 2012, 11:29am, Amanda Hope lost her battle to Leukemia. Amanda’s dream was that one day when she was healed she would make a clothing line for kids going through chemo that would allow them to keep their “modesty and dignity.” You see, Amanda always hated her body being exposed to a room full of strange doctors, nurses, and others and wanted better for other children. Comfycozy’s are making Amanda’s dreams come true.

Our goal is that every child in America who needs a port will receive a “Comfycozys for Chemo” T-shirt from Amanda Hope’s Dream. With God’s blessing, please touch a child’s life today by supporting this amazing cause!

Comfycozy’s for Chemo give the gifts of Comfort, Modesty and Dignity of self in the harsh world of children’s cancer. Sponsor a child today for just $25.

Your $25 donation will bring a Comfycozy tee-shirt to a child with cancer.

Amazing, a little tee-shirt can change a life. With Comfycozy’s, Moms no longer have to struggle to get their children clothes off for treatment, nurses and Dr’s. have easy access to there port or brovaic. Dignity and modesty are returned to kids with cancer. The harsh world of protocols, regulations and battling cancer is hard enough on its own. Comfycozy tee-shirts are one small step to give the gift of empowerment to our children. No matter what the age, no ones likes being exposed to every person that walks through a chemo treatment center.

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a wonderful Holiday Season
and a New Year filled with joy and success.

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