

INSIDE
THIS ISSUECommunity
Outreach
Page 4, 5Regional Issues
Page 6Legislative Update
Page 8, 9, 10Physician Advocacy
Page 11, 17Patient Wellness
Page 12, 13Practice
Management
Page 14, 18, 19Insurance Issues
Page 15Board Policy
Page 16

Dr. Kikano Congratulates Case Graduates

On behalf of The Academy of Medicine Cleveland/Northern Ohio Medical Association, President **George E. Kikano, M.D.**, welcomed medical school graduates into the profession during his commencement greeting address at Case Western Reserve University.

Dr. Kikano delivered his welcome message as slated in the commencement schedule prior to the conferring of diplomas and hoods. Included in his remarks were congratulations and accolades on the many milestones the day marked for the 141 medical degree candidates gathered.

"With achievement comes responsibility," he said. "See this not just as another challenge, but rather as a gift. You have worked hard to get here, enjoy your success. But remember that the greatest accomplishment of all is the opportunity you now have to do more. Let this be your reward. Involve yourself in the profession in any way you can."

He went on to cite the myriad advances in research and state-of-the-art medical technology that serve to improve the profession as a whole.

"Regardless of what developments and inventions come about during your career," he advised, "remember that what you do, how you act and how you treat others carries the greatest impact and import, so do it well."



Dr. George E. Kikano delivers welcoming remarks on behalf of the AMC/NOMA at the May 15 commencement.

Kikano further challenged the graduates to apply all they had learned and "focus on patient interactions, family dynamics, and perhaps most importantly, the relationship of individual health to the community, the environment and the impact of legislation and politics on our profession."

"Aspire to greatness and decency," he concluded, "Go forward and make a difference and do the thing you have set your heart to do."

(Continued on page 4)

AMC/NOMA Presents at Grand Rounds with AMA
President: Dr. Nelson Prescribes Hope for the Future

On a recent visit to Cleveland, American Medical Association President John C. Nelson, M.D., MPH, laid out a multi-pronged plan to revamp the health care system from the inside out during an address to area physicians.

(Continued on page 3)

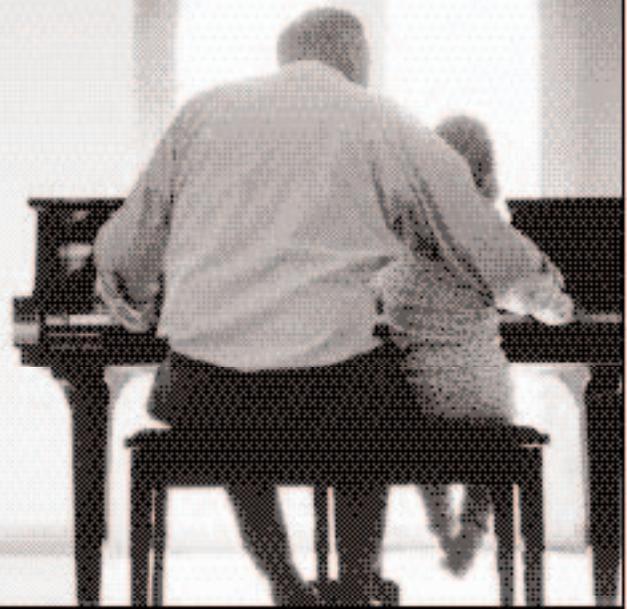


Dr. John Nelson and Dr. John A. Bastulli following their Grand Rounds presentations at Fairview Hospital May 20.

AMC/NOMA
6000 Rockside Woods Blvd.
Ste. 150
Cleveland, OH 44131-0999

ADDRESS SERVICE REQUESTED

THE BEST
INVESTMENTS
*often have nothing
to do with money.*



PRIVATE
CLIENT
GROUP

Stock indexes and asset allocations are one thing. But in the end, what really matters are the investments we make in the lives of those around us. At the Private Client Group, we help people manage, grow and preserve their wealth, so they can provide for those they care about most. We offer expertise in trust, private banking, investment management, estate administration and philanthropic endeavors; providing insightful strategies that help you achieve your goals. To learn more about our financial services, please contact Jane C. Lehman at 216.222.2442.

Managing wealth for over 160 years.

National City

NationalCity.com/wealth
©2005, National City Corporation
CS-19199

AMC/NOMA presents at Grand Rounds with AMA president

(Continued from page 1)

Central to his message was a consistent prescription for hope, that is, for rallying in a time of adversity, for facing challenges as they come, which he said physicians have historically always done — with aplomb.

“I am a practicing doctor like you,” he began. “Though we face many obstacles, I have hope for the future.”

Likening the current state of medical affairs to waves crashing on a shore, Nelson said there was little one could do to stop the onslaught of legal and governmental “waves” on the practice of medicine.

“But if we can control the tide,” he advised, “We can overcome this ‘crisis.’”

The tide of professionalism, he went on to explain, involved embracing evidence-based truth, caring for and caring about one’s patients and adherence to ethical standards.

Nelson used anecdotal examples to illustrate what he termed “the interlocking patient/physician relationship,” which was key, he said, in getting back to the roots of the profession he had dedicated his life to.

He then honed his focus on the issues currently beleaguering the health care system as a whole.

Priority one, he said, was the fact that recent statistics showed 45 million Americans are without access to adequate care.

“There are so many arguments, but the AMA has a plan,” he said.

Tax credits and inverse-rated incomes, wherein the poor get the most help were not new ideas, he conceded. The challenge, however, was enlisting bi-partisan support in Congress for the estimated \$30-\$60 billion it would cost to cover the uninsured.

“What is the cost of not insuring these individuals?” he posed, “According to recent government estimates — \$95 billion.”

On this point he cited a 2003 Institute of Medicine report that looked at those who earn little or no incomes and the cost of their medical care down the road ranging from \$1.7 to \$3.2 trillion.

“The financial argument must get our attention,” Nelson said.

He went on, if job number one is the uninsured, job number two would be addressing the race-based inequities of treatment, specifically citing a study which found African American patients not receiving needed heart medications by as much as 15% as their white counterparts.

“We cannot allow this,” he said. “The numbers don’t lie. We will identify these disparities and address them.”

Referencing the sustainable growth rate, Nelson said this was government-speak for a payment system that had become a disgrace.

“What does the GNP have to do with disease?” he asked. “The GDP was calculated down by a couple billion dollars,” he said. “This is not a growth rate, it’s a 5 percent cut.”

The AMA, however, is “excited” to be involved in meetings on the subject in Washington, D.C., Nelson said, where they are fighting hardest for the senior populations in light of recent figures claiming 24% of family doctors across the country are not accepting new Medicare patients. (See related article on page 11. Write Congress today in support of HR 2356 & S 1081!).

Next Nelson turned his attention to his topic title, medical liability, and began with the following definitive statement.

“What we have is a broken liability system that cannot be fixed,” he said, “so it must be replaced.”

Nelson cited many negative outcrops of the current system, including the costs involved both in going to court if need be or even the average \$62,000 spent in out-of-court expenses before any settlement monies are exchanged, tales of radiologists not reading mammograms, Obstetricians not delivering babies, or worse in his mind, performing C-sections that aren’t necessary to avoid a potential lawsuit — all adding up to the aforementioned “crisis” today’s physicians face.

“We can’t practice medicine this way,” he said. “This system is broke.”

With regard to federal tort reform, the AMA President criticized Congressional Democrats he said were stalling the Senate with filibusters. Good news was to be found on the state levels, however, and he gave a number of examples including Florida, Nevada, Oregon and South Carolina where pre-litigation

screening panels and caps on awards had been instituted.

Finally, Nelson referred to a recent Gallup poll that found 72% of Americans agree there should be limits set on pain and suffering claims and his own personal meeting this spring with President George W. Bush, who promised the administration was working on resolving the liability issue.

“We have our work cut out for us,” Nelson concluded, “But it is going to happen. We can’t focus on gloom and doom. Can we change it? Yes! The biggest plague of today is apathy. Take the bull by the horns, get involved in your hospitals, communities, medical societies and specialty societies. Just get involved.”

More than 90 local physicians and residents attended the May 20th presentation at Fairview Hospital, which fulfilled a Grand Rounds CME requirement. The Surgery Department at Fairview Hospital coordinated the event delivering both welcoming and summary remarks around the featured guest’s address.

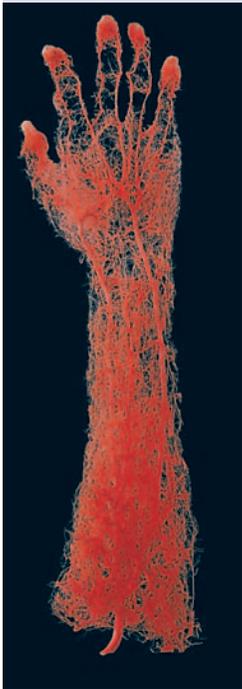
And in a special presentation following Dr. Nelson’s remarks, **John A. Bastulli, M.D.**, Vice President of Legislative Affairs of The Academy of Medicine Cleveland/Northern Ohio Medical Association, provided a regional perspective on the issues surrounding medical liability including a brief background discussion as well as current updates on initiatives in the Ohio legislature which AMC/NOMA members and lobbyists have focused on in recent months, with special attention on SB 88 (see related story on page 10).

Bastulli encouraged those gathered to get involved personally on the issues discussed, especially as Northeast Ohio physicians face county-specific challenges with respect to premiums and liability and the area’s hospitals have been proven to be a crucial economic driver for the region. He urged letter writing campaigns and commitments to organized medicine in the interest of what he termed politically feasible legislation.

Following the event, Dr. Nelson commended Dr. Bastulli on his “impressive” presentation.

“It is clear why you were elected to represent your colleagues,” he said. “Thanks for your involvement. ■

Exhibit Reveals Slices(s) of Life



For ages medical scholars have examined real human specimens to better understand the physical form and its functions. The Academy of Medicine Cleveland/Northern Ohio Medical Association is pleased to provide its members an opportunity to visit the dynamic Body Worlds 2 exhibit of specimens through a special discount admission offer listed below.

The exhibit, currently running at the Great Lakes Science Center, features more than 200 authentic specimens, including entire bodies, individual organs and tissue slices all preserved via a patented process termed plastination. German physician Gunther von Hagen, developed the process in 1977 at the University of Heidelberg initially for the purpose of medical education. He discovered a way to replace the body's water volume with liquid polymers that harden after a vacuum-forced infiltration. It has broadened the possibilities for viewing specimens in a more natural form without formaldehyde and/or barrier glass.

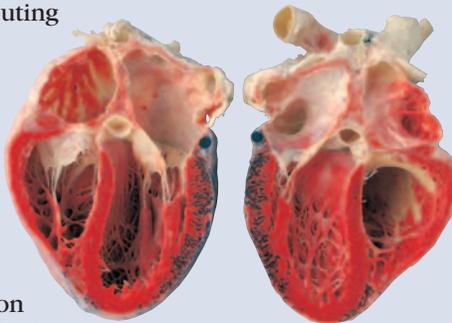
Dr. von Hagen began a visiting professorship last year at the New York University where he will design the first non-dissection anatomy curriculum in the U.S., using plastinated specimens exclusively as education models.

Many of the full body plastinates are exhibited in dynamic poses; kicking a soccer ball, flipping upside-down on a skateboard, performing acrobatics, etc., in an effort to showcase how the body works when it's healthy and, in contrast, how it breaks down when it's not.

Cleveland is only the third city in the U.S. to host von Hagen's exhibit after Chicago and Los Angeles. The event run in Chicago was similarly featured by the Chicago Medical Society's publication with discounts offered to its members as well. Body Worlds 2, debuting in Northeast Ohio, equals its predecessor Body Worlds, in size and proportion, but focuses more on the aforementioned lessons of leading a healthy life.

Some 16 million people have visited the exhibit worldwide, making it one of the most successful touring events in decades. Many report leaving the Body Worlds display with a new-found respect for their bodies, and perhaps new motivation to commit to healthier eating and exercise habits.

Body Worlds 2 discounts for AMC/ NOMA members are valid through August 31, 2005, from 9:30 a.m. to 9 p.m. The Great Lakes Science Center is located at Northcoast Harbor, between the Rock and Roll Hall of Fame and Browns Stadium. ■



Dr. Kikano congratulates Case Graduates (Continued from page 1)

The May 15 ceremony, held at Severance Hall in Cleveland, included a keynote speech by Jordan J. Cohen, M.D., President of the Association of American Medical Colleges.

According to the department of residency and career planning at the School of Medicine, 44 of the 141 graduating students matched in Northeast Ohio and five others in Columbus and Cincinnati. The most popular residency choices of graduating students were Pediatrics at 15 residencies and Internal Medicine with 14. Emergency medicine, orthopaedics, pathology, psychiatry and diagnostic radiology each accounted for nine matched residencies among the graduating class of 2005. ■

CLEVELAND PHYSICIAN

THE ACADEMY OF MEDICINE OF CLEVELAND/
NORTHERN OHIO MEDICAL ASSOCIATION
6000 Rockside Woods Blvd., Suite 150
Cleveland, Ohio 44131-2352
Phone: (216) 520-1000
Fax: (216) 520-0999

STAFF

Executive Editor

Elayne R. Biddlestone

Administrative Assistant

Taunya Rock

Membership & Marketing

Coordinator
Linda Hale

Communications Coordinator

Sara Lieberth

THE CLEVELAND PHYSICIAN (ISSN# 1084-0982) is published bi-monthly by the Academy of Medicine Cleveland/Northern Ohio Medical Association (AMC/NOMA), 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131. Periodicals postage paid at Cleveland, Ohio. POSTMASTER: Send address changes to CLEVELAND PHYSICIAN, 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131. Editorial Offices: AMC/NOMA, 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131, phone (216) 520-1000. \$36 per year. Circulation: 2200.

Opinions expressed by authors are their own, and not necessarily those of the *Cleveland Physician* or The Academy of Medicine of Cleveland/Northern Ohio Medical Association. *Cleveland Physician* reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted.

ADVERTISING

George H. Allen, Jr.
Commemorative Publishing Company
P.O. Box 450807, Westlake, Ohio 44145
P: (440) 808-0240 • F: (440) 808-0494

© 2005 The Academy of Medicine of Cleveland/
Northern Ohio Medical Association, all rights reserved.

AMC/NOMA Member Discount offer valid through August 31, 2005

HALF PRICE!

Buy one adult ticket and get the second for half price.

This offer valid Monday-Friday after 5:30 pm

\$3.00 OFF

Full price adult ticket.

Valid Monday-Friday from 9:30 am – 5:30 pm

PRESENT THIS COUPON AT THE GREAT LAKES SCIENCE CENTER BOX OFFICE.

Good for one admission per coupon only. Not valid with any other discount or offer.



The Great Lakes Science Center • 601 Erieside Avenue • Cleveland, OH 44114 • 216.696.2000 • www.GreatScience.com

Castele Center Opens Doors to Future

When Lutheran Hospital hosted an open house to officially introduce its new Dr. Ted and Jean Castele Learning Center, it opened the door to the future of scientific research and education in Northeast Ohio.

The state-of-the-art facility includes a 170-seat auditorium with interactive capabilities, an anatomic bio-skills laboratory for hands-on learning, four surgical suites equipped for live, potentially global broadcast and a pre-function lobby for exhibition and demonstration. The Center is expected to host several medical teaching and research seminars each week, as well as serve the community at large through workshops, programs and other special events.

“The strong orthopaedic program at Lutheran Hospital provides a unique opportunity to attract national and international medical, nursing and allied health professionals for education and interactive learning,” said **William Seitz, M.D.**, executive director of the Cleveland Orthopaedic and Spine Hospital at

Lutheran. “It will enhance Cleveland’s global reputation of providing world-class healthcare and cutting-edge medical research to aid people around the world.”

These sentiments were echoed by several presenters at the unveiling in mid-April, including **Dr. Ted Castele** himself, for whom the Center is named along with his wife, Jean. Also in attendance at the opening event was The Academy of Medicine Cleveland/Northern Ohio Medical Association Executive Vice President/Chief Executive Officer Elayne Biddlestone.

“Lutheran has always had an excellent reputation for delivering outstanding orthopaedic care,” Castele said during his remarks. “To be able to teach our future physicians, nurses and ancillary staff the very latest techniques and skills truly advances the mission of the hospital.”

A past-president of the AMC/NOMA (1974-75), Castele served on the medical staff of Lutheran Hospital for much of his career, as the medical center’s director



Drs. Seitz, Castele and Loop visit during the opening ceremony festivities at the new Castele Learning Center at Lutheran Hospital April 19.

from 1966-89 and was chief of staff from 1975-81. He is the current chairman of the Fairview/Lutheran Foundation Board, which provided a \$1 million grant toward the \$1.8 million facility total. Castele is known to many as the familiar “Dr. Ted,” who worked for 25 years as the nation’s first “television doctor” presenting health information to the public on local WEWS-TV5. ■

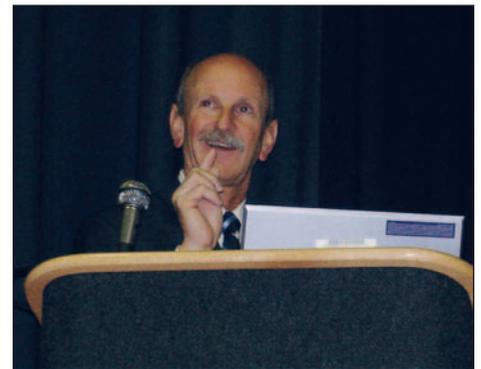
AMC/NOMA Members Give ENCORE Presentations

To help educate senior citizens in the community on medically related issues as well as legislative matters, the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) has been working at the request of staff at Tri-C’s Eastern Campus to provide continuing education programs for seniors. The program, known as ENCORE, is sponsored by the Tri-C Department of Gerontology.

During the month of April, two AMC/NOMA members spoke on separate occasions to a group of seniors at Tri-C Eastern Campus on two very diverse topics. **Dr. John Bastulli** presented background information on the community resources available through the AMC/NOMA, including our referral service and Web site. However, the main focus of his presentation was on the mandatory arbitration legislation currently under review in Ohio (SB 88.) He provided a detailed overview of the legislation, how it would help to reduce costs and assure a faster process. In addition, he provided the group with a copy of the AMC/NOMA legislative directory and information on what committee to write to in the Ohio

Senate to ask for support of the legislation. In addition to questions about the legislation, the seniors in the group asked Dr. Bastulli about the topics of boutique medicine, conscience clause issues (pharmacists refusing to fill prescriptions for moral reasons) and Medicare coverage matters.

The following week, **Dr. Bernard Stulberg**, addressed the group on the topic of total joint replacement. His presentation included a discussion about one of the most common causes of knee pain — osteoarthritis. He provided information on conservative treatments such as steroidal and nonsteroidal anti-inflammatory drugs. He then provided detailed background information on total knee replacement — what the surgery entailed and the techniques involved in the procedure. He also provided the group with information on the Stryker Computer-Assisted Navigation System. Known as SURGNAV, this computer-assisted surgical monitoring is meant to enhance longevity of knee replacement through more precise surgical implantation and intraoperative evaluation. Dr. Stulberg entertained several questions from the



Dr. Bernard Stulberg speaks on osteoarthritis and total joint replacement at the Eastern Campus of Cuyaboga Community College.

audience regarding his presentation and the procedures outlined.

The Tri-C ENCORE program periodically asks for the assistance of the AMC/NOMA in obtaining presenters on medically related and other health care-related topics. Tri-C has the final decision on whether or not there would be an interest in a specific subject matter. Members of the AMC/NOMA interested in presenting to this group should contact Ms. Sara Lieberth at the AMC/NOMA offices at (216) 520-1000, ext. 320. ■

Study Finds Hospitals Vital to Economy of Region

Bill Ryan, President & CEO, The Center for Health Affairs

Healthcare is the lifeblood of our local economy. Hokey puns aside, the fact is undeniable. Many of the largest employers in our area are hospitals, and rarely a day goes by when we don't read headlines about healthcare in one of our local news outlets. Pages are filled with stories about the implementation of new treatments and technologies, the commencement of new research initiatives, and the care given to patients by local physicians in local hospitals. Hospitals alone employ more than 50,000 members of the Northeast Ohio community, not to mention all of those employed in other care settings, including your own practices.

Yet while we know healthcare is vitally important to our economy, until recently we had been unable to discuss it in quantitative terms. For this reason, The Center for Health Affairs engaged the University of Cincinnati to conduct an analysis of the economic impact of hospitals in Northeast Ohio. We focused on our membership, which covers Ashtabula, Cuyahoga, Geauga, Lake, Lorain and Medina counties. We chose the University of Cincinnati because of their experience in performing these sorts of analyses for hospitals and other industries.

The overall conclusions of the study came as no surprise, but the numbers themselves were impressive. Altogether, the total economic impact of area hospitals and their related healthcare facilities in both direct and indirect activities came to \$11.58 billion. This includes direct activities engaged in by hospitals, such as capital investments and payroll, as well as the ripple effect generated by these activities when an employee spends their paycheck or a construction company is commissioned to do work and has to hire labor and purchase materials.

Most of the economic impact of hospitals comes from activities that fall under the umbrella of operations. This includes labor-related expenses and expenditures associated with a variety of supplies, services, pharmaceuticals and liability insurance. The direct and indirect impact associated with hospital operations totals about \$10.4 billion, which is close to 90 percent of the overall impact. Of that, about \$4.9 billion is in direct expenditures and \$5.5 billion is in indirect impact.

Not surprisingly, a significant chunk of hospital impact is tied to employment. The total household earnings, which includes both direct and indirect impact, is calculated at \$3.28 billion, with a total employment estimated at 109,107 jobs. Of that, hospitals and their related facilities directly employed 51,542 people and paid out \$2.86 billion in wages and benefits.

One of the most surprising findings of the study relates to the amount of money brought into the region from outside of it by area hospitals. While it might seem that the money generated by hospitals isn't new money — that it's simply moving from one pocket to another within the region — the study suggests otherwise.

In 2002, inpatient charges for the region's hospitals totaled \$5.22 billion. Of this, almost 22 percent, or more than \$1.1 billion, was associated with patients who do not reside in any of the six counties that comprise the study area. In addition to money directly spent on care, patients, their families and visitors, and professionals from outside of the area eat at local restaurants, stay in local hotels and otherwise generate activity within the economy while they are here. When this indirect impact is figured in, a total of about \$2.16 billion in economic activity is generated by people who live outside of the six-county area and come to Northeast Ohio hospitals for care. A similar study also conducted by the University of Cincinnati for Greater Cincinnati-area hospitals found that those hospitals create a \$363 million impact, which provides some perspective for the enormous impact we see in Cleveland.

Why is it important to consider the economic impact of our hospitals? At all levels of government, discussion is taking place about hospitals' tax exemptions. While it's understandable that cash-strapped state and local governments are turning over every stone in search of opportunities to generate revenue and streamline spending, it is important that they do not create incentives for hospitals to make decisions differently about where they will locate their facilities and how they will conduct business. As man-

ufacturing jobs continue to dwindle, we need to nurture the healthcare industry. It is becoming ever more apparent that healthcare is the future of our region.

Earlier this year, a proposal was made by a Cuyahoga County official to generate additional revenue for local government by asking hospitals to make Payments In Lieu of Taxes (PILOTs). The proposal compared Cleveland to a handful of other cities, like Baltimore and Pittsburgh, that use PILOTs. There is a significant difference, however, in how basic city services are funded in Cleveland and in these other cities.

In both Baltimore and Pittsburgh, basic services such as police and fire are paid for primarily through property taxes, while in Cleveland these types of services are paid for largely through payroll taxes, from which area hospitals are not exempt. In fact, almost \$32 million is generated annually in local payroll taxes by Northeast Ohio hospitals, with another \$64 million generated in state income taxes. Altogether, through their operations and related indirect activities, hospitals account for more than \$250 million in state and local tax revenues annually.

The estimated value of property tax exemptions for all nonprofits in Cuyahoga County, including hospitals, educational institutions, churches and other organizations, is about \$87 million. In exchange, hospitals across the region provide more than \$130 million annually in care to the poor, create an economic impact of more than \$11 billion, and provide a host of services to the community that would otherwise not be provided. Clearly, hospitals are a bargain.

Editor's Note: The commissioned study, "The Impact of Hospitals in NE Ohio on the Economy of the Region" was presented during a recent board of directors meeting of the Center for Health Affairs, on which the President of The Academy of Medicine Cleveland/Northern Ohio Medical Association sits. Additionally, AMC/NOMA members have incorporated data from the study into testimony in support of SB 88. ■

It's Time For Your Financial Check-Up

Thanks in large measure to the work of health care professionals like you, Americans are enjoying longer, healthier lives than ever before. Plan to make the most of the coming years. Retirement planning is like preventive medicine, build a nest egg now and be more comfortable later.

At Sagemark Consulting, we will help you build a financial plan that helps meet your needs and achieve your goals. We can help you discover the right financial strategies through our comprehensive planning services. We provide an unrestricted selection of products and services to help meet your goals in:

- Retirement planning
- Investment planning
- Education funding
- Insurance analysis
- Corporate benefit packages
- Estate planning

Personal financial planning involves creating a plan to help you reach specific financial goals. We can help. Call for an appointment and let's get started.

Philip G. Moshier, CFP®

Sagemark Consulting
31500 Bainbridge Road, Suite One
Solon, Ohio 44139
216-831-0800 x350
pgmoshier@LNC.com
www.philmoshier.com



Advisory services offered through Lincoln Financial Advisors Corp., a registered investment advisor, or Sagemark Consulting, a division of Lincoln Financial Advisors Corp., a broker/dealer (member SIPC). Lincoln Financial Group is the marketing name for Lincoln National Corp. and its affiliates.



Rose Petty Alexander, RN
Hospice Registered Nurse

HOSPICE CARE AND MORE

- Certified hospice services
- Pain and symptom management
- 24-hour on-call availability
- Palliative Care consultation
- Pre-hospice home health care
- Counseling and bereavement support

Hospice 
& Palliative Care Partners *of Ohio*

For patient referrals, please call
800-862-5253
or visit on the web at
www.hospiceohio.org

An Agency of the Visiting Nurse Association.

State Operating Budget Approved

Mike Caputo, AMC/NOMA lobbyist

After more than fifty committee hearings spanning the better part of four months, State Legislators approved a two-year operating budget of slightly more than \$51 billion dollars. Included in the budget is the spending priorities for Ohio, as well as the most significant overhaul of Ohio's tax code in more than forty years.

While issues such as tax reform, education funding and nursing home reimbursement rates have dominated most of the headlines related to the 2900+-page document, there are numerous provisions, which will directly affect physicians and those in the health care provider industry. The following provisions are those that are of significance to members of the AMC/NOMA.

Physician Loan Repayment Program

Under current law, physicians providing primary care services in a primary care specialty may participate in the Physician Loan Repayment Program. Current law defines primary care services as professional comprehensive health services, which may include health education and disease prevention, treatment of uncomplicated health problems, diagnosis of chronic health problems, and overall management of health care services. Primary care specialties are defined as general internal medicine, pediatrics, obstetrics and gynecology, or family medicine. Physicians who participate in the program are required to provide primary care services in an underserved area of the state. The bill would make physicians with a specialty in psychiatry eligible to participate in the Physician Loan Repayment Program if the physician intends to provide primary care services in an underserved area. The bill includes psychiatric services in the definition of primary care services.

J-1 Visa Waiver Program

Federal law requires a foreign-born person who wishes to pursue graduate medical education or training in the United States to obtain a J-1 Exchange Visitor Visa, or J-1 Visa. The J-1 Visa authorizes the person to enter the United States and remain until he or she has completed the graduate medical education or training, but requires that the

person return to his or her home country on completing the education or training and remain there for at least two years before returning to the United States. This requirement may be waived if the person agrees to serve as a physician for at least three years in an area of the country designated by the United States Secretary of Health and Human Services as a health professional shortage area (HPSA).

Under the bill, the Department of Health must administer, in accordance with the Immigration and Nationality Act, the J-1 Visa Waiver Program to recruit, for the purpose of providing health care services in underserved areas of the state, foreign-born physicians seeking to obtain J-1 Visa waivers. The Department must accept and review applications for placement of those seeking waivers.

Reimbursement of Medical Liability Insurance Premiums Paid by Free Clinics

The bill creates the Medical Liability Insurance Program to reimburse "free clinics" for the premiums the clinics pay for medical liability insurance coverage for clinic's staff and volunteer health care professionals and health care workers. The coverage must be limited only to the diagnostic, treatment, and care activities of the clinic. The program reimburses the clinics from money appropriated from the General Revenue Fund for 80% of the premiums' costs, up to \$20,000. A free clinic must register with the Department of Health by January 31 of each year in order to participate and obtain reimbursement under the program. At the time of registration, the clinic must provide to the Department a statement of the number of volunteer and paid health care professionals who provide services at the clinic, a statement of the number of health care services rendered in a year, a signed form acknowledging that the clinic will follow its medical liability insurance policies, and a copy of the medical liability insurance policy. The bill defines "free clinic" to be any nonprofit organization exempt from federal income taxation whose primary mission to provide health care services for free or for a minimal admin-

istrative fee. The bill places certain limitations on a clinic if the clinic elects to charge a minimal administrative fee.

Medicaid HICs to Post Performance Bond

The bill requires each health insurance corporation (HIC) providing coverage to Medicaid recipients to post a performance bond in the amount of \$1 million, as security to fulfill the HIC's obligations to its contracted providers for services rendered to Medicaid recipients in the event of liquidation or rehabilitation proceedings. The bond is payable to the Department of Insurance in the event that the HIC is placed in rehabilitation or liquidation proceedings. In lieu of a performance bond, the bill permits a Medicaid HIC to deposit securities that are acceptable to the Superintendent of Insurance in the amount of one million dollars, with the Superintendent; the HIC is entitled to the interest on these securities as long as the HIC remains solvent. The bond or securities become a special deposit upon the start of the delinquency proceedings.

The bill requires the performance bond to be issued by a surety company licensed with the Department. The bond or deposit, or any replacement bond or deposit, must be in a form acceptable to the Superintendent and must remain in effect for the duration of the HIC's license and thereafter until all claims against the Medicaid HIC have been paid in full. Documentation of the bond must be filed with the Superintendent prior to the issuance of a Medicaid HIC's certificate of authority. Annually thereafter, 30 days prior to the renewal of the HIC's certificate of authority, HICs are required by the bill to furnish the Superintendent with evidence that the required bond remains in effect.

Under the bill, a rehabilitation plan for a Medicaid HIC may include the use of the proceeds of the performance bond or securities first to pay the claims of the HIC's contracted providers for services rendered. Contracted providers with claims against the HIC are given first priority under the bill against the proceeds of the bond or securities, to the exclusion of other creditors.

(Continued on page 9)

AMC/NOMA Legislative Report*(Continued from page 8)***Prompt Payment Requirements for Health Insuring Corporations (HICs) Covering Medicaid Recipients**

Under current law, HICs providing coverage to Medicaid recipients are exempt from statutes that would otherwise require them to comply with prompt payment laws applicable to other HICs. Under the bill, the provision of law excluding HICs that provide coverage to Medicaid recipients from the prompt payment requirements are eliminated. The bill requires the Department of Job and Family Services (ODJFS) to determine whether a waiver of federal Medicaid requirements is necessary to implement this provision. If a waiver is necessary, the Director of ODJFS is required to apply to the U.S. Secretary of Health and Human Services for the waiver. If the Director determines a waiver is unnecessary or receives approval of the waiver, the Department is required to notify the Department of Insurance so that the prompt payment requirements can be implemented.

Statistics on Frequently Dispensed Drugs Under the Ohio's Best Rx Program

Current law requires ODJFS, by April 1, 2005, to create a list of the 25 drugs most often dispensed to Ohio's Best Rx Program participants under the Program and to determine the average percentage savings Program participants receive for each of these 25 drugs. The percentage savings is to be calculated by comparing the average amount that terminal distributors charge Program participants for each of the drugs, on a date selected by ODJFS, to the average of the terminal distributors' usual and customary charge for each of the drugs on that date. The bill requires ODJFS to calculate the prices annually no later than March 1.

Medicaid Payments for Graduate Medical Education Costs

Current law allows the Ohio Department of Job and Family Services (ODJFS), through the Medicaid program, to reimburse providers who serve Medicaid recipients for the costs associated with graduate medical education. The amount of reimbursement is established by ODJFS in rules. A provider may be reimbursed for treatment of all Medicaid recipients,

including recipients enrolled with a managed care organization under contract with ODJFS. The managed care organization can pay the provider, in which case ODJFS will include in its payment to the organization an amount sufficient to cover the costs of reimbursement. Alternatively, ODJFS can directly reimburse the provider for the costs of education. If ODJFS reimburses the provider, the provider cannot seek payment from the organization and the organization is not required to pay the provider for education costs.

The bill allows ODJFS to deny payment to a hospital for direct graduate medical education costs associated with the delivery of services to any Medicaid recipient if the hospital refuses, without good cause, to contract with a managed care organization that serves participants in the Medicaid care management system who are required to be enrolled in a managed care organization and the organization serves the area in which the hospital is located. ODJFS must specify, in rule, what constitutes good cause. The bill provides an exception to ODJFS's authority to deny payment for direct graduate medical education cost if all of the following are met:

- (1) The hospital is located in a county in which participants in

the care management system are required before January 1, 2006; to be enrolled in a Medicaid managed care organization that is a HIC;

- (2) The hospital has entered into a contract before January 1, 2006, with at least one HIC serving the participants who are required to be enrolled;
- (3) The hospital remains under contract with at least one HIC serving participants in the care management system who are required to be enrolled in a HIC.

In addition to the items contained in the budget bill, the AMC/NOMA has taken a position on numerous House and Senate bills as well as participating in meetings regarding SB 88 (see page 10.) However, due to the lengthy budget debate many of these bills will probably not have a lot of activity until the coming months. Additional information on these bills will be included in the next issue of the Cleveland Physician magazine. For more information on the budget bill or other AMC/NOMA legislative activities contact Ms. Elayne R. Biddlestone at the AMC/NOMA offices at (216) 520-1000, ext. 321. ■

Did You Know?

The Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) has partnered with Cuyahoga Community College's (Tri-C) Center for Health Industry Solutions to offer Certification Courses and Continuing Education Unit Seminars at discount prices to AMC/NOMA members and their staffs.

Programs are taught either by Practice Management Institute (PMI) or local Cleveland expert instructors and focus on the specific needs of a medical practice.

For a complete listing of course titles, dates and costs, refer to page 19 in this issue. Contact Linda Hale at the AMC/NOMA offices at (216) 520-1000, ext. 309 for more information on the discount offer made exclusively available to AMC/NOMA members. ■

Update on SB 88 – Mandatory Arbitration Legislation

During the last few months, the AMC/NOMA legislative chairman, lobbyists and staff have been meeting with the sponsor of SB 88, Senator Kevin Coughlin (R-57) as well as with the Director of the Ohio Department of Insurance to discuss the content of the legislation. In addition to individual meetings with the Senator and Director, AMC/NOMA representatives have also met with the staff from the Ohio Supreme Court and a group of interested parties put together by Senator Coughlin to discuss the bill.



Dr. John A. Bastulli, Ann Womer Benjamin, AMC/NOMA lobbyist Mike Wise and Michael Jordan of Walter and Haverfield following their meeting on SB 88.

There is ongoing discussion as to whether or not the pilot program outlined in SB 88 should be limited to specific counties rather than implemented on a statewide basis. The AMC/NOMA has requested that if the pilot program were to be implemented in a specific area of the state that Northeastern Ohio counties definitely be included in the

program. There are also other forms of alternative dispute resolution under discussion. For example, the Ohio Medical Malpractice Commission report developed by the Ohio Department of Insurance suggested that mediation, and/or special courts or dockets be evaluated as a possible form of ADR to be considered for a pilot program in the state. The Ohio Supreme Court has indicated that they would like to see a mediation process included as an option in SB 88 as well. There are already some counties that utilize mediation on a regular basis for other types of cases. There is also some reluctance to insist that the process be mandatory. There was, however, consensus among the interested parties reviewing SB 88 that some form of ADR to evaluate medical liability cases should be considered in Ohio.

The AMC/NOMA representatives have been strong advocates for a mandatory process with a caveat included in the bill that certain elements put forth in the review process would be admissible if the case were to proceed to trial. Without the inclusion of these two key elements the ADR process will more than likely be without merit. The AMC/NOMA representatives continue to stress that mandatory arbitration conducted prior to the filing of a claim that included

admissibility of information if the case were to proceed to trial would be of assistance to physicians in the Northeastern Ohio region. There is ongoing discussion about applying multiple options across the state, such as the development of different pilot projects using various forms of ADR in various counties.

The AMC/NOMA representatives are participants in an interested parties group that is reviewing the aspects of the legislation and the items noted in this article. The AMC/NOMA will continue to stress the importance of implementing a pilot program in Northeastern Ohio with the elements we believe are necessary to assist physicians to deal with medical liability issues in this part of the state. AMC/NOMA members will continue to receive updates on the progress of SB 88 through our email blasts and our publications. For additional information on this issue, contact E. R. Biddlestone at the AMC/NOMA offices at (216) 520-1000, ext. 321. ■



Dr. John Bastulli and Sen. Kevin Coughlin meet in Columbus to discuss SB 88.

Legislation Under Review

Federal Funds May Create New Mediation Programs

Rep. Brian Baird (D-WA) introduced medical malpractice reform legislation in the U.S. House that would establish a grant program of federal funds, administered by the Department of Justice and dispersed to states and health care providers for establishing mediation programs and providing training in mediation and program administration. HR 2657, introduced May 26, proposes to offer a more effective and inexpensive alternative to litigation by encouraging parties to seek out-of-court resolutions. The bill specifically references and is loosely modeled after the mediation program at Rush University Medical Center in Chicago which has successfully mediated medical malpractice disputes for ten years. Baird suggests the training and grants to initiate programs should be

funded entirely by the federal government, but once a program was up and running the state or health care entity would be responsible for its funding.

Washington Legislature Proposes Exception for Arbitration, Award Limits

A bill making its way through the Washington legislature would bring new flexibility to the state's mandatory mediation system for medical malpractice disputes by carving out an exception for parties that would opt to settle claims through arbitration rather than mediation. Mediation would still be allowed for interested parties. HB 2292 addresses health care liability reform in a way several other states have attempted in recent years but failed. Specifically, the legislation language puts limits on awards, yes, but also on the process itself, requiring commence-

ment of arbitration within 270 days of filing. Written awards would be due within 14 days of the end of the hearing and could not exceed \$1 million for both economic and noneconomic damages. Each side would be entitled to two experts on the issue of liability, two on the issue of damages and one rebuttal expert. Discovery would be limited to 25 interrogatories and 10 requests for production of document and finally the arbitrator may not make an award of damages under a theory of ostensible agency liability. HB 2292 passed the Washington House of Representatives in April and was then sent back to the Rules Committee by the senate.

A bill that would have authorized informing parties of mediation or other ADR processes for resolving medical malpractice claims failed in the Virginia 2005 legislative session. ■

Physicians Encouraged to Voice Their Support for HR 2356 and S 1081 - The Preserving Patient Access to Physicians Act of 2005

Congress recently introduced two bills aimed to adjust the Medicare reimbursement formula. Under current law, the Centers for Medicare and Medicaid Services (CMS) is required to adjust payments to physicians based on a formula that ties reimbursement changes to the gross domestic product. Using that formula — physician payments would be cut an estimated 4.3 percent in 2006.

The current reimbursement formula is projected to impose physician payment cuts of 26 percent over six years beginning in 2006, while the cost of running a practice and caring for patients increases 15 percent. From 2006-2014 — Medicare payments in Ohio would be cut by \$4.97 billion. For physicians in Ohio, the cuts over this period will average \$20,000 per year for each physician in the state. The first of the 6 annual Medicare pay cuts is slated for January 1st of next year. Medicare physician payment rates in Ohio would be cut by \$101 million in 2006. (Figures are derived from the 2005 Medicare Trustees' Report and an impact analysis completed by the AMA in March 2005.)

The House legislation, HR 2356 sponsored by U.S. Rep. Shaw (R-FL) and Rep. Cardin (D-MD) would stop looming Medicare payment cuts and avert an access-to-care crisis. It sets a Medicare physician payment increase for 2006 at no less than 2.7 percent, instead of the 4.3 percent cut projected by the current formula. The 2.7 percent increase is in accordance with the recommendation of the Medicare Payment Advisory Commission (MedPAC.) HR 2356 would also replace the current Medicare physician payment update formula with one that increases the update each year, beginning in 2007.

The Senate Bill, S 1081, sponsored by Sens. Kyl (R-AZ) and Stabenow (D-MI) would make a two-year adjustment to physician payments. It calls for at least a 2.7 percent increase for 2006 and a rise in 2007 linked to the Medicare Economic Index, which measures changes in costs faced by physicians. It includes no adjustments after 2007 to prevent the physician payment cuts anticipated each year through 2011. MedPAC's report suggested that next year's physician reimbursement update should equal the projected MEI of 3.5 percent minus a 0.8 percent increase in physician efficiency

that the commission predicts will occur.

The American Medical Association supports both bills. AMC/NOMA members are encouraged to voice strong support for HR 2356 and S 1081 — the Preserving Patient Access to Physicians Act of 2005. As of press time, Sens. DeWine and Voinovich indicated they were in fact in support of the legislation. Write to your members of Congress today urging their support of **HR 2356 and S 1081**. Some AMC/NOMA members are writing to their patients as well encouraging their support of these two bills.

On behalf of the AMC/NOMA, President **George E. Kikano, M.D.**, drafted correspondence to the Northeast Ohio

Congressional representatives in support of this legislation. A subsequent mailing to AMC/NOMA members outlined the content of these two important bills and urged their physician support. Included with the member mailing were sample letters to Congress that are also posted on our Web site at www.amcnoma.org. AMC/NOMA members may email Ohio Senators and Representatives directly through our site. Go to the "Legislation" link, then "Find your legislator/'Eye on the Statehouse" then click "My Elected Officials" to select the individual you wish to contact and compose your letter. We encourage you to do so in support of HR 2356 and S 1081. ■

AMC/NOMA Connects with Cleveland

Dr. John Bastulli, M.D., presented comprehensive discussion points on the issue of mandatory arbitration and related legislation as the featured guest on *Cleveland Connection* with host Jim McIntyre earlier this Spring.

Dr. Bastulli's April 24 program appearance provided listeners with a point-for-point debate on the intricacies of SB 88, a brief synopsis of the Ohio legislature's work to date on the matter, as well as a round-up of other states' pending legislation across the country. He noted the now-common practice of defensive medicine as the unfortunate result of a medical malpractice system gone wrong and cited human behavior as the indicator of why many physicians are leaving the state to practice elsewhere. Cuyahoga County, he said, has been hardest hit with higher premiums than in other regions across the state, which could have a real impact on the health care system, its practitioners and patients in Northeast Ohio for years to come. ■

SAVE THE DATE

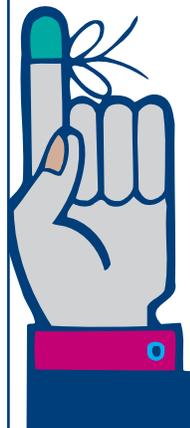
There is STILL TIME to register for the **2nd Annual Marissa Rose Biddlestone Memorial Golf Outing on Monday, August 8, 2005** at the Chagrin Valley Country Club
Members: Watch your mail for a registration flyer coming soon!

"Solving the Third Party Payor Puzzle"

A seminar intended to educate physicians and their staffs regarding the many third party payor claims and managed care issues
Wednesday, November 9, 2005 at the AMC/NOMA Executive Offices.
Contact Professional Relations Coordinator Taunya Rock (216) 520-1000 ext. 314 or trock@amcnoma.org for further information

The 21st Annual Mini Internship Program November 14-16, 2005

Members: Are you interested in participating as faculty for this year's program? Membership Coordinator Linda Hale, (216) 520-1000 ext. 309 or lhale@amcnoma.org is waiting to hear from you!



Raccoon Strain Rabies: Avoid, Vaccinate, Educate

Terrence M. Allan, RS, MPH & Anna M. Mandalakas, MD, MS
Cuyahoga County Board of Health

Raccoon strain rabies (RSR) first crossed the Pennsylvania border into Ohio in 1997. This strain of rabies infects many other wild animals as well as domestic animals (especially cats). In newly infected areas, RSR results in a 10-fold increase in human rabies exposures and treatments. In 1997, the Ohio Department of Health (ODH) initiated a program to create a barrier by immunizing wild raccoons using an oral rabies vaccine, Raboral V-RG. This program created a 25-mile-wide immune barrier that was successful in preventing the western spread of the disease until July 2004, when a rabid raccoon was found in Lake County about seven miles west of the barrier. In 2004, a total of 45 animals (44 raccoons and 1 skunk) tested positive for RSR in Lake, Geauga, and Cuyahoga counties. As of June 1st, thirteen raccoons in Ohio (1 from Cuyahoga County) have tested positive for rabies this year.

In April 2005, a coyote captured in the North Chagrin Reservation of the Cleveland Metroparks was confirmed positive for RSR. This coyote was captured after charging a Park Ranger who was investigating attacks on a cyclist and a dog earlier that day. This was the first coyote in Ohio to test positive for rabies.

More than 223,560 Oral Rabies Vaccine (ORV) baits were distributed in April in a 1,149-square-mile area that includes all of Lake and Geauga counties, northern Portage and Summit counties, and Eastern Cuyahoga County. ORV baiting will occur again in the fall. ORV will be distributed by air in rural areas whereas ground baiting will occur in urban and residential areas. The baits are brown and square in shape. The bait outer shell is hard and composed of a fishmeal polymer bait matrix. The vaccine, Raboral V-RG, is enclosed in heat sealed plastic in the center of the bait matrix. The vaccine consists of the rabies glycoprotein antigen inserted into the thymidine kinase gene of an attenuated strain of the Copenhagen vaccinia virus. This strain of the vaccinia is much weaker than what is used in smallpox vaccines.

Although more than 40 million doses of Raboral V-RG have been distributed in the U.S. and Europe, there has been only one documented human adverse reaction

to the vaccine. This occurred in a pregnant woman in Ohio with exfoliative skin disease who was bitten by her dog while trying to pull the bait out of its mouth. The case was documented in the *New England Journal of Medicine* (Rupprecht, C.E., et al. Human infection due to recombinant vaccinia-rabies glycoprotein virus. *N Engl J Med*, 2001; 345(8): p.582-6). For this reason, pregnant women or persons with eczema or immunosuppression are considered to have an increased risk of adverse reaction, especially if vaccine is introduced into a wound or scarified skin without a thorough cleaning and disinfection. Physicians should be alert for papules or vesicles at the site of exposure, with possible local erythema and regional lymph node involvement.

The following information may be beneficial to your patients:

- To avoid human exposure, removing the baits from an animal's mouth should not be attempted. Eating the baits will not harm the pet.
- If baits are found, they should be removed from where a pet could eat them and placed where they are more likely to be eaten by raccoons and other target animals.
- Gloves or a towel should be used when handling the bait. There is no harm in handling the undamaged bait, but they do have a strong fish-meal smell.
- If there is a possibility that the vaccine sachet has been ruptured, hands and any exposed skin should be washed thoroughly with soap and water.
- Persons who have eczema, are pregnant and/or immunocompromised, as well as children under 18 years of age should seek medical attention if they have had skin or mucous membrane exposure to the red vaccine liquid and experience any rash or redness within 14 days of the exposure.

Thank you for helping to distribute this prevention information to the residents of Cuyahoga County. Your partnership is a tremendous asset.

We would also appreciate reinforcement of our primary prevention message among your patients: **AVOID, VACCINATE, EDUCATE**

Avoid feeding or approaching wildlife while at a park or walking in the woods. Do not place food outside to feed wild animals or your pets.

Vaccinate your companion animal(s) from the rabies virus. Indoor cats require rabies vaccinations because they often frequent the outdoors or they can be exposed to a rabid bat inside of your home.

Educate your children to stay away from wildlife and do not attempt to help any injured animals. Children must notify their parents if they were scratched or bitten by wildlife or a companion animal. The wildlife or companion animal should be collected/identified by an adult or animal control officer for rabies testing or verification of rabies vaccination.

Algorithms for human exposure to Raboral V-RG bait and human and animal exposure to rabies can be found on the Cuyahoga County Board of Health's Web site (<http://www.ccbh.net/rabies2005.html>). Human exposure to rabies is defined as an incident whereby the saliva of a potentially rabid animal is introduced into a bite wound, open cut in the skin or onto a mucous membrane. In Ohio, raccoons, skunks, foxes, coyotes, bats, cats, dogs and ferrets are considered target species.

Editor's note: A physician member of the AMC/NOMA board and staff sit on the Medical Advisory Committee of the Cuyahoga County Board of Health. This article is part of an ongoing series of published submissions from CCBH on topics relevant to the readership of The Cleveland Physician. ■

Prebooking Flu Vaccine Key For Priority Groups

When the National Immunization Conference met earlier this year to review last season's flu vaccine shortages, they also looked ahead to the 2005-06 season with little more than hope that circumstances will be any different.

As of late March of this year, the supply of inactivated influenza vaccine projected for the 2005-06 season will be adequate to meet the historical demand for persons in the priority groups established by the Advisory Committee on Immunization Practices (ACIP). Whether or not additional doses become available depends on several factors the CDC is actively working to resolve. Chief among them is the licensure of Chiron Corp. to manufacture the vaccine. The British Medicines and Healthcare Regulatory Agency lifted its October 2004 suspension on the company, but approval is still pending from the U.S. Food and Drug Administration. Currently Sanofi Pasteur and MedImmune, the only sanctioned producers of influenza vaccine in the U.S., project approximately 61 million doses are ready for distribution. This is relatively the same amount made available last year.

In light of these issues, the CDC encourages implementation of a two-tiered prebooking strategy for customers of inactivated vaccine. It will require providing two requests for supplies; one for the number of doses needed based on anticipated demand among persons in the priority groups and two, for the number of doses needed above plus other groups should supplies meet demand from those seeking vaccination. It is important to note that these strategies do not apply to live attenuated influenza vaccine, which can be ordered in the usual manner for those for whom LAIV is indicated.

The CDC additionally suggests a distribution strategy in which partial shipments are initially shipped to prebooked customers early in the vaccination season, followed by additional shipments later in the season. This plan will enable all providers to administer to high-risk persons, even when supplies are limited.

For further updates on vaccine availability throughout the upcoming season, log onto www.cdc.gov/flu. ■

According to the CDC, the following priority groups should be used as a guide for prebooking orders of inactivated influenza vaccine:

- Persons aged ≥ 65 years
- Persons aged 2-64 years with underlying chronic medical conditions
- All women who will be pregnant during the influenza season
- All children aged 6-23 months
- Health care workers involved in direct patient care
- Out-of-home caregivers and household contacts of children 6 months
- Residents of nursing homes and long-term care facilities
- Children aged 6 months to 18 years on chronic aspirin therapy

NOTE: If more vaccine becomes available, additional groups can be targeted for immunization

Annual Walk Struts Success

Cool winds and rain that misted over the meandering 5K course at Elmwood Park and Civic Center in Independence were no match for the determination and commitment of participants in the 11th Annual Run/Walk for Stronger Bones presented by the Osteoporosis Foundation.

Pioneered by AMC/NOMA member **David R. Mandel, M.D.**, the April 30th event included a health and fitness fair with more than 30 booths featuring bone density screenings, healthy cooking and exercise demonstrations, blood pressure checks, health related workshops and much more. In addition to Dr. Mandel's efforts, the nonprofit Osteoporosis Walk Foundation was formed with a board of several community leaders.

The annual run/walk is held each year during National Osteoporosis Week to highlight the importance of exercise and increase awareness of the debilitating effects of the disease. This year event coordinators reported more than 300 participants ran or walked while another 150 volunteers staffed the information

booths inside the civic center. Honorary celebrity co-chairs Kim Scott and Kim Wheeler were on hand along with special appearances by Mrs. Ohio Carrie Layne and Moondog, mascot for the Cleveland Cavaliers. The City of Independence Police and Fire Departments set-up safety displays, a special "Kids Strong Bones" activity area was sponsored by the Independence High School SADD Club and Dress Barn hosted a fashion show featuring couture for women with arthritis and osteoporosis.

Participants received an event t-shirt and an opportunity to have their own "Got Milk" mustache photo taken with souvenir frame. Plenty of calcium-enriched food samples were offered including ice cream, milk, orange juice, yogurt and more.

For more information on this event, visit www.walkforstrongerbones.com. Mark your calendar for next year's Run/Walk for Stronger Bones to be held May 20, 2006 at the Independence Civic Center. ■



Event founder **Dr. David Mandel** in the Independence Civic Center April 30.

ATTENTION MEMBERS:

If you have an event or related activity you would like staff to attend and potentially feature in *The Cleveland Physician*, please contact our offices at (216) 520-1000 ext. 320. Deadline for submissions is one month prior to publication. ■

Legal Hurdles to Boutique Practice Formation

W. Cliff Mull, Walter & Haverfield LLP

This article provides general information in summary form with the understanding that it does not constitute legal advice. If legal advice is required, the services of competent professional counsel should be sought.

Physicians dissatisfied with the current state of traditional medical practices are considering turning to smaller, boutique practices. This article addresses the legal and contractual issues in forming a boutique practice, including (1) Medicare assignment and limiting charge rules, (2) Provider contracts with private payors, and (3) State insurance law.

Background on Boutique Practices

Boutique practices come in several models, but all offer greater access to and personal attention from the physician. The greater access or attention can include 24/7 access to the physician through telephone, pager or e-mail, same-day or no-wait appointments, house calls, and coordination of care with specialists or even physician attendance at specialist appointments. To provide this greater service, the physician typically limits the practice to around 600 patients and charge either a fixed periodic fee or a fixed fee per visit. Sometimes the fee covers primary medical services in addition to increased access.

Medicare Issues

Boutique practices must first address the Medicare assignment and limiting charge rules. The Medicare assignment rule requires participating physicians to accept the Medicare allowable as full payment for covered services and applies to most Ohio physicians due to state laws prohibiting Medicare balance billing. The limiting charge rule prohibits nonparticipating physicians from charging more than a percentage of the Medicare allowable.

In March 2002, some U.S. Representatives voiced concerns to the Secretary of Health and Human Services that charging a periodic fee and billing Medicare for office visits violated the assignment and limiting charge rules and falsely understated the actual charges billed to Medicare beneficiaries. Acknowledging the physician's claim that the fee was for noncovered services, the Representatives nonetheless contended that (1) some

services included under the fee, such as "coordination of necessary referrals," overlapped with covered services, and (2) it was inaccurate to characterize the fee as solely for noncovered services because the fee was a condition to receiving covered services. However, the Secretary concluded that since physicians have the discretion to choose which patients to accept and the limiting charge provisions do not directly affect charges for noncovered services, the periodic fee did not violate Medicare law so long as it was truly for noncovered services.

Two years later, the Office of Inspector General stated that participating providers could charge Medicare beneficiaries extra for items and services not covered by Medicare without violating terms of their assignment. However, if participating physicians request any payment besides copays and deductibles for covered services, they may be liable for substantial monetary penalties and exclusion from Federal health care programs. For example, the OIG alleged that a physician violated his assignment agreement by charging beneficiaries an annual fee for a boutique practice. The physician argued that the fee was for noncovered services such as (1) coordination of care, (2) a comprehensive assessment and plan for optimum health, and (3) extra time spent on patient care. However, the OIG concluded that at least some of the contracted services were covered services. The physician agreed to pay a settlement and stop offering these contracts.

The OIG also stated that the penalties and exclusion apply to nonparticipating providers, regardless of an assignment agreement. Consequently, a boutique practice should clearly delineate and document the noncovered services the fee covers to avoid violating Medicare law, or choose not to see Medicare beneficiaries or "opt out" of Medicare completely.

Private Payor Issues

A physician considering a boutique practice must review contracts with private payors since many contain provisions similar to the Medicare assignment and limiting charge rules or require a physician to provide enrollees the same level of treatment given to the physi-

cian's other patients. A physician will need to extensively review current provider contracts to determine if (1) the proposed practice model would breach the current contracts, (2) it is possible to structure the proposed practice to fit within the current contracts, or (3) it will be necessary to terminate the current contracts.

State Insurance Law Issues

Finally, a boutique practice must steer clear of state insurance laws. Insurance involves the reallocation of risk from the purchaser of the policy to the insurer. In exchange for a premium, the insurer assumes the risk that a loss or event will occur. A corporation offering insurance is subject to regulation, including monetary reserves and rate regulation. Although the Ohio Department of Insurance has not yet challenged a boutique practice, other states have claimed that a boutique practice operates as an insurer by offering medical services in exchange for a periodic fixed fee. Essentially, the states contend that the boutique practice assumes the risk that the fixed periodic fee will not be sufficient to pay the costs of the medical services covered by the agreement between the patient and the boutique practice. For example, Washington issued two proposed advisories stating that arrangements where the physician provides similar or equivalent medical services as those covered by health insurance for a fixed periodic fee transfer risk and result in insurance agreements which physicians cannot offer without a certificate of registration. This state action, along with similar actions in Florida, New Jersey, and New York, show the potential dangers of including medical services in a periodic fee charged by a boutique practice. Since Ohio has not issued formal guidance, a physician should work with legal counsel to structure the arrangements and possibly seek guidance from the Ohio Department of Insurance to avoid being viewed as insurer.

Conclusion

Boutique practices must comply with Medicare law, provider contracts, and state insurance law. HHS and the OIG have stated that the fee charged by

(Continued on page 18)

Understanding Health Savings Accounts: Weighing the Benefits

By Tara DeVore, Associate, McDonald Hopkins Co., LPA

Health Savings Accounts (HSAs) exploded in popularity since their inception in 2004 when Congress, through the Medicare Modernization Act of 2003, added Section 223 to the Internal Revenue Code. Their popularity has been fueled in large part by the various benefits linked to creating and maintaining them. HSAs work as follows: An individual purchases, through an employer or otherwise, a high deductible health plan with a minimum deductible of \$1,000 for self-only coverage (\$2,000 for family coverage) and a maximum out-of-pocket limit of \$5,100 for self-only coverage (\$10,200 for family coverage). The premiums for these high deductible health plans are considerably less than traditional healthcare coverage because of the reduced risk to the insurance company. The premise underlying the HSA theory is that the premium savings, or at least some portion of it, is contributed, by the employer or the employee, to an HSA on a tax-free basis. Once contributed, the funds grow tax-free and are even distributed tax-free when done so for qualified expenses.

The ideal HSA arrangement exists where the individual contributes the maximum amount (generally the amount of the annual deductible) on an annual basis to the HSA and is relatively healthy or is otherwise able to permit the assets in the HSA to grow as opposed to utilizing them for healthcare expenses. Although the concept will work well for some, thereby providing additional funds for use during retirement, as with most everything else, the system is not flawless. There are some inherent implications that may impact physicians. These implications are rooted in the fact that HSAs, like all consumer-driven health care products, are intended to give patients more control over their treatment and payment options. One consequence is that patient care may be compromised if patients make health care decisions which are driven by cost alone. Additionally, patients with high deductible health plans may pose a larger collection risk on physicians than those with more traditional coverage.

The entire HSA system is designed, at least in part, to empower individuals with the ability to become more involved in their own health care decisions. The nature of an HSA is such that the individual assumes a certain amount of risk because of the high deductible in the coverage required in order to have an HSA. Assuming, for the sake of argument, that a particular patient has a \$1,000 deductible and a fully funded (\$1,000) HSA. Further, the patient's physician advises him that he should undergo a particular test, which is certainly not covered by the first dollar coverage of his high deductible policy as preventative care. At this point, the patient has a decision to make. He can have the test and pay for its cost either out of his pocket, or out of his HSA. He can also decide not to have the test and therefore not incur an expense he would be directly responsible for as part of his deductible.

The intent of Congress in creating HSAs was not to encourage individuals who need medical treatment to deny themselves such treatment. Nevertheless, there are, and will continue to be, those individuals who for one reason or another feel that a recommended procedure or treatment is unnecessary and, driven primarily by cost, will opt not to incur the expense. Under these circumstances, the system is designed, albeit unintentionally, to encourage non-physician patients to make healthcare decisions which were traditionally only made by appropriate medical personnel.

Along these same lines is the case where the patient has high deductible coverage and an HSA that is either underfunded or not funded at all. In this case, although the patient may wish to proceed with the recommended treatment or test, he is aware that he does not have the funds to cover the portion that will be his responsibility as a result of the high deductible. In these circumstances, as HSA opponents argue, the system denies the patient access, or the ability, to obtain appropriate or quality health care.

In either situation, it may be necessary for physicians to consider obtaining

waivers from those patients who opt not to receive a recommended medical treatment, regardless of the patient's reason for doing so. The waivers would serve as an attempt to protect the physician from future medical malpractice claims that are a direct or indirect result of the patient not receiving the recommended treatment. At the very least, impeccable notes should be in the chart that the treatment was in fact recommended to, and subsequently declined by, the patient.

Another consideration for physicians who have patients who participate in high deductible health plans and coordinating HSAs, is the billing methodologies employed by the particular insurance company. In most instances, insurance companies who provide products consisting of a high deductible health plan and coordinating HSA do not pay the provider directly. Rather, the patient is billed by the physician after the insurance company has processed the claim for the amounts the patient owes as part of his deductible. Thus, the patient with the underfunded HSA becomes more of a collection risk to the physician than does a patient with traditional coverage or a funded HSA. Even when the patient has a sufficient amount in the HSA to cover a particular expense, where the patient is billed directly by the physician, it remains up to the patient to pay the bill. Therefore, collection may still be a problem regardless of any amount held by the patient in their HSA. Ultimately, outside of completely uninsured patients, patients who are covered by an HSA arrangement and who are required to pay the provider directly, may create more of a collection risk for physicians than do other types of patients.

Although it will be some time before we see whether the benefits of an HSA arrangement outweigh the potential consequences for both patients and their providers, for now, physicians should at least be aware of the consequences that may directly impact them as a result of their patients participating in this type of an arrangement. ■

AMC/NOMA Board Discusses DOQ-IT Project

Dr. Alice Stollenwerk Petrusis, Medical Director for Ohio KePRO provided a presentation to the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) board of directors in April on the history of the quality improvement organizations (QIOs — formerly peer review organizations or PROs — such as Ohio KePRO and the Eighth Scope of Work (SOW) — which includes the Doctor's Office Quality Information Technology (DOQ-IT) project.

The 8th SOW will run from 8/05 to 8/08. Ohio KePRO is to focus on quality and review in long-term care, home health, hospital, and outpatient physician offices. Dr. Petrusis mentioned that the Doctor's Office Quality-Information Technology project is a significant piece of the next CMS contract and SOW for Ohio KePRO. Specifically, Ohio KePRO and other QIOs are to: promote adoption of electronic health records, promote workflow changes as related to population management/patient self-management, and promote data reporting to a clinical warehouse. Down the road, the QIOs will probably be looking at pay for performance, and public reporting for nursing homes, home health and hospitals. CMS would maintain the Web site and there would be voluntary submission. It is distinctly possible that in the future there may be a move to provide a similar type of report for physicians.

At present Ohio KePRO is adding to their staff to implement the DOQ-IT and they are building stakeholder partnerships. They are trying to get letters of support, build their capacity, conduct pilots, and develop the tools to implement the program. Ohio KePRO will

assist with vendor selection, vendor relationships, project management, support for reporting and data submission. This project is to be wholly funded by Medicare. The goal is to reduce costs, assist in managing patient flow, help a practice gain efficiencies, and provide access to charts. She briefly outlined how they were obtaining their DOQ-IT participants — through an application process, gaining a practice profile, a workflow assessment, signing an agreement and being accepted into the DOQ-IT.

The AMC/NOMA board wanted to know if Ohio KePRO planned to provide physicians with a list of vendors along with a comparison of their various services. In addition, the board asked if this list of vendors would include any comments from Ohio KePRO relative to the qualifications of the vendor. Ohio KePRO staff responded that CMS is looking into a certification of vendors and they are looking into interoperability issues. The board members stressed the point that if a physician were to express an interest in the DOQ-IT, it would be very important for the physicians to receive information which clearly showed what the vendor can offer and whether or not the vendor's product can interface with other established IT programs. Small practices are in fact the most vulnerable and can least afford to make a mistake in their vendor choice. There would have to be some distinct evaluations done of these vendors and physicians would need to know that they were making the right choices.

The staff from Ohio KePRO indicated that they are operating as "vendor neutral"; however, they do have data on specific vendors. There are also Web sites

available that contain data on vendors that Ohio KePRO could point to for information. The AMC/NOMA board also noted there are a number of hospitals in the Northeastern Ohio area, which encompasses the AMC/NOMA membership region, that either have or are in the process of deciding which vendor to utilize within their institutions — and their choice could have an impact upon the vendor choice of physicians in the area. Ohio KePRO staff indicated there are many other parts of the state that have not implemented electronic health records to the degree that has already taken place in Northeastern Ohio.

Based on the AMC/NOMA board review of this issue, it was clear there are some real concerns about the process outlined for choosing a specific vendor. In addition, because there are already several hospitals in Northeastern Ohio that have either implemented or are in the process of implementing EHR with a particular vendor, it is probably best that the physician practices in this region wait until their hospital has chosen a vendor prior to considering one for their office to assure interoperability. Therefore, the AMC/NOMA board opted not to provide a letter of support for the project at this time. Although the AMC/NOMA board decided not to provide a letter of support for the DOQ-IT project, we have invited Ohio KePRO to periodically submit articles regarding the project to the *Cleveland Physician* magazine to keep physicians in our area apprised of their progress with this concept.

For more information on the board discussion, contact Ms. Elayne R. Biddlestone at the AMC/NOMA offices at (216) 520-1000, ext. 321. ■

The Board of Directors recently approved changes to The Academy of Medicine Cleveland/Northern Ohio Medical Association Bylaws. ***In accordance with Article VIII of the Academy Bylaws, the Board of Directors voted to publish the following proposed Bylaws amendment.***

Upon motion duly seconded, the executive committee recommends that the board of directors approve the following change to the AMC/NOMA bylaws:

Section 4. RULES OF ORDER.

"All meetings of the AMC/NOMA, the Board of Directors, and committees shall be conducted in accordance with parliamentary procedure as prescribed in the current edition of ~~Davis' Rules of Order~~ ROBERTS' RULES OF ORDER."

Medical Matters In Brief

Center for Medicare and Medicaid Services (CMS) announces National Provider Identifier (NPI) changes.

CMS has announced the availability of a new identifier for use in standard electronic health care transactions. The National Provider Identifier (NPI) will be the single identifier for health care providers following the phase-out of provider identifications numbers, or PINs. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers with multiple health plans. Many health plans, including Medicare, Medicaid, and private health insurance issuers, and all health care clearinghouses must accept and use NPIs in standard transaction by May 23, 2007. Small health plans have until May 23, 2008. After those dates, health care providers may use ONLY their NPIs to identify themselves in standard transactions. Between May 23, 2005 and January 2, 2006, Medicare claims processing systems will accept an existing PIN and reject claims with only an NPI. Beginning October 2, 2006 and through May 22, 2007, Medicare systems will accept and existing PIN and/or an NPI. This will allow for 6-7 months provider testing before only an NPI is accepted. As of May of this year, physicians may apply online for their NPI. Paper applications will be accepted after July 1, 2005. For more information, please refer to the following: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

The NUCC invites public comment on proposed changes to the CMS-1500

The National Uniform Claim Committee recently announced the opening of a 45-day public comment period, ending July 25, 2005, for the changes made to the 1500 Professional Claim Form to accommodate the NPI. The NUCC is conducting this final survey to better understand the timelines and transition issues surrounding implementing the changes to the 1500 form. Survey results will be reviewed at the next NUCC meeting on August 10, 2005 in Chicago. At www.nucc.org/draft1500/ you will find a link to the survey, a copy of the draft 1500 claim form and explanations for the proposed changes.

Pennsylvania Study Proves Defensive Medicine Widely Practiced

According to a study published in the June 1, 2005 issue of the Journal of the American Medical Association (JAMA), the practice of defensive medicine is wide-

spread among the 824 Pennsylvania physicians who participated in the study funded by the Pew Charitable Trusts. Study participants were chosen in the specialties most frequently involved in litigation: emergency medicine, general surgery, neurosurgery, obstetrics and gynecology, orthopedic surgery and radiology. Of these, 93 percent reported engaging in defensive medicine — a practice that has been shown to lead to higher costs, lower quality of care and less access to services. "Assurance behavior" such as ordering tests, performing diagnostic procedures, and referring patients for consultation, was very common (92%). Avoidance of procedures and patients who were perceived to elevate the probability of litigation was also widespread. Forty-two percent of respondents reported that they had taken steps to restrict their practice in the previous 3 years, including eliminating procedures prone to complications, such as trauma surgery, and avoiding patients who had complex medical problems or were perceived as litigious. Defensive practice correlated strongly with respondents' lack of confidence in their liability insurance and perceived burden of insurance premiums.

Final HIPAA Portability Regulations released

Effective for plan years beginning on or after July 1, 2005, the final HIPAA portability regulations were released to clarify and revise the 1997 interim rules relating to pre-existing condition exclusions, creditable coverage, special enrollment and excepted benefits. The final regulations do not modify significantly the April 1997 interim rules but instead add several clarifications to the general framework already established. To note: In these final regulations, a preexisting condition exclusion continues to be defined broadly, as any limitation or exclusion of benefits based on the fact that the condition was present before effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received. To read the Federal Register report of HIPAA Portability regulations, go to www.dol.gov/ebsa/regs/fedreg/final/2004028112.htm.

Study finds physician supply increases in states with malpractice lawsuit award caps

According to a new study from HHS' Agency for Healthcare Research and Quality (AHRQ), states that have placed

caps on malpractice lawsuit awards have seen a significantly larger growth in the number of practicing physicians than those states without such caps. Study authors found that specific dollar amounts of the caps also had an impact on the supply of physicians, especially in rural areas. Caps generally increased physician supply by 2 to 3 percent three years after adoption, and after accounting for several other variables that impact physician supply detailed in the report. In addition, the authors accounted for the effects of four other state malpractice reforms, including collateral source rule reform, prejudgment interest reform, joint and several liability reform and caps on punitive damages. To read the full text of the study, go to <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.250>.

OSMB welcomes new executive director

Richard A. Whitehouse, Esq. was named Executive Director of the Ohio State Medical Board effective May 1, 2005. A native of Warren, Ohio, Mr. Whitehouse earned a B.A. in Economics from Youngstown State University and a J.D. from The University of Akron. In 1987, he joined the Office of the Franklin County Prosecuting Attorney as an Assistant County Prosecutor and later served as director of that office's Economic Crime Unit. In 1992, he was appointed Deputy Chief Elections Counsel for the Ohio Secretary of State where he served prior to joining the Office of Inspector General in 1995, where he served as Chief Legal Counsel and Deputy Inspector General before coming to the OSMB. ■

CLASSIFIEDS

PHYSICIAN OPPORTUNITIES - Full- or Part-Time in medicine, general surgery, cardiothoracic surgery, pediatrics and OB/GYN. \$135-250K, never on call, paid malpractice. Physician Staffing, Inc., 30680 Bainbridge Rd., Cleveland, OH 44139. (440) 542-5000, Fax: (440) 542-5005, E-mail: medicine@physicianstaffing.com

PREMIUM MEDICAL SPACE AVAILABLE at Mentor Medical Campus in Lake County. Shared waiting room and common areas. Private reception, exam rooms (4) and office. Approximate size 1100 sq. ft. Excellent referral potential. (440) 205-5878 daytime, (440) 255-3226 evening.

FOR SALE: GOLD COAST CONDOMINIUM, totally renovated, 3 BR, 2 bath, dressing room, office, 2 balconies, 2 garage spaces. Exceptional amenities. Available August 2005. Appointments (216) 221-2315

Legal Hurdles to Boutique Practice Formation

(Continued from page 14)

boutique practices does not violate Medicare law if the fee is only for non-covered services. A physician must review his provider contracts to make sure that a boutique practice model will not violate the terms of the contracts, for example, by charging a fee for services covered by the patients insurance. Finally, a boutique practice should not cover medical services under a periodic fee to avoid violating state insurance law. Therefore, it is essential that the fee charged by a boutique practice is only for non-medical services that are not covered by Medicare and possibly private insurers. Since the demarcation between medical and nonmedical services is subjective, consultation with one's attorney prior to transitioning to a boutique practice is prudent.

Editor's Note: *The AMC/NOMA Retainer Practice Policy, adopted April 2004 and reprinted in full in the July/August issue of Cleveland Physician of the same year, in part holds that "Individuals are free to*

select and supplement insurance for their health care on the basis of what appears to them to be an acceptable tradeoff between quality and cost. Retainer contracts, whereby physicians offer special services and amenities to patients who pay additional fees distinct from the cost of medical care, are consistent with pluralism in the delivery and financing of health-care. However, they also raise ethical concerns that warrant careful attention, particularly if retainer practices become so widespread as to threaten access to care." The above referenced policy is meant to serve as an ethical guideline. If any AMC/NOMA member has a question referable to this policy, please contact E.R. Biddlestone at the AMC/NOMA offices. ■

Bibliography

1. John R. Marquis. Legal Issues Involved in Concierge Medical Practices, *Health Lawyers Weekly* (February 18, 2005).
2. Letter from Representative Henry Waxman et al. to Tommy G. Thompson, Secretary of the Department of Health and Human Services (March 4, 2002).

3. Letter from Tommy G. Thompson, Secretary of the Department of Health and Human Services, to Representative Henry Waxman (May 1, 2002).
4. Acting Principal Deputy IG Dara Corrigan, OIG Alerts Physicians About Added Charges for Covered Services: Extra Contractual Charges Beyond Medicare's Deductible, Coinsurance: A Potential Assignment Violation, *OIG Alert* (March 31, 2004)

MEMBERSHIP REMINDER

AMC/NOMA 2006 Dues

Statements will be mailed in

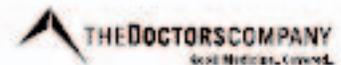
August. Dues payments can

be made by check, Visa

or MasterCard by mail or phone

to (216) 520-1000 ext. 309.

CAN A MALPRACTICE INSURANCE COMPANY BE THIS PROTECTIVE?



In a world where insurance companies often choose settlements instead of aggressive defense, The Doctors Company prides itself on vigorously putting your reputation first. That's why, when plaintiffs filed over 1,000 breast implant claims against physicians covered by The Doctors Company, none resulted in verdicts against the doctors. Protection both comforting and ferocious—what else would you expect from a medical malpractice insurance company called The Doctors Company? To learn more, visit us on the Web at www.thedoctors.com or call us at (800) 862-0375.

Involve your patients in the billing process

Most patients are willing to take the time to assist you when having a problem with payers, and many savvy practices are using this willingness to their advantages.

What does this mean for you?

If you are frustrated with billing issues, get your patients to help you:

- Carbon copy patients on your appeal letters. If you are appealing a claim that was denied for lack of medical necessity, for example, send the letter to the patient, too. This shows him/her that you are working on his/her behalf, and prompts him/her to call his insurance carrier if for no other reason, out of fear that the pending balance may be his/hers. If you have to transfer a balance to the patient, attach a note that outlines the efforts you made to get the claim paid. The patient will be much more apt to pay you if, he/she sees you have been on his/her side.
- Be a patient advocate. Most billing rules have nothing to do with the practice policy. For example, it is not the practice that establishes co-payment and deductible amounts or decides what the insurer will and won't cover. Put yourself in a patient advocacy role. When you ask for your co-payment, state: "You insurance company expects us to collect your co-payment." When you ask for a balance applied to a deductible, show the patient his/her explanation of benefits instead of simply saying, "You owe us \$100."
- Conduct three-way conference calls. If the insurance company has pended the claim for "additional information needed from the patient," call the patient. Once you get him/her on the phone, explain the denial and ask if he/she would be able to speak with a representative of his insurance company right then

and there. While keeping him/her on the line, call the carrier and explain that you have the patient there to respond to its inquiry. After the patient gives the carrier the information, wait until he/she hangs up and ask the adjudicator when you should expect payment now that the carrier has the additional information it requested.

- Revise your statement. Many practices send out practically incomprehensible statements. They are full of acronyms and cryptic messages and often reflect no balance at all. Establish a "patient advocacy group" within your practice to help you tackle a statement-improvement project, and consider using them for other similar projects. Use the "Patient Friendly Billing" initiative as a key resource, at www.patientfriendlybilling.org. ■

Discounted Tri-C Class List for AMC/NOMA Members and Staff

The AMC/NOMA is partnered with Cuyahoga Community College's (Tri-C) Center for Health Industry Solutions to offer certification courses and continuing education unit seminars at discount prices for members and staff.

DAY COURSES - Earn Certification and CEUs through Cuyahoga Community College's Medical Practice Management Seminars. CEUs are offered from AAPC, AHIMA, and PMI depending on the course content.

- **ADVANCED CPT CODING CONCEPTS (.4 CEU)**
Nov. 2 8:30a-1:00p
Corporate College East Price \$120.00
- **ADVANCED ICD-9-CM CODING CONCEPTS (.4 CEU)**
Nov. 16 8:30a-1:00p
Corporate College East Price \$120.00
- **CCA CODING EXAM REVIEW (.5 CEU)**
Oct. 29 9:00a-2:30p
Corporate College East Price \$135.00
- **CCS CODING EXAM REVIEW (.5 CEU)**
Nov. 19 9:30a-2:30p
Corporate College East Price \$135.00
- **CCS-P CODING EXAM REVIEW (.5 CEU)**
Dec. 3 9:30a-2:30p
Corporate College East Price \$135.00

- **CERTIFIED MEDICAL CODER (2.8 CEU) by PMI**
Sep. 13, 20, 27, 8:30a-4:30p
Corporate College East Price \$800.00
Oct. 4, 11, Nov. 15,
(no class 22 due to Holiday),
29, Dec. 6, 13, 20 8:30a-4:30p
Corporate College East Price \$800.00

EVENING COURSES - Receive Certificates of Completion for accelerated medical practice courses taught by expert local instructors at Tri-C Campuses

- **CUSTOMER SERVICE WORKSHOP FOR HEALTH CARE**
Price \$74.00
CCE-August 8 (Monday) 6:00-9:00 pm
- **MEDICAL TERMINOLOGY/ANATOMY & PHYSIOLOGY (3 CEU)**
Price \$216.00
Corporate College East
August 31-Oct. 12
(Monday & Wednesday) 6:00-8:30 pm
Corporate College Westlake
Sept. 6-Oct. 13
(Tuesday & Thursday) 6:00-8:30 pm
Corporate College Westlake
Nov. 1-Dec. 13
(Tuesday & Thursday) 6:00-8:30 pm
Corporate College East
Nov. 2-Dec. 14
(Monday & Wednesday) 6:00-8:30 pm

- **SURGICAL CODING/MODIFIERS/HCPCS CODING FUNDAMENTALS (4.8 CEU)** Price \$507.00
West Campus
Sept. 26-Nov. 30
(Monday & Wednesday) 6:00-8:30 pm
Corporate College East
Oct. 11-Dec. 18
(Tuesday & Thursday) 6:00-8:30 pm
- **MEDICAL BILLING REIMBURSEMENT (2.4 CEU)** Price \$282.00
Corporate College East
Oct. 26-Dec. 21
(Wednesday) 6:00-9:00 pm
- **CUSTOMER SERVICE WORKSHOP FOR HEALTH CARE (.35 CEU)**
Price \$113.00
Corporate College East
Nov. 3
(Thursday) 6:00-9:30 pm

Members and/or their staff will need an exclusive AMC/NOMA course number to register and obtain the discount. For course numbers, phone Linda Hale at (216) 520-1000, ext. 309, or e-mail lhale@amcnoma.org ■

comfortable | confident

There's a fine line between what you **know** and what you **feel**.

Chances are, you've had financial plans for your practice and personal wealth in place for years. And you're pretty comfortable with them. But can you feel confident they're the most effective ones available?

McDonald Financial Group's truly integrated approach can make the difference between what works and what works harder for medical professionals. Because your goals become our central focus, we develop a unique and broader perspective that allows us to meet them by pulling everything together. Banking, investments, trust, and retirement planning. True integration, established through a single provider. One day everyone may offer it, but you'll find it with us, today.

Achieve anything.

Call Keith Kormos at 216-563-2424 or visit www.Key.com/MFG to learn more.



McDonald Financial Group is a program offering banking and trust from KeyBank National Association, Member FDIC, securities from McDonald Investments Inc., Member NASD/NYSE/SIPC, insurance from KeyCorp Insurance Agency USA Inc. and other affiliated agencies, and other services from KeyCorp banking and non-banking subsidiaries.

Securities and insurance products are:

**NOT FDIC INSURED • NOT BANK GUARANTEED • MAY LOSE VALUE • NOT A DEPOSIT
NOT INSURED BY ANY FEDERAL OR STATE GOVERNMENT AGENCY**

©2004 KeyCorp